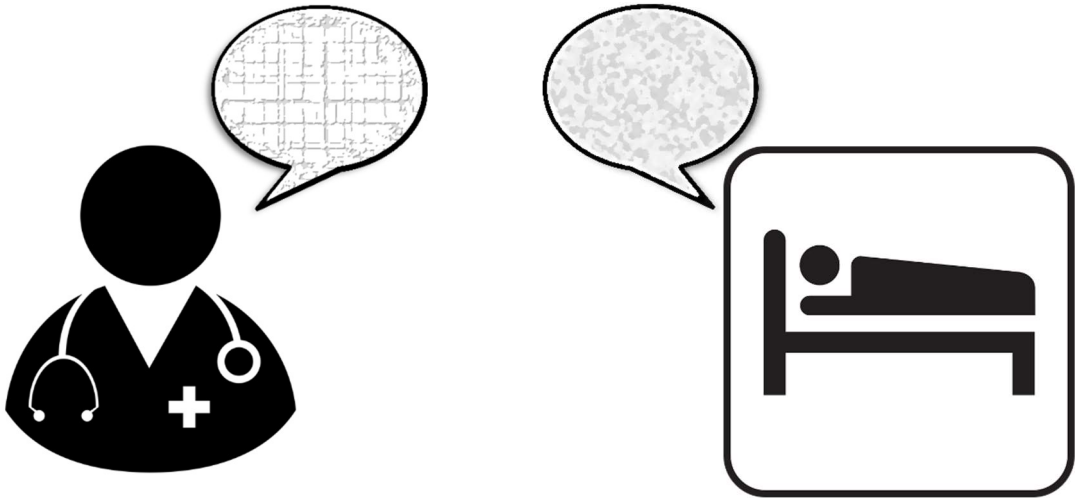
Communication: A High Risk Procedure and the Task of Teaching Others



Internal Medicine Grand Rounds

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This is to acknowledge that Caitlin Holt Siropaides, DO has disclosed that she does not have any financial interests or other relationships with commercial concerns related directly or indirectly to this program. Dr. Siropaides will not be discussing off-label uses in his/her presentation.

Biosketch

Dr. Caitlin Holt Siropaides is an Assistant Professor of Internal Medicine and Palliative Care at UT Southwestern Medical Center. She graduated Philadelphia College of Osteopathic Medicine in 2012, and subsequently completed her internal medicine residency and palliative care fellowship training at the University of Pittsburgh Medical Center in 2016. Throughout her education at UPMC, she received specialized communication skills training under the direction of Dr. Robert Arnold, which instilled in her a passion to improve the quality of clinician communication with patients and families. She found the structured approach to communication skills training very powerful and came to UTSW with a significant drive to share that experience with others. She led an institutional initiative to train 24 multispecialty care providers in a procedural approach to communication skills, with 12 faculty completing an intensive Faculty Development course to provide courses at UTSW.

Purpose and Overview

Communication skills are essential to medical practice, though these skills are often acquired through trial and error or observation of one's peers and supervising physicians. National organizations representing a broad cross section of subspecialties are calling for improved patient-physician communication in the context of serious and life-limiting illnesses. Poor communication is linked to physician burnout, increased risk of malpractice suits, and patient dissatisfaction. When clinicians communicate effectively, patients retain more information and have more trust, improved outcomes, and a better quality of life. Extensive research shows that physicians often feel uncomfortable having difficult conversations, and that communication skills can be improved through education. While there are nuances to the use of clinician-patient communication frameworks, the general concepts are consistent: Provide clear information, recognize and respond to emotion, elicit patient values, and provide patient-specific medical recommendations based on their values. When provided with a defined structure for approaching difficult conversations, evidence shows that most physicians immediately feel more confident and are eager to learn more. When experienced clinicians can recognize and identify the skills they use to communicate effectively with patients, this in turn enhances the learning environment for peers and trainees.

Educational Objectives

1. Explore the importance of patient-clinician communication
2. Describe a structured approach to clinician communication skills
3. Examine a teaching method for communication skills education

Introduction

Communication encompasses a broad scope of our daily interactions. It includes not just the words we use, but how they are interpreted, how we interact with others, and our body language. Experts in the field of communication use several buzzwords to describe the ideal interaction between patients and clinicians: goals of care, shared decision-making, motivational interviewing, patient centered communication, and values based recommendations to name a few. Each of these terms is subtly different, but they share many qualities and require a common skill set (1, 2). Though communication research began within the fields of oncology and palliative care, the concepts are applicable to all clinicians, regardless of specialty or patient population (2, 3).

Why is it "High Risk"?

Explore the importance of patient-clinician communication

Clinician communication is a vital part of the patient experience and can shape medical decisions that alter the trajectory of care. Several studies have shown that patients value communication with their clinicians. Early qualitative research in communication indicated that patients specifically valued the following in difficult conversations: straightforward and sensitive sharing of information and education, emotional support, accessibility, competence, inclusion of family, attention to patient's values, and support of patient decision making (4).

One study highlighted that greater than 90% of patients with advanced cancer want to be actively involved in conversations about their care and value frank, sensitive conversations about quality of life, prognosis, and treatment choices (Figure 1) (1). Patients' understanding of their health comes primarily from their communication with their medical providers. so the stakes are high if we are not communicating effectively (5).

Patients Want to Talk

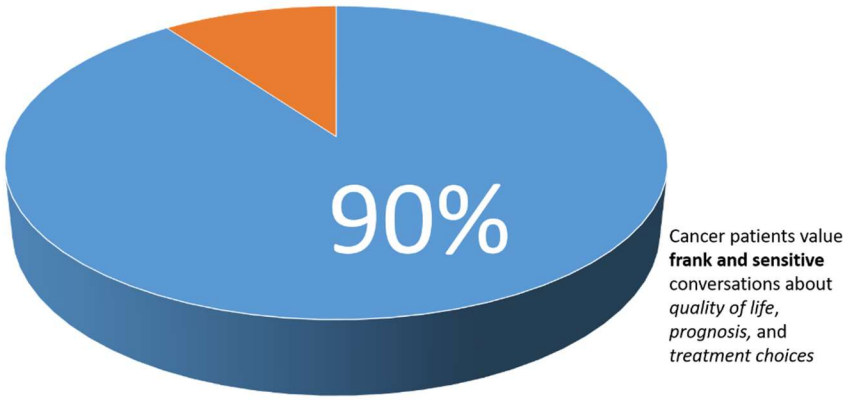

Figure 1 (1)

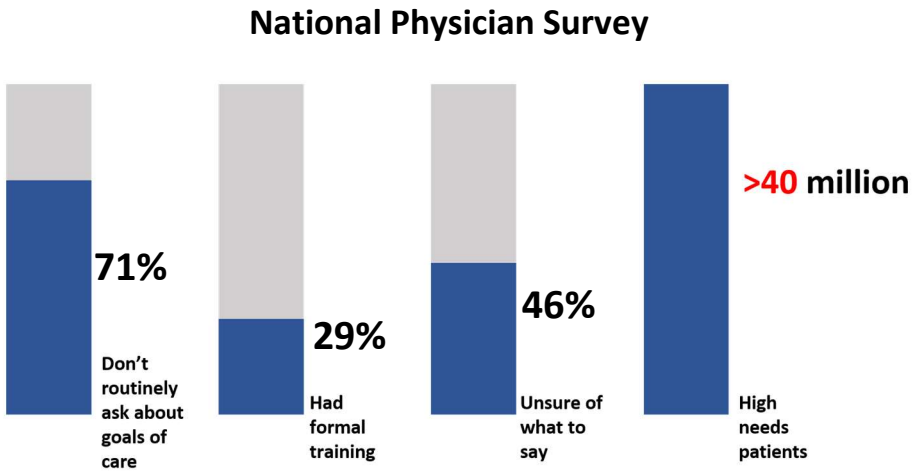

Figure 2 National Survey Conducted by The John A. Hartford Foundation, The California Health Care Foundation (CHCF), and Cambia Health Foundation (2016) Infographic from: communication-skills-pathfinder.org

Physicians often report discomfort and a lack of preparation for difficult conversations (Figure 2). In a recent national survey, the vast majority of responding physicians indicated that conversations about goals of care are important. However, 71% do not routinely ask about goals of care. Only 29% reported formal training in how to conduct goals of care conversations, and nearly half (46%) indicated they were unsure of what to say (6). These findings were consistent throughout all specialties. For example, 73% of nephrology fellows reported they were not taught how to communicate that a patient was dying (7). Given that there are currently more than 40 million patients living with serious illness in the United States who would benefit from conversations about goals of care and medical decision making (8), these responses are sobering.

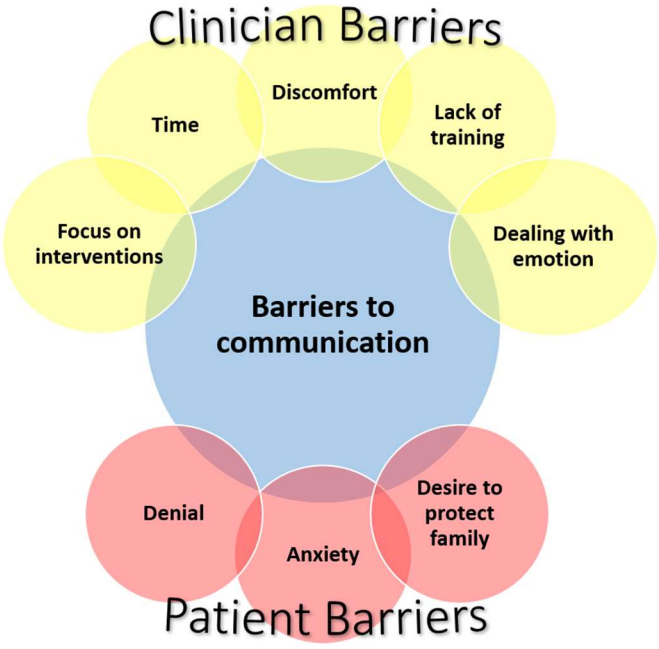

Figure 3

Several barriers to good communication stand between patients and their care providers. Clinician barriers include general discomfort, lack of time, lack of training, difficulty dealing with emotions, and a focus on specific interventions when discussing goals of care with patients (7). Clinicians commonly report particular discomfort with sharing prognosis and unfavorable information (9, 10). Some of that discomfort stems from a lack of specialized training in these tasks and a resultant reliance on what one has seen done before. Time is a precious resource, and many clinicians perceive that difficult conversations take more time than we can spare. As such, most clinicians focus critical conversations on decisions or interventions (e.g. code status) rather than patient values or emotions. Patient barriers include anxiety when receiving serious news, denial and a desire to protect family (Figure 3) (7).

These barriers can be burdensome and, as most clinicians can attest, difficult conversations are emotionally draining. There is evidence to suggest that poor communication and resultant conflicts with patient and families correlate with physician burnout. Further, a number of studies have shown a connection between lack of communication skills training and specific symptoms of physician burnout such as depersonalization, low perceived personal accomplishment, and difficulty in dealing with patients suffering (Figure 4) (11).

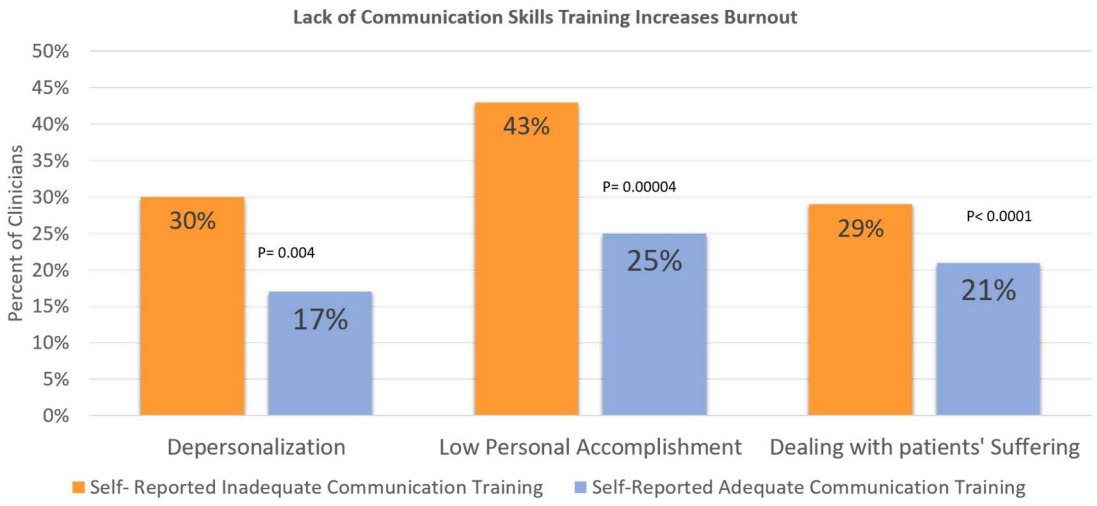

Figure 4

Poor communication also impacts risk of malpractice suits. The patient's decision to litigate is most often associated with a perceived lack of caring or collaboration in health care delivery. Among the most common reasons cited by patients for a perceived lack of care or collaboration were feeling that physicians devalued patient and/or family views, delivered information poorly, failed to understand the patient or family perspective, or deserted the patient (12).

Communication with patients is high stakes, as shown by the significant impact on patient and physician well-being, satisfaction and outcomes. There are many barriers, though patients are demanding improved communication and clear in their preferences.

Can Communication be a Procedure?
Describe a structured approach to clinician communication skills

We have reviewed the evidence to show the importance of communication: patients want it, and poor communication can impact physician burnout and patient outcomes. Many clinicians feel that talking with patients is instinctive and that their intuition should be sufficient to ensure effective communication, but the data suggests there are elements of good communication that can be missed with this approach (9).

Though communicating with patients is obviously a very personal experience, experts in the field of communication suggest treating difficult conversations as procedures. The Joint Commission created a 37-point checklist for central-line insertion, because standardizing practice is considered paramount to avoiding complications like infections or other medical errors (13). Given the high risk nature of communicating about serious illness, experts have similarly worked to establish "best practice" frameworks for difficulty conversations (14). This approach allows clinicians to avoid pitfalls of bad communication and to break complex processes into smaller, simpler steps that can be focused on individually. These frameworks exist for a variety of discussions including advance care planning, disclosing medical errors, breaking bad news, late or high-stakes goals of care discussions, responding to emotion, and providing prognostic information. Communication frameworks help us to improve upon our experiences, rather than lessening connections with our patients. Each framework has many steps and intricacies, though there are key concepts that are consistent throughout.

Step 1: Give a clear and concise headline

Studies show that up to 80% of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect (Figure 5) (5).

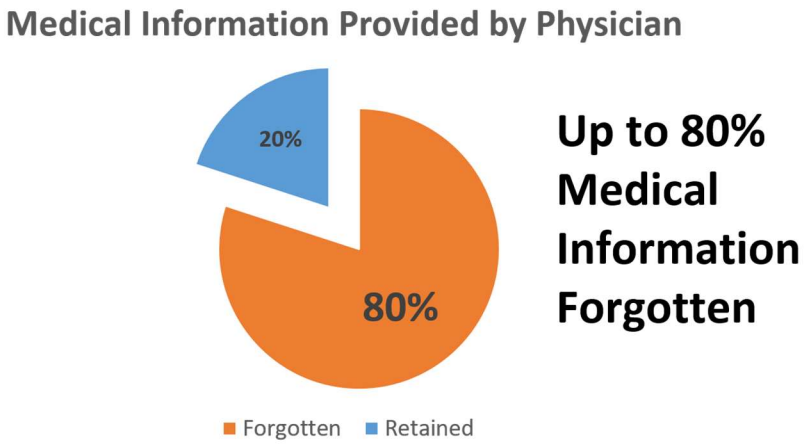

Figure 5 (5)

Clinicians' baseline tendency is to share comprehensive medical updates with the underlying assumption that patients need all of the available medical details in order to make informed medical decisions. Studies show consistently that, in ICU family meetings, the clinical team spends an average of 70% of the time talking and family only 30% of the time (Figure 6) (15, 16). In one study, clinicians began the meeting with monologue that averaged 4 minutes in length before patients or family spoke. Total duration of family meeting and physician monologue correlated with lower proportion of family speech (15).

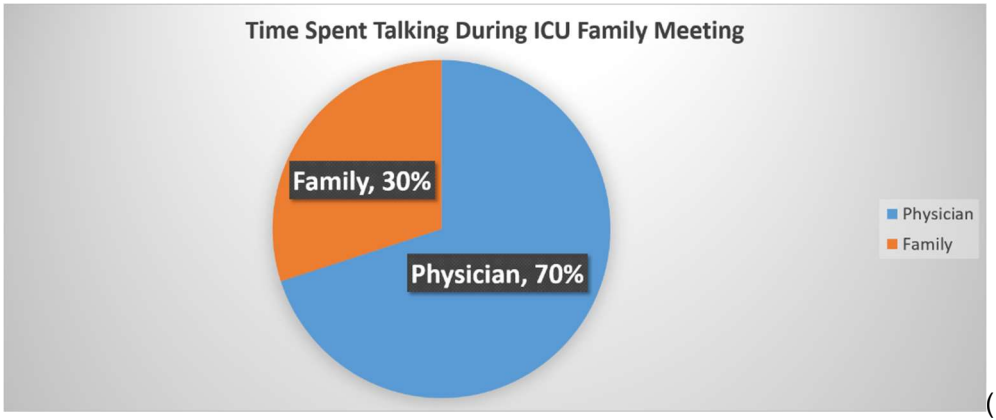

Figure 6 (15, 16)

Family satisfaction increases with the proportion of time that they spend talking, and there is no association between total time of conference and family satisfaction. Thus, clinicians do not need to have longer meetings, but simply prompt families to speak more. Patient and family speech is not only therapeutic but it also provides clinicians with more information to understand values, questions, and preferred plan of care (Figure 7) (15, 16).

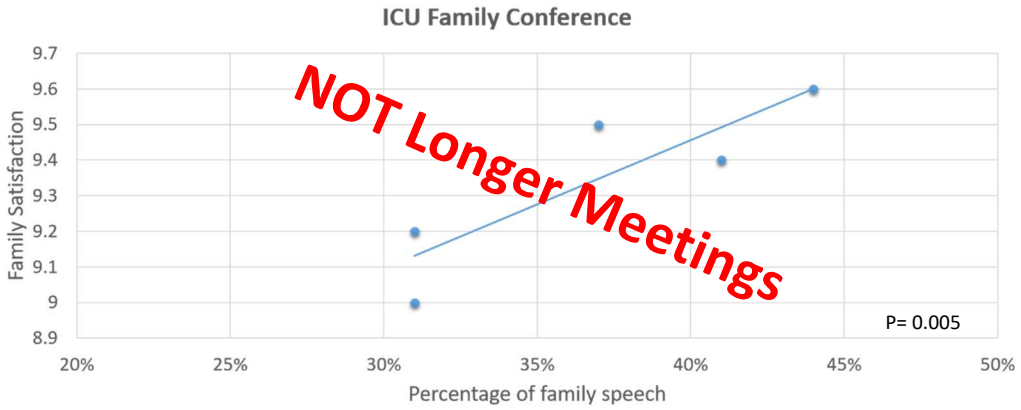

Figure 7 (15)

Patient satisfaction is significantly increased when communication is patient-centered with utilization of techniques such as partnership building, empathy, shared decision-making and consideration of patient goals and care preferences (16).

Step 2: Recognize and respond to emotion

Complex communication and difficult conversations are likely to produce an emotional reaction from a patient or family. Each communication framework involves emotion as a critical step in the process. Responding to emotion is crucial before one can move forward, as emotional processes occur faster than rational thought, and can significantly impact serious decisions and actions (17, 18). Pausing to address patient emotions can be difficult, as they are often masked by cognitive questions or may elicit emotions in the provider, but it should be equally as important as providing medical information. Research shows that just 40 seconds of emotional support from clinicians is associated with decreased anxiety in patients making difficult decisions (18). Patients also report improved satisfaction and trust in clinicians who respond to their emotions by expressing verbal empathy (Figure 8) (17, 19). These findings are not only applicable to serious illness but also in the primary care setting such as when discussing weight loss and hypertension (17).

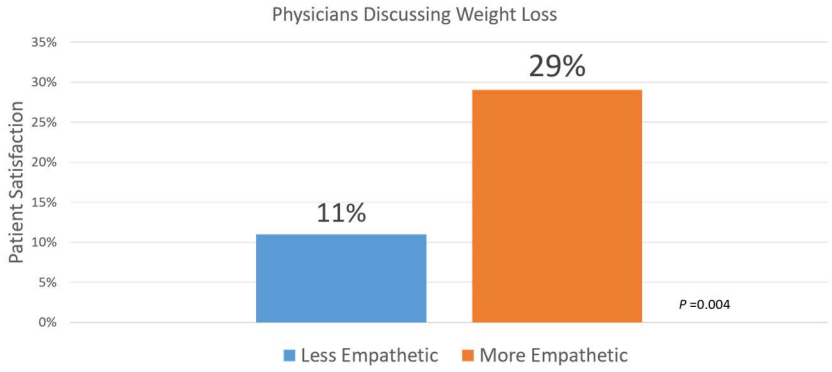

Figure 8 (17)

By responding to emotions first, providers can often decrease the emotional intensity enough to allow for more constructive conversation about values and decisions.

Step 3: Understand Values

As noted above, emotions can interfere with rational decision making and thus patient or surrogate decisions may not align with patient values. Similar to eliciting the history of present illness to determine a differential diagnosis, clinicians must elicit a "values history" to better determine an appropriate care plan to match their values. Our goal is to understand what the patient values about their life, what tradeoffs they are willing to make for those values, and what they define as an acceptable or unacceptable quality of life (7, 18). Often, responses are related to the patient's emotions, and thus further discussion about the reasoning behind those values is crucial. These concepts apply not just to end of life or high-stakes decisions but to management of issues such as weight loss, hypertension, dementia, diabetes, and congestive heart failure. This effort to understand a patient's values can provide a long-standing foundation for care decisions made throughout the course of a patient's illness (7).

Step 4: Make a recommendation

Respecting patient autonomy is often the primary motivation behind clinicians providing extensive information about treatment options, risks, and benefits, and then simply asking patients to make a choice. It is possible, however for clinicians to make recommendations on care and still avoid "paternalistic" roles. The majority of patients value physician recommendations, with most preferring shared-decision making (Figure 9) (20).

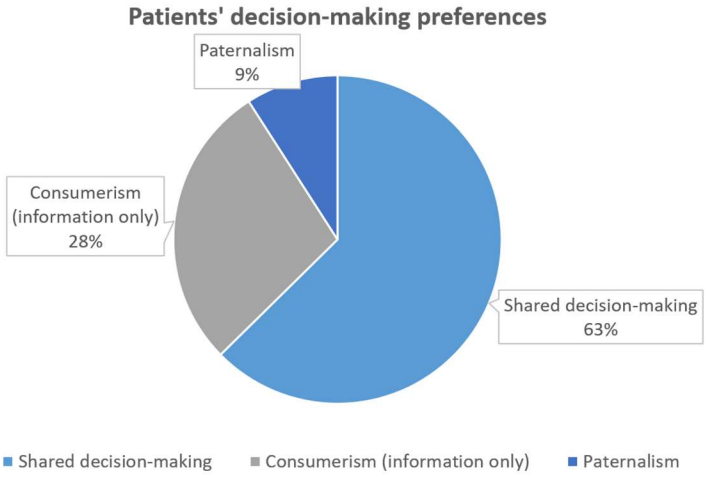

Figure 9

The concept of shared-decision making and patient centered care is to make a treatment plan that is unique and reflective of who the patient is and what they value (14, 18). In those recommendations, clinicians should emphasize that all pathways involve active treatment and explain that the difference is in what goal or outcome each treatment is likely to achieve. Qualitative studies have shown that many patients value their physicians' involvement in decision-making (4).

> *"It's beyond giving you all the information that you need to make a decision… it is just a sense that… this person really cares that we make the right decision for us. With a lot of them, … they put out all the information and say 'Well, it's your decision. Let me know.' But they should really be concerned that… they've done everything they can to help you make the best decision for you." --(Patient with cancer) (4)*

How a procedure addresses the barriers to patient-clinician communication

Recall that many clinicians are unsure of what to say in difficult conversations (6). Communication frameworks prepare the clinician for what may come next in a conversation. This improves confidence, encourages reflective practice, and prompts the clinician to involve the patient in each step of the process. Additionally, by acknowledging that emotion is a significant part of all difficult conversations, communication frameworks can prompt the clinician to consider the emotional impact of a conversation on an individual, increase recognition of emotional cues, and prepare the clinician for how to respond (7, 9, 14). Frameworks can also provide consistency across the care team. This consistency creates an opportunity for different clinicians to continue conversations over the course of several visits, thus increasing efficiency. Though this values-based approach may require more time to be invested at the start of difficult conversations, it most often saves time later in the process by avoiding confusion

about care plans that do not align with patients' hopes or expectations (14, 18). When clinicians only ask about specific medical decisions or interventions, patients may not fully understand their prognosis, may struggle with worry and distress, and may fail to plan for alternative outcomes. A focus on values can ensure that patients make decisions that are consistent with their values and can prompt them to involve family members in the conversation (7).

The Task of Teaching Others

Examine a teaching method for communication skills education

By having a cognitive framework with identifiable skills to reference during difficult conversations, we can more easily teach those skills to others (21). Communication training is applicable throughout all levels of learning, from undergraduate, to graduate and continuing medical education. The time-honored method of teaching medicine has been watching the expert, who is often considered the "sage on the stage". Research shows, however, that people learn by doing rather than watching. Procedural skill training has changed significantly over the past several decades, now including simulation practice and rules about supervision involving a "guide on the side". Communication training is undergoing a similar transition (21-23).

Institutions are responding to a serious need and demand for training new clinicians to cope with difficult communication. A cognitive framework helps us to improve, and it helps training clinicians apply a framework to what they are seeing which makes those experiences more meaningful (21, 23). The teaching method for standard medical procedures is based on progress in adult learning theory, behavioral change, and pedagogy. An example teaching method is broken down in Figure 10 with comparative steps of teaching communication skills.

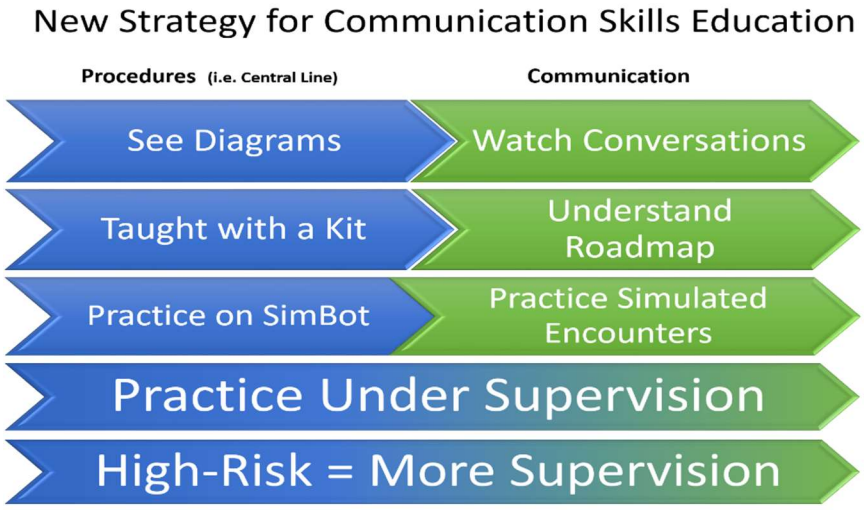

Figure 10 (21, 23)

Understand skills and observe

First, a learner studies diagrams and sees the procedure done by someone with proficient skills. Similarly, a learner should observe role models in specific communication procedures, such as breaking bad news. The experience of watching the expert, however, is not alone sufficient and would be similar to a person believing they can become a skilled golfer by watching Phil Mickelson play on TV. Thus, a key component to this step involves a debrief after the conversation to identify the particular skills utilized in order to maximize the learner's retention and ability to apply those skills in the future.

In order to adequately perform a debrief, both the educator and learner must be familiar with the cognitive framework for communication. This is comparable to learners being familiar with a central line kit, the necessary steps to complete the procedure, and the order in which to perform those steps.

Practice in safe environment

After the learner understands the necessary steps of the procedure, and has seen it done successfully, they are provided opportunities to practice in a low-risk environment and to prepare for various challenges. Evidence shows that simulated education results in behavior change that persists over time (21). While medical procedures are practiced in high or low fidelity simulation environments, communication skills practice most often occurs with simulated patients. The tenants are the same, however, emphasizing deliberate practice of specific skills in the procedure, with facilitator observation and direct feedback (22).

Practice with patients

Next, in both medical procedures and communication, learners must perform deliberate practice in real time, under direct supervision. The new strategy for teaching communication skills involves the educator serving as a coach who sets up the learner for a successful encounter. This technique, based on empirical work in learning sciences, incorporates learner engagement, goal setting, and reflective feedback (21). Regardless of the procedure, higher risk scenarios deserve more supervision with potential for intervention by an experienced clinician (23). The task of breaking bad news to a family with complex dynamics, for example, is comparable to the equally complex task of placing a central line in a patient with profound thrombocytopenia.

Trainees are not alone in this process of deliberate practice. Professional athletes undergo constant self-improvement and perform drills between "the big game", working closely with a coach to improve and refine their skills throughout their careers. In the same way, proficient clinicians can continue to improve their skill set with focused reflection on daily experiences through the help of their peers.

Communication training programs

Communication skills training programs were designed to provide the practice and tools needed to improve our skills. They are effective in changing clinician behaviors, as well as affecting patient outcomes. One NIH-funded study found that a 4-day workshop focused on small group skills practice with a simulated patient significantly improved oncology fellows' communication skills. In particular, participants acquired a mean of 5.4 skills involved in breaking bad news, with a significant increase in

accurately assessing patient perception, using clear and concise language, emotional attention, and verbal empathy. Additionally, they acquired a mean of 4.4 transitions skills (in having a goals of care conversation) including specific skills such as assessing patient understanding, values, concerns and responding to emotionally-based questions (22).

These training programs not only impact clinician behavior as discussed earlier, but can improve patient satisfaction, anxiety and trust. A recent prospective study confirmed prior findings that communication skills training improves patient and family satisfaction in ICU family meetings (24).

While we value patient experience, objective outcomes are also improved with communication skills training (25, 26). A notable study published in 2018 showed that patient-centered communication skills workshop utilizing didactic and small group sessions affected hypertension outcomes. The study provided training to primary care physicians and compared outcomes to a control group. The group of physicians who underwent the training had significant improvement in their communication skills, and subsequently their patients had significantly reduced systolic blood pressure, improved self-efficacy, and improved medication adherence in comparison to the physician control group's patients. The proposed theory is that improved physician communication can improve patient health literacy, trust in their provider, and provide an opportunity for questions or concerns about the treatment plan (26).

End of life outcomes are also shown to improve when clinicians are trained in communication skills. Orford et al (2017) studied outcomes for critically ill patients with life-limiting illnesses in the ICU before and after providers completed a 2-day, small group, simulated-patient communication skills course. The training significantly decreased 90-day frailty group readmission rates and 90-day mortality rates for patients with organ failure or cancer, which is suggested to be resultant from pursuing treatment plans concordant with patient's goals of care and minimizing aggressive interventions at end of life. The documentation of patient-centered goals of care discussions significantly increased both within 48 hours of ICU admission and for patients who died within 90 days of ICU admission (25).

These studies show that refining our communication skills improves not just physician and patient satisfaction and experience, but can significantly affect patient outcomes as well.

UT Southwestern Accomplishments

In a 2017 survey, UTSW Internal Medicine residents confirmed national consensus that trainees felt uncomfortable with goals of care conversations, and desired more training and supervision in communication skills (27). Over 60% of trainees reported that they had never or rarely had direct observation of their goals of care discussions, and consequently 75% reported they never or rarely received direct feedback about those discussions. In 2017, Sekar et al. piloted a communication curriculum at UTSW, which introduced a procedural approach to goals of care conversation with small group case-based discussions. Ninety-one percent of residents felt that it helped them to improve their communication skills and 88% would recommend that program to other trainees.

By standardizing the language we use to describe our patient discussions, we can provide a consistent learning environment for all levels of trainees and an enhanced patient experience through continuity across providers. In an effort to provide a foundation of clinicians who are familiar with a structured approach to difficult conversations, we collaborated with Vital Talk, a national non-profit organization founded to disseminate their NIH-funded research in communication skills training. Their program, a widely accepted national model, aims to provide communication skills education to clinicians and train faculty how to teach those skills to others. Their workshops are known by many names, including OncoTalk, NephroTalk, PalliTalk, CardioTalk, IntensiveTalk, etc. While the educational

construct is the same, the cases on which they're built are tailored to provide the most valuable learning experience to the participants' real-world practice.

In January 2018, with the support of generous UTSW donors, 24 faculty and APP clinicians from various specialties completed the Vital Talk - Mastering Tough Conversations full day course (participants included specialists in cardiology, oncology, neuro-critical care, geriatrics, internal medicine, and palliative care). The excellent feedback included 100% of respondents stating they would definitely recommend the course to a colleague.

In order to meet the demand, 12 specially trained faculty have completed the Vital Talk Train-the-Trainer certification in August 2018. Prior to 2018, there were only 4 faculty certified in the state of Texas and approximately 250 certified faculty nationally (28).

In 2018, we adapted Vital Talk as a pilot for all Internal Medicine residents at UTSW and incorporated simulated patient cases. Ninety-two percent of residents stated they would recommend the training to others and 89% felt that it helped them to improve. We anticipate continue enthusiasm as our faculty are now fully certified and UTSW SWAT small grant funding has pledged support to utilize trained actors for the first time in 2019.

In Conclusion

Communicating with patients is a high-risk endeavor. Patients place great value on their conversations with clinicians and communication can affect their satisfaction, anxiety, trust, medical decisions and outcomes. While high risk for patients, clinicians are also significantly affected in the form of burnout, risk of malpractice and personal satisfaction and confidence.

A procedural approach to patient communication is not only possible but provides more gratifying and meaningful experiences for both the clinician and patient as well as improve outcomes. Communication skills training is well established, founded in evidenced-based practices, and widely applicable to all specialties. The commonalities of many procedures for goals of care discussions include:

1. Give a headline (clear and concise message)
2. Recognize and respond to emotion
3. Understand values
4. Make a recommendation based on those values

Teaching communication skills mirrors the step-wise approach to any other medical procedure, with progressive independence after a learner understands the foundation of necessary skills and performs supervised practice. UT Southwestern now has the valuable resource of trained faculty with hopes to provide communication skills training to improve continuity across providers and create a consistent experience for our patients and learning environment for our trainees.

References

1. Epstein RM, Duberstein PR, Fenton JJ, Fiscella K, Hoerger M, Tancredi DJ, et al. Effect of a Patient-Centered Communication Intervention on Oncologist-Patient Communication, Quality of Life, and Health Care Utilization in Advanced Cancer: The VOICE Randomized Clinical Trial. JAMA Oncol. 2017;3(1):92-100.
2. Street RL, Jr., Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Educ Couns. 2009;74(3):295-301.
3. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. Health Aff (Millwood). 2010;29(7):1310-8.
4. Curtis JR, Wenrich MD, Carline JD, Shannon SE, Ambrozy DM, Ramsey PG. Understanding physicians' skills at providing end-of-life care perspectives of patients, families, and health care workers. J Gen Intern Med. 2001;16(1):41-9.
5. Kessels RP. Patients' memory for medical information. J R Soc Med. 2003;96(5):219-22.
6. The John A. Hartford Foundation TCHCF, and Cambia Health Foundation. National Physician Survey. 2016.
7. Bernacki RE, Block SD. Communication about serious illness care goals: a review and synthesis of best practices. JAMA Intern Med. 2014;174(12):1994-2003.
8. The Dartmouth Atlas of Health Care. The Dartmouth Institute; 2018.
9. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000;5(4):302-11.
10. Lakin JR, Block SD, Billings JA, Koritsanszky LA, Cunningham R, Wichmann L, et al. Improving Communication About Serious Illness in Primary Care: A Review. JAMA Intern Med. 2016;176(9):1380-7.
11. Ramirez AJ, Graham J, Richards MA, Cull A, Gregory WM, Leaning MS, et al. Burnout and psychiatric disorder among cancer clinicians. Br J Cancer. 1995;71(6):1263-9.
12. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Arch Intern Med. 1994;154(12):1365-70.
13. Preventing Central Line-Associated Bloodstream Infections: Useful Tools, An Internaltional Perspective. The Joint Commission; 2013.
14. Childers JW, Back AL, Tulsky JA, Arnold RM. REMAP: A Framework for Goals of Care Conversations. J Oncol Pract. 2017;13(10):e844-e50.
15. McDonagh JR, Elliott TB, Engelberg RA, Treece PD, Shannon SE, Rubenfeld GD, et al. Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction. Crit Care Med. 2004;32(7):1484-8.
16. October TW, Hinds PS, Wang J, Dizon ZB, Cheng YI, Roter DL. Parent Satisfaction With Communication Is Associated With Physician's Patient-Centered Communication Patterns During Family Conferences. Pediatr Crit Care Med. 2016;17(6):490-7.
17. Pollak KI, Alexander SC, Tulsky JA, Lyna P, Coffman CJ, Dolor RJ, et al. Physician empathy and listening: associations with patient satisfaction and autonomy. J Am Board Fam Med. 2011;24(6):665-72.
18. Scheunemann LP, Arnold RM, White DB. The facilitated values history: helping surrogates make authentic decisions for incapacitated patients with advanced illness. Am J Respir Crit Care Med. 2012;186(6):480-6.

19. Zwingmann J, Baile WF, Schmier JW, Bernhard J, Keller M**.** Effects of patient-centered communication on anxiety, negative affect, and trust in the physician in delivering a cancer diagnosis: A randomized, experimental study. Cancer. 2017;123(16):3167-75.
20. Murray E, Pollack L, White M, Lo B**.** Clinical decision-making: Patients' preferences and experiences. Patient Educ Couns. 2007;65(2):189-96.
21. Back AL, Arnold RM, Baile WF, Tulsky JA, Barley GE, Pea RD, et al. Faculty development to change the paradigm of communication skills teaching in oncology. J Clin Oncol. 2009;27(7):1137-41.
22. Back AL, Arnold RM, Baile WF, Fryer-Edwards KA, Alexander SC, Barley GE, et al. Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. Arch Intern Med. 2007;167(5):453-60.
23. Back AL, Arnold RM, Tulsky JA, Baile WF, Edwards K**.** "Could I add something?": Teaching communication by intervening in real time during a clinical encounter. Acad Med. 2010;85(6):1048-51.
24. Awdish RL, Buick D, Kokas M, Berlin H, Jackman C, Williamson C, et al. A Communications Bundle to Improve Satisfaction for Critically Ill Patients and Their Families: A Prospective, Cohort Pilot Study. Journal of pain and symptom management. 2017;53(3):644-9.
25. Orford NR, Milnes S, Simpson N, Keely G, Elderkin T, Bone A, et al. Effect of communication skills training on outcomes in critically ill patients with life-limiting illness referred for intensive care management: a before-and-after study. BMJ supportive & palliative care. 2017.
26. Tavakoly Sany SB, Peyman N, Behzhad F, Esmaeily H, Taghipoor A, Ferns G**.** Health providers' communication skills training affects hypertension outcomes. Medical teacher. 2018;40(2):154-63.
27. Sekar DR SL, Siropaides C, Nguyen OK**.** Pilot Study of a Half-Day Mini-Curriculum to Improve Resident Confidence in Conducting Goals of Care Discussions. In: Southwestern UoT, ed; 2017.
28. Vitaltalk.org. 2018.

For More Information, Check out These Links

- Vitaltalk.org
- Vital Talk App for download on Android or Apple
- Ariadnelabs.org/areas-of-work/serious-illness-care/
- Communication-skills-pathfinder.org