Assessing Interpersonal Communications Skills: The Use of Standardized Patients in Graduate Medical Education

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The Challenge

Recently, much attention and increased awareness has been placed on patient-centered care in medicine.[1] Within the education milieu, 1 facet of patient-centeredness is examining the communication and interpersonal skills competence of resident physicians. Interpersonal communication is 1 of the most difficult competencies in which to ensure proficiency. Many instances of patient-trainee interactions occur without the direct supervision of an attending physician. Thus, these skills are less often assessed through direct attending physician observation.

Often the assessment of communication and interpersonal skills relies upon residents' United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills scores obtained during medical school, which leaves a gap in adequately assessing residents' competency and comfort in using communication skills early in their practice.

What Is Known

Extensive practice of skills is necessary to learn new skills and maintain existing competencies.[2] Most communication skills courses occur at the beginning of medical school[3] and often culminate with the USMLE Step 2 Clinical Skills—a performance-based MD (doctor of medicine) licensure certification assessing communication skills. After this examination, attention may shift toward Step 3 and board certifications, both of which lack an observed performance component.

The use of standardized patients (SPs) is 1 way to develop and assess competency in interpersonal communication and facilitate patient-centered care. Objective Structured Clinical Examinations have also been demonstrated to be an effective tool to assess content and communication skills, knowledge, patient satisfaction, and professionalism in residency programs.[4] The cost of SP programs range from $50 to $500 per resident depending on the type of exercise and the feedback provided.[5–8] The cost of developing a program de novo is likely cost-prohibitive to most residency programs—in which case it might be best to focus on training faculty or staff to portray a case.

Rip Out action items

Program Directors must:

1. Integrate active learning strategies, such as role-playing and case-based learning, into didactic-only sessions.
2. Use the rich resource of standardized patient (video and assessment) data for semiannual resident feedback and evaluation meetings to further facilitate individual remediation/learning plans.
3. Integrate patient panels to supplement standardized patient activities so residents can receive additional patient perspectives to support patient-centeredness.
4. Endorse and support the standardized patient assessments of their residents, and enlist faculty and chief resident buy-in. Complete the activity yourself (feedback and self-assessment). In the words of Atul Gawande, "Like most work, medical practice is largely unseen by anyone who might raise one's sights. I'd had no outside ears and eyes."[14] Completing the activity yourself can raise your own awareness and improve insight.

Common Program Requirements

Integrating SP exercises into a residency program's curriculum has the potential to fulfill requirements in the areas of patient care, interpersonal and communication skills, and formative evaluation.[9] Program directors are required to "provide each resident with documented semiannual evaluation of performance with feedback."[10] This evaluation may prove beneficial with additional multimedia modalities. Some programs require digital recordings of resident-patient encounters or direct faculty observation for assessment of each resident's competency in

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interpersonal skills.[11] A digitally recorded encounter can be used as a springboard for an individual learning plan or remediation program, or to provide documentation and evidence of a mastered skill. Standardized patient scenarios can be developed to supplement actual patient scenarios by having a resident demonstrate, role-play, or practice a skill not yet demonstrated during clinic or hospital experiences, such as treating patients from various socioeconomic and cultural backgrounds or breaking bad news. Finally, SP encounters, both summative and formative, can provide a rich resource for resident assessment and program evaluation. They can be structured to use multiple evaluators (eg, faculty, peers, patients, and other professional staff) as well.

How You Can Start TODAY

1. Develop a checklist of demonstrable competencies that you want to measure via an SP encounter.
2. Map milestones to specific competencies you would like to measure via the SP modality.
3. Partner with your medical school or local SP program. There may be an existing case or tool (eg, Kalamazoo Essential Elements of Communication or SEGUE Framework, Association of American Medical Colleges MedEdPORTAL, Association of Standardized Patient Educators)[12,13] that can be modified to suit your needs.
4. Collect current baseline information through direct observation to inform and prioritize the communication and interpersonal skills training needs of your residents.

What You Can Do LONG TERM

1. Collaborate with a simulation center/SP program to create hybrid simulation/SP encounters linked to competency milestone priorities. Maintaining authenticity is crucial when working with higher-level residents used to evaluating/managing real patients.
2. Institute early intervention or remediation programs for residents with weaknesses in domains where a simulation/SP case would be beneficial. Provide an SP case as a resource for those whose self-assessment identifies an area of weakness or who do not achieve minimum competency standards.
3. Use SP data (both video and assessment) to inform program evaluation.[5]
4. Incorporate unannounced SPs into the resident clinic to determine areas in need of improvement.

Resources

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