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Physicians' Perceptions and Suggestions for the Adaptation of a US-Based Serious Illness Communication Training in a Non-US Culture: A Qualitative Study

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Abstract

Context.—US-based serious illness communication training pedagogy has not been well studied outside of the United States.

Objectives.—To explore the perception of a US-based, serious illness communication training pedagogy in a non-US culture and to identify aspects requiring cultural adaptations.

Methods.—In September 2019, we conducted a qualitative study using convenient sampling at two urban, academic medical centers in Tokyo, Japan. Semistructured interviews were conducted to japanese physicians who participated in the four-hour VitalTalk training in Japanese. We explored six majored themes: 1) global impression of the training; 2) main goals from participation; 3) appropriateness of didactics; 4) role play experiences; 5) take away points from the training; and 6) changes in their own communication practice after the training. Interviews were transcribed, coded, and analyzed using phenomenological approach.

Results.—All 24 participants found the VitalTalk pedagogy novel and beneficial, stressing the importance of demonstrating empathy, reflecting on own skills, and recognizing the importance of feedback that emphasizes the use of specific words. Participants also pointed out that Japanese patients generally do not express their strong emotions explicitly.

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Conclusion.—Our study found empirical evidence that the VitalTalk pedagogy is perceived to be novel and beneficial in a non-US cultural setting. Cultural adaptations in expression and response to emotion may be required to maximize its efficacy in Japan. To meet the needs of clinical practice in Japan, further studies are needed to empirically test the suggested refinements for the VitalTalk pedagogy.

Keywords

End-of-life discussion; serious ill patients; communication skills training; Japanese physicians; emotions; qualitative study

Introduction

Communication with seriously ill patients is a fundamental aspect of patient-centered care. Good physician-patient communication results in various positive outcomes, including decreased anxiety,[1] better prognostic awareness,[2] higher patient satisfaction, and adherence to medical care.[3] Yet, most clinicians do not receive formal serious illness communication training, and the clinician competence is extremely variable.[4] Japanese clinicians are not exceptions[5–7] and are known to adhere less frequently to the best practices in serious illness communications.[5,6] Several Japan-based communication trainings have been developed, which focus on basic communication skills and addressing emotions.[8–11] They have shown to improve clinicians' ability to provide emotional support and decrease depression in patients.[7,12,13] Yet the most comprehensive communication trainings are targeted for oncologists.[7,9] Cancer accounts for only 27% of death in Japan.[14] Furthermore, the prevalence of advance care planning is 16% among primary care clinicians in Japan.[15] As a result in 2016, 82% of Japanese would choose "comfort" over "living as long as possible", and 55% would prefer to die at home,[16] yet the majority (76%) died in hospitals.[14] As seen in the United States, additional evidence-based, serious illness communication training may improve the nationwide effort to disseminate advance care planning as each training may be complementary to other trainings.[17–19]

VitalTalk[20] is an evidence-based, serious illness communication training complementary to existing trainings in Japan. Its pedagogy focuses on learners' attitudes on emotions and leverages a positive feedback loop: the learner 1) receives positive feedback about his/her strength; 2) identifies a salient skill to practice; 3) practices the skill with an actor to acquire the first-hand experience; 4) reflects on the practiced skill; and 5) articulates how to implement the newly practiced skill in his/her clinical practice.[21] Originally developed for oncologists in the United States,[22] VitalTalk is now practiced by various noncancer specialties; geriatrics and palliative medicine, nephrology, cardiology, and other specialties.[23–28] Such success with nononcology clinicians could complement existing trainings in Japan. Trained clinicians reported increased preparedness for difficult communications,[23–28] and multiple studies have demonstrated better quality of communication, higher level of trusts from patients, and increased goal-concordant care.[29–31] To date, VitalTalk has trained more than 10,000 clinicians[20] and has become the standard of communication training pedagogy in the United States.

VitalTalk pedagogy has been widely disseminated by no-oncology clinicians in the United States. However, it has not been studied in the cultural settings outside of the United States. To complement the existing trainings in Japan focusing on communication with cancer patients, we sought to explore the perception of the pedagogy and solicited suggestions for cultural adaptations.

Methods

Study Design

We conducted a qualitative study using semistructured interviews of Japanese physicians who participated in the four-hour VitalTalk training in Japan. We used a phenomenological approach as our qualitative study theory. This study was approved by the institutional review boards of Teikyo University. We followed the consolidated criteria for reporting qualitative research.[32]

Study Setting and Recruitment

The trainings were conducted in two urban, academic medical centers in Tokyo, Japan. The study team advertised the VitalTalk training via e-mails in Japanese to physicians in the various departments in the participating institutions. A convenience sample of physicians from diverse clinical backgrounds voluntarily participated in the training.

VitalTalk Training in Japanese

We translated the four-hour VitalTalk training into Japanese. Study team members who translated the training (E. O., S. N., T. U., M. Y., K. I., K. O.), were Japanese natives and underwent VitalTalk training in the U.S. Formal forward and backward translations with cognitive testing were not performed. We created two clinical vignettes: a 60-year-old female with meta-static pancreatic cancer presented with progression of disease; and a 78-year-old male with advanced Parkinson's disease admitted with recurrent aspiration pneumonia. Following the VitalTalk pedagogy, the sessions included several types of formal learning activities: 1) didactic sessions on delivering bad news (SPIKES)[33] and responding to emotions (NURSE statements);[34] 2) demonstration of a role-play encounter; 3) small group skill practice sessions using role plays described in the Introduction; and 4) future commitment to practice the learned skills. We held four sessions and trained a total of 24 Japanese physicians. The trainings were led by two facilitators (E. O. and S. N.), natives of Japan and trained in the VitalTalk faculty development program.

Data Collection

After the training, participants were recruited to complete 30- to 60-minute qualitative interviews on the phone. All 24 physicians agreed to participate in interviews to assess their experiences and provided written informed consent. A semistructured interview guide was created, iteratively revised, and finalized by the interdisciplinary research team (Appendix Table 1). It included open-ended questions to explore how participants experienced the training and adaptations required for the clinical practice of Japan: 1) global impression of the training; 2) main goals from participation; 3) appropriateness of didactics; 4) role-play experiences; 5) take away points from the training; and 6) changes in communication

practice after the training. Interviews were conducted by three Japanese-native interviewers (Y. S., Y. K., and K. O.). Two interviewers (Y. S., a female undergraduate student; and Y. K., a female critical care physician) were trained in qualitative interviews by the third interviewer (K. O., a male emergency and internal medicine physician investigator with graduate level training in qualitative research and previous publications using semistructured interviews) and a communication researcher (H. I., a female investigator with doctorate level training in qualitative research methods). The two interviewers attended 1-hour, virtual didactic session on the basics of qualitative research methods. Then, practice interviews were conducted with K. O. and H. I. using the interview guide. Once interview techniques were deemed acceptable by K. O. and H. I., the interviewers received additional coaching during the initial five interviews conducted on the study participants by K. O. to refine their skills in asking open-ended questions. All interviews were conducted in Japanese over the phone within 10 days of the training, audio-recorded, professionally transcribed, and de-identified. The interviewers did not participate in the VitalTalk training and had no existing relationships with the interviewees. The transcripts were not returned to participants for comments or correction.

Data Analysis

The analytic approach used framework analysis,[25] which allowed the flexibility of incorporating priori considerations as well as emergent themes from the data. The coding structure was collaboratively developed by Y. K., K. I., Y. S., K. O., and H. I. using the first 10 transcripts and iteratively revised to include both prefigured and emergent codes.[26] Y. K. and Y. S. double coded 10% of all transcripts to ensure high inter-coder reliability before proceeding with the rest of the transcripts. Through comprehensive indexing and charting using Microsoft Excel (Microsoft Corporation, 2019), we explored and compared interviewees experiences within and across interviews. Final themes were presented to K. O. and H. I., for validation and completeness of analysis, and consensual resolution of discrepancies. Representative quotes for each theme were collectively agreed on by the entire study team. Participants did not provide feedback on the team's findings.

Results

We interviewed all 24 participants who completed the training. The characteristics of participants are summarized in Table 1. Six participants (25%) were female, and the average postgraduate years (PGY) was 9.9 (range 3 to 32) years. The specialty of participants was mixed as shown, and the most popular specialty was family medicine or general internal medicine combined (46%). Sixteen participants (67%) were affiliated with academic medical centers. The following major themes were explored, and detailed descriptions and their representative quotations are found in Table 2.

Global Impression of the Training

All participants had positive global impression. Fifteen participants (63%) felt that the experience was valuable as they had never experienced similar training in the past. Eleven participants (45%) stated that watching colleagues role play was valuable, and nine

participants (38%) stated that they could reflect and reaffirm their own skills from the training.

Main Goals from Participation

Fourteen (58%) participants' goal was to improve general communication skills. Three participants (13%) specifically wanted to improve delivering bad news, four participants (17%) wanted to build a rapport with patients and their families, and one participant sought to prevent burnout.

Appropriateness of Didactics

Seven participants (29%) felt that using "SPIKES" and "NURSE" mnemonics in English was appropriate, yet five participants (21%) thought that it would be easier to understand if the mnemonics were in Japanese. Two participants (8%) expressed discomfort in "naming emotions" as it may not be well accepted among Japanese patients.

Role-Play Experiences

All participants had an overall positive impression about the role play, such as it was "a realistic experience" (n = 15, 63%) and "opportunities to learn from others" (n = 6, 25%). Twelve participants (50%) felt that the scenarios simulated the Japanese clinical settings, yet nine participants (38%) commented that many Japanese patients would not show obvious emotions as the actors did in the training. Sixteen participants (67%) believed that the time-out was effective. Eight participants (33%) stated that the feedback by the facilitators and other learners were effective for their learning. Sixteen participants (67%) felt that the time allocated for each individual role play was adequate, yet seven participants (29%) wanted more time.

Take Away Points From the Training

Thirteen participants (54%) realized the importance of demonstrating empathy toward patients. Seven participants (29%) felt that the role play was "realistic" which made it "very useful to learn communication skills." Five participants (21%) also took away new teaching methods through the training, and four participants (17%) appreciated the safe learning environment that allowed them to test their skills and receive feedback. Four participants (17%) recognized the importance of giving feedback that focused on the use of specific words.

Changes in Communication Practice After the Training

Nine participants (38%) would recommend this course to colleagues. Six participants (25%) realized the importance of communication skills, and eight participants (33%) would seek further training. Two participants (8%) explicitly expressed interest in becoming a VitalTalk faculty in Japan if available. Furthermore, two participants (8%) proactively suggested strategies to promote the training to physicians who would benefit from the training but unlikely to participate in Japan.

Discussion

All participants found our VitalTalk training novel, beneficial, and had a positive impression on their role-play experiences. The majority stated that they either recommend the training to colleagues and/or want to seek further training. Many participants identified the pedagogy of VitalTalk training such as understanding the importance of demonstrating empathy, reflecting on their own skills, and recognizing the importance of feedback that emphasizes the use of specific words[23–27,35]. Participants also noted that the essence of good communication skills was similar despite cultural differences ("The core of communication skills was the same despite cultural difference between the United States and Japan and the training structure itself fit in well with me" #1, PGY7). Our findings provide empirical evidence that the pedagogy of VitalTalk training was perceived to be beneficial to these participants from a non-US culture. Outside of the United States, our study is the first to describe the perceptions of participants in the translated, VitalTalk training.

The participants suggested some potential areas for adaptation of the training to fit the Japanese practice of medicine. One such area is in response to emotional expression. VitalTalk training focuses on attending and responding to emotions.[21,35] The actors are trained to demonstrate their emotions explicitly to allow the learners to recognize and respond. Many participants newly discovered the importance of recognizing emotions and demonstrating empathy ("In the past, when a patient expressed a certain emotion, a part of me had always tried to convince the patient by being logical. Instead, in response to these patients' emotions, physicians must use proper techniques." #14, PGY3″). However, some participants also stated that it would be very unusual for Japanese patients to demonstrate such obvious emotions which made them feel awkward and unrealistic ("The simulated patient was emotionally expressive, but I think it's rare to see Japanese people verbally express their feelings to someone who they met for the first time." #7, PGY7). Many participants understood the importance of attending to patients' emotions, but some expressed that Japanese patients generally do not express strong emotions as our simulated patients did. This conflicting observation may have resulted because Japanese patients' emotions may be suppressed to maintain politeness.[36,37] Acting within the societal norm is considered a virtue in Japan, and reactions outside of this norm is considered "impolite and shameful," negatively influencing the reputation of the entire society.[37] Furthermore, patient's societal status is less powerful compared to physicians, which may additionally contribute to their suppressed emotions.[37] Although no empiric evidence to suggest these interpretations was found in our study, these unique cultural aspects may explain our findings. As a result, patients are less likely to express their negative emotions, and physicians are less likely to recognize their suppressed emotions, thus failing to address key emotions.[36]

Although not explicitly expressed, Japanese patients and families experience high levels of emotional distress during serious illness conversations.[6] Some of the participants realized that it is beneficial for them to address the emotional distress, which helps promote positive patient-physician relationships[38] and reduce patients' emotional distress.[6] ("I thought that it's necessary to take the time to empathize with the patients … Building trust is essential, and I really thought about how to build this with my patients …. I learned that I need to be

conscious of my interactions with their families on a daily basis (as well as the patient).” #8, PGY3) Two participants also expressed discomfort with “naming” emotions. (“it’s difficult to assess whether showing our interpretation of patient’s entire emotion is the right thing to do.” #18, PGY7). “Naming” is one of the most used skills in our experiences in the United States. The discomfort may stem from Japanese culture, where articulating someone’s negative emotions may be perceived as ill-mannered.[37] Given some participants expressed discomfort using “naming” as a skill to address emotions in our study, future training may emphasize “explore” or “support” skills. A prior study in Japan found that cancer patients valued explicit emotional support and exploring from their physicians,[39] which could support this emphasis in the future.

Based on participants’ suggestions, we propose the following adaptations for the VitalTalk training for the Japanese culture of medicine: 1) In didactic, explicitly name and normalize the Japanese culture influencing the patient’s suppression of emotions and emphasize the importance to acknowledging the suppressed emotions; 2) Train actors to demonstrate their emotions quietly and politely; and 3) Encourage learners to address the suppressed emotions using “support” or “explore” statements. These suggested adaptations must be empirically tested to adapt VitalTalk to Japanese medical culture.

This study has several limitations. We performed convenient sampling to capture a wide range of clinical experiences and specialties for our qualitative study. Therefore, unlike the VitalTalk pedagogy, learners were not in the same specialty and did not have similar clinical experiences. As a result, the mixed background of participants may have altered the overall quality of their learning. Our participants were young and voluntarily participated in our novel training, which may have biased their receptiveness in our new pedagogy. Further attempts to explore the feasibility and acceptability among clinicians from diverse backgrounds may be needed. Second, a formal translation process for the Vital Talk training was not performed. However, the results would not have substantially differed given the study team’s strength in clinical, cultural, and language competencies. Third, the training facilitators were natives of Japan, fluent in Japanese, and trained in VitalTalk, yet lacked clinical experience in Japan in recent decades. This may have affected the quality of the training itself, as they may not be familiar with commonly used terminology in the current clinical practice of japan. Finally, our findings are specific to adaptations for the Japanese practice of medicine. Alternative cultural adaptations may be required in other non-US cultures.

Conclusion

Our study found empirical evidence that the VitalTalk, US-based, serious illness communication skills training pedagogy was perceived by physicians to be novel and beneficial in a non-US culture. Cultural adaptations in expression and response to emotion may be required to maximize its efficacy in Japan. To meet the needs of clinical practice in Japan, further studies are needed to empirically test the suggested refinements for the VitalTalk pedagogy.

Disclosures and Acknowledgments

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Appendix: Semi-Structured Interview Guide for Powered VitalTalk Japan Sessions in Japanese Experience

Introduction

Thank you for taking the time to meet with me. We are speaking with you today as part of a study that seeks to assess the approaches and content of the VitalTalk® communication training that require adaptation to japanese practice of medicine from Japanese clinicians' perspective. More specifically, we want to speak with you today about the your experience of the VitalTalk® communication training you had in Japanese, beliefs, suggestions, and reasonings of your statement regarding which approaches and content of VtitalTalk® need adaptation for Japanese practice of medicine, and your attitude toward communication training for Japanese clinicians using VitalTalk® format. Your ideas can help us to improve training methods and ultimately, will help with better patient care and decrease physician burden as well in the future.

Purpose of Audio-Recording

Your ideas and perspectives are tremendously important, and we do not want to miss anything. With your permission, I would like to audio record this interview. This is just to make sure that we can capture all of your comments and accurately represent your perspectives. Even though I am recording, our conversation will be kept strictly confidential and you will not be identified in any reports or write-ups.

Confidentiality

I want to make sure that you understand that whatever you mention in this interview with me is confidential and will be shared only after de-attached your name and contact information among study team for the analysis. Your age, gender, post-graduate years, and your medical subspecialty will be shared with the content of the interview.

Do you have any questions before we begin?

Outline of the Interview

This interview will be a little bit different in that I want to better understand not only your experience with the training session but also how you thought through some of the content and approaches of the VitalTalk® model of communication training that require adaptation to Japanese practice of medicine. Just as a reminder, going forward, we are going to refer to the half-day VitalTalk® training session that you had on 9/7 or 9/9/2019 simply as "the training." We will go over each section of this training and I will ask you specifically about your inputs in three general areas:

1. Your global impression of the training.
2. Your experience of going through the training. We will ask your impression, thoughts and suggestions for each content of the training by section. Your beliefs, suggestions and reasoning of your which approaches and content of VitalTalk® need adaptation for Japanese practice of medicine.
3. Your attitude toward communication training for Japanese clinicians using the VitalTalk® format in Japan.

Question 1: Global Impression

a. What was your overall impression of the training?

Probe 1 : Can you describe to me what it was like to go through the training?

Probe 2: How do you feel about the training overall?

b. From your perspective, what do you think the main goal of the training was?

Question 2: Your experience of the training (Cognitive Interviews)

Now I would like to discuss your experience and perspectives on the actual training that you went through on 9/7 or 9/9/19.

a. In your own words, how would you describe what happened in the training? (How would you describe the process to someone else?)

b. In general, how did you feel during the training?

Probe 1: Physically?

Probe 2: Mentally?

Probe 3: Was anything particularly difficult during the training?

Now I would like to walk through each of the content and approach during the training. We want to adjust the content and approaches of the VitalTalk® communication training to adapt to japanese practice of medicine.

1. Introduction “Why Do We Do This Work?” (15 minutes)
   - **a.** How appropriate was the “Introduction” to the training?
   - **b.** How would you describe the content of the “Introduction”?
   - **c.** How adequate was the time allocation for the “Introduction”?
   - **d.** If any, how would you modify the content of the “Introduction” to adapt to japanese medical pratices? Why?
   - **e.** If any, how would you modify the approach of the “Introduction” to adapt to japanese clinicians? Why?
2. Didactic “GUIDE” and Demonstration (30 minutes)

a. How appropriate was the “Didactic” to the training?

b. How appropriate was the “Demonstration” to the training?

c. How would you describe the content of the “Didactic”?

d. How would you describe the content of the “Demonstration”?

e. How adequate was the time allocation for the “Didactic”

f. How adequate was the time allocation for the “Demonstration”?

g. How well did the content of the “Didactic “meet the objective of the training?

h. How well did the content of the “Demonstration” meet the objective of the training?

i. If any, how would you modify the content of the “Didactic” to adapt to japanese medical practices? Why?

j. If any, how would you modify the content of the “Demonstration” to adapt to japanese medical practices? Why?

k. If any, how would you modify the approach of the “Didactic” to adapt to Japanese clinicians? Why?

l. If any, how would you modify the approach of the “Demonstration” to adapt to japanese clinicians? Why?

3. Small Group Set-up (30 minutes)

a. How well did the content of “Small Group Set-up” prepare you for the skill practice?

Content of the Set-up:

- Introductions
- Learning Environment/Group Rules
- Note Taking/Giving Feedback rules and suggestions
- Group Exercise: ‘Why I hate role-play”
- Gather Learning Objectives

b. How adequate was the time allocation for the “Small Group Set-up”?

c. If any, how would you modify the content of the “Small Group Set-up” to adapt to japanese medical practices? Why?

d. If any, how would you modify the approach of the “Small Group Set-up” to adapt to japanese clinicians? Why?

4. Skill Practice: (55 minutes ×2)

a. How appropriate was the content of the scenarios during the role play for Japanese practice of medicine?

Patient 1 (Insert case information here)

Patient 2 (Insert case information here)

b. What was your **overall impression** of the role play?

Probe 1: Can you describe to me what it was like to go through the role play?

Probe 2: How do you feel about the role play overall?

c. In general, how did you feel during you are participating in the role play?

Probe 1: Physically?

Probe 2: Mentally?

Probe 3: Was anything particularly difficult during the role play?

c. Can you walk me through your impression, suggestions and thoughts of each approach of the facilitation during the role play?

- Establishing a goal for yourself
- Role play
- Time out
- What went well discussion
- After the time out, what can you do differently
- Rewind and replay
- Take home point

d. How adequate was the time allocation for the whole role play?

e. How adequate was the time allocation for each learner to do a role play?

f. If any, how would you modify the content of the role play facilitation to adapt to Japanese medical pratices? Why?

g. If any, how would you modify the approach of the role play facilitation to adapt to japanese clinicians? Why?

5. Large Group Wrap Up/Taking Home (15 minutes)

a. How well does the content of the “Wrap up/Taking Home” meet the objective to summarize the training?

b. How adequate was the time allocation for “Wrap up/Taking Home”?

c. If any, how would you modify the content of the “Wrap up/Taking Home” to adapt to japanese medical pratcies? Why?

d. If any, how would you modify the approach of the “Wrap Up/Taking Home” to adapt to Japanese clinicians? Why?

I have just a few general questions about the experience during the training:

a. Is there anything that you want to share regarding your experience during the training that you think is important?

b. Are there any concerns about the content and approaches we did not discuss above?

Question 3: Your Attitude toward communication training for Japanese clinicians using VitalTalk® format

Thank you for sharing your experience with me. I just have a few more questions about your general perspectives on VitalTalk® format training in Japan.

a. Did the half day training introduce **anything new information** that made you think differently about the VitalTalk® format training in Japan?

Probe 1: Did the training give you any new ideas that you want (or do not want) to assist and promote communication education using VitalTalk® format in Japan?

Probe 2: Was any part of the training surprising to you?

b. In what ways, if any, did the training change the way you think about communication skills, training methods for seriously ill patients?

Thank you so much for your time to talk to us.

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Key Message

This article describes a qualitative study which found empirical evidence that a US-based serious illness communication skills training pedagogy was perceived to be novel and beneficial in a non-US cultural setting (Japan). Cultural adaptations in expression and response to emotion may be required to maximize the efficacy of the training.

Table 1

Characteristics of Study Participants

Total Participants	
Sample size	24
Gender	
Female, n (%)	6 (25)
Specialties, n (%)	
Family medicine/general internal medicine	11 (46)
Emergency medicine	5 (21)
Palliative medicine	5 (21)
Internal medicine subspecialties	3 (13)
Postgraduate years, n (%)	Mean 9.9
	SD 7.4
< 5	7 (29)
5 ≤ and <10	7 (29)
10 ≤ and <15	6 (25)
15 ≤ and <20	2 (8)
20 ≤ and <25	1 (4)
25 ≤ and <30	0 (0)
30 ≤	1 (4)
Main institutions participants are affiliated with, n (%)	
Academic university hospitals	16 (67)
Community hospitals	8 (33)

SD = standard deviation.

Table 2

Summary of Main Findings

Main Category	Emerging Themes	n/24	Examples of Quotes From the Participants
Global impression of the training	Novel experience	15	"I have never experienced trainings such as how to deliver news to patients and what to be conscious about when communicating with them." #1 (PGY7)
	Learning from other participants through observation	11	"Objectively watching other participants was different from just doing it myself." #3(PGY3)
	Reflection on one's own skills	9	"I was able to discover and recognize my own skills … and reflect on my communication techniques and my emotions in the moment …. Furthermore, I can take myself to the next step by developing concrete strategies to improve myself for the future." #12(PGY32)
	Systematic training	5	"It was systematic, and the training taught me that communication is a learaable skill." #1(PGY7)
	Efficient training	5	"The content was compact and straight to the point." #21 (PGY14)
	Multipurposed training	2	"We can use these skills in many different clinical settings, not only in the palliative care setting." #6(PGY11)
	The course was too long	1	"I am not sure if other learners will be interested in spending half a day just for the beginner's course." #17 (PGY14)
Main goals from participation	Improving general communication skills	14	"When I encounter difficult situations in the future, I think the communication process may go smoothly by using the skills that we learned." #22(PGY24)
			"I was able to consider the patient's emotions using the communication skills." #23(PGY3)
			"I think the purpose of this course is to be able to consciously use the training tools, such as SPIKES and NURSE." #24 (PGY19)
	Delivering bad news	3	"The goal is to help patients best understand the bad news, and we practiced this with the aid of the simulated patients." #5 (PGY3)
	Building a relationship	4	"Communication skills—not only clinical competence —are very important, and I think they are crucial in building a rapport with patients and their families." #3 (PGY3)
	Prevention from burnout	1	"I think I acquired skills to prevent myself from being burned out." #13 (PGY4)
	Conceptualizing	1	"By implementing acronyms like NURSE into the lecture, the content and messages conveyed in the conversation with the patient can be conceptualized." #19 (PGY14)
Appropriateness of didactics	SPIKES/NURSE mnemonics are acceptable in English	7	"English mnemonics are often used in Japan, so I don't think acronyms like SPIKES would be an issue." #5(PGY3)
	Adaption for SPIKES/NURSE mnemonics	5	"Acronyms made in Japanese are much easier to understand." #2(PGY9)
	Discomfort with "Naming" the emotion	2	"The skill of naming the emotion was difficult to accept. I was concerned that this could influence the conversation in a negative way in Japanese culture. However, after using the skill myself, I have realized that it actually shows my willingness to acknowledge the patient's emotions." #12(PGY32)
			"Since we don't understand if that emotional expression is correct, it's difficult to assess whether showing our interpretation of patient's entire emotion is the right thing to do." #18(PGY7)
Role-play experiences	Realistic experience	15	The acting was so realistic, so I was able to get into my character naturally." #14(PGY3)
			"The actor seemed like a real patient and even moved my emotions." #22(PGY24)

Main Category	Emerging Themes	n/24	Examples of Quotes From the Participants
	Learning from others through observation	6	“I felt like I got twice the learning experience, so that was great.” #10(PGY10):
	Effectiveness of timeouts	16	“It seemed as if the facilitator really knew the “best” timing to have the timeout to give the learners some advice when we were stuck and completely at a dead end.” #2(PGY9)
	Effectiveness of feedback	8	“I was able to receive feedback, which I rarely get in a clinical setting. At first, I was reluctant to do role-play, but in the end, I’m very glad that I was able to do it.” #14(PGY3)
	Japanese patients often would not show emotions	9	“In Japan, many people simply stay silent and accept whatever we (physicians) say without stating their opinions. So, I guess (expressive, emotionally simulated patients) would be helpful in that respect. #2(PGY9)
			“The simulated patient was emotionally expressive, but I think it’s rare to see Japanese people verbally express their feelings to someone who they meet for the first time. It may have been better to see variations like someone who fells silent or does nothing but cries. #7(PGY7)
			“Many patients in Japan don’t say ‘no’, and they often tell the nurses their true feelings later.” #13(PGY4)
	Recording will be helpful	3	“I think it is a good idea to record the role play so that we know exactly what was said.” #11 (PGY7)
Take away points from the training	Importance of demonstrating empathy	13	“Building trust is essential, and I really thought about how to build this with my patients …. I learned that I need to be conscious of my interactions with their families on a daily basis. #8 (PGY3)
			“In the past, when a patient expressed a certain emotion, a part of me had always tried to convince the patient by being logical. Instead, in response to these patients’ emotions, physicians must use proper techniques. That was the biggest takeaway.” #14(PGY3)
	Realistic role plays	7	“I was really amazed at how realistic the simulated patients were. That was the most surprising part.” #8 (PGY3)
	New teaching methods	5	“I learned new teaching skills which will be beneficials to share with my residents.” #21 (PGY14)
	Safe environment	4	“Watching other participants’ communication processes allowed us to exchange constructive feedback, and it was a safe environment to evaluate my own role play and how it looked like from other people.” #20(PGY17)
	Feedback is focused on words	4	“In the past workshops and communication courses that I have experienced, I often received feedback on the nonverbal parts of communication, but this time, I got feedback on what I said …. “ #15 (PGY6)
			“… the language and the wording … these are a set and do not change. The language, the vocabulary, and conjunctions used … these are universal and are the same to everyone, so I was amazed at how feedback was repetitively given, focusing on these points.” #20(PGY17)
Changes in communication practice after the training	Recommend participation to others	9	“I want everyone to take the course!” #8 (PGY 3)
	Realization of importance of communication skills training	5	“I again realized the importance of communication skills training. #1 (PGY 7)
	Importance of ongoing training	8	“I would like to take the course again or take a similar course.” #2 (PGY 9)
	Interest in becoming a future educator	2	“I hope I can help and support to promote VitalTalk in Japan, as this is such a compacted educational method.” #20 (PGY17)
	Strategies for physicians who are hesitant with role plays	2	“I think there are quite a few people who do not want to be critiqued in front of others. Depending on the situation, it may be necessary to create a course that allows participants to have the choice to observe.” #12 (PGY 32)