CURRICULUM ON INTERPERSONAL AND COMMUNICATION SKILLS
MSU INTERNAL MEDICINE RESIDENCY PROGRAM

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I. Educational Purpose and Goals

Effective communication and interpersonal skills are cornerstones of physicians' professional identities. The successful internist must be able to establish therapeutic doctor-patient relationships, work within multidisciplinary teams, and communicate orally and in writing in a manner that facilitates patient care. In addition, internal medicine residents at our institution act as teachers of other residents and students, a role facilitated by the same skill set.

II. Principal Teaching Methods

a. Supervised Direct Patient Care Activities: During clinical activities, residents observe physicians and other personnel modeling effective communication and interpersonal skills, and are observed in their turn. Such modeling may occur during bedside rounds, clinic visits, family meetings, case conferences, documentation activities, or while performing care-oriented tasks.

b. Morning report, attending rounds and other small group discussions: Residents provide concise oral presentations of patient history and physicals, participate in academic discussions of medical issues, and perform problem focused histories and physicals during teaching rounds for general medicine inpatient and intensive care unit rotations. Faculty members moderate these discussions. Similar interactions occur in a variety of other small group formats throughout the three years of residency, and may include ancillary personnel participation. Biopsychosocial Morning Report emphasizes the application of an evidence-based patient centered interviewing technique.

c. Orientation: The required first year orientation emphasizes communication within systems, including hospital and clinic orientations, training in the Electronic Health Record (EHR), and corporate compliance training. In July, each new first year resident also undergoes an Observed Clinical Skills Examination at the Learning and Assessment Center with feedback from faculty and standardized patients, which includes interpersonal communication.

d. Psychosocial Rotation: Residents receive extensive training in medical interviewing, patient centered communication, the doctor patient relationship, and self-awareness during their required Psychosocial rotation, completed in the R1 or R2 year.

e. Complex Care Clinic: R2 and R3 residents are assigned up to eight sessions in this special clinic each academic year. Specially trained faculty members monitor resident-patient interactions by secure audio and video monitors, and give directed feedback on patient centered communication and motivational counseling skills.

f. Required Presentations:
    i. Scholarly Project. All residents must complete a scholarly project during their training. The end product may be an oral presentation, poster, or publication. Residents receive supervision from sponsoring faculty and the residency research director.
    ii. Lectures/discussions for peers. Residents are required to deliver talks to their peers in several settings (morning report, Journal Club, Morbidity and Mortality, Interesting Case Conference, Board Review, and FM/IM/Psych special sessions). These presentations are discussed in advance with the supervising key faculty member

g. PEER Day: R1 residents must attend a seminar highlighting their communication roles as teachers of medical students.

III. **Educational Content**

a. Mix of skills
    i. Information exchange: Effective information exchange encompasses both oral and written interactions, with behavioral, cognitive, and time dimensions. That is, the successful physician can:
        - actively listen,
        - organize information succinctly and efficiently ,
        - use language (medical terminology and common English) effectively to convey that information in either verbal or written formats,
        - use non-verbal cues in face to face or other verbal interactions,
        - use technology (electronic medical records, dictation systems, pagers, etc.) effectively for purposes of information exchange,
        - write legibly, and
        - assess and address barriers to information exchange.

ii. Doctor-patient relationships (DPR): The effective DPR requires the physician to exchange information (as above), educate patients and/or their families, and develop diagnostic and therapeutic plans using informed (and shared) decision making, all within the context of ethically sound relationships.

iii. Working within teams: In fulfillment of their duties, residents must work with personnel at a variety of levels within the system, both as a team member and as a leader. Essential skills include:

- communication skills as addressed above;
- the ability to coordinate, prioritize, and initiate tasks or activities;
- professionalism (please see the Professionalism Competency Curriculum).

b. Patient characteristics: The Greater Lansing area and hospital cachement area boasts a diverse population. Residents interact with a broad array of individuals as team members and patients, requiring them to utilize excellent interpersonal and communication skills for effective functioning.

c. Learning venues are as previously described.

d. Interactions with Other Team Members: Residents interact with a variety of other physicians at all levels of training, in their own and a variety of other specialties. These interactions may be as a junior member of the team, as a peer, or as a supervisor. In addition to other physicians, they also work closely with case managers, nursing personnel, and other ancillary staff. They supervise medical students on inpatient rotations.

IV. Principal Ancillary Educational Materials

The residency office has a number of resources available, including textbooks and electronic subscriptions, addressing the doctor-patient relationship. Residents receive individualized packets for the required Psychosocial rotation. Expectations for written documentation are described in the manual, and templates for inpatient H&Ps and progress notes are available for general medicine and critical care settings.

V. Methods of Evaluation

a. Resident Performance:

i. Faculty and staff complete web-based resident evaluation forms assessing interpersonal and communication skills as listed below; paper-based evaluations are denoted with a (P). Mini-CEXes specific to patient centered interviewing are completed by attending physicians during the Psychosocial rotation and Complex Care Clinic. All evaluations are available for review by the resident at their convenience, and are sent to the residency office for internal review. The evaluations are part of the resident file and are incorporated into the semiannual performance review for directed resident feedback.

1. Faculty evaluation of rotation performance

2. Peer evaluation of rotation performance (anonymous for an evaluation of someone at higher level of training)
3. Mini-CEXes (P)
4. Patient centered interviewing mini-CEXes (P)
5. Residency office and clinic staff evaluations of performance (P)
6. Nurse/case manager evaluations

ii. Patient satisfaction surveys: Patients who see residents in the continuity clinic receive a paper patient satisfaction survey when they check out at the end of their visits. Anonymous results are aggregated for each resident, placed in the residents' portfolios, and included in the semiannual performance review.

b. Program and Faculty Performance
Upon completion of each rotation, the resident completes a service evaluation form commenting on the faculty, facilities, and service experience. These evaluations are sent to the residency office for review. The attending faculty physician receives anonymous annual summative data from completed evaluations. The Training and Evaluation Committee reviews results annually.

VI. Institutional Resources: Strengths and Limitations

c. Strengths: On an institutional level, the College of Human Medicine has a commitment to the biopsychosocial context of medicine, with a variety of faculty having expertise in interpersonal skills and communication training. The required Psychosocial rotation in particular highlights this expertise. The rotation director, Dr. Robert Smith, is nationally known for their work on physician-patient communication. Drs Dwamena, Freilich, and Laird-Fick have completed postdoctoral training in patient centered communication. Residents receive extensive training in medical interviewing, patient-centered communication, the doctor-patient relationship, and self-awareness. The diverse patient and health care provider population within the context of a university community expands residents' exposures to different communication styles and belief systems. Complementing this wealth of interpersonal interactions is the technological base of the MSU and Sparrow EHRs, allowing residents to explore a new and different form of communication.

d. Limitations: Some residents are unable to complete the Psychosocial rotation until the second year of their training.

VII. Interpersonal and Communication Skills Competency-Specific Objectives.

Residents should achieve competence by the conclusion of their training year.

e. R1:

i. Communication: R1 residents should:

1. Provide thorough yet succinct oral presentations regarding patient care, using appropriate medical terminology;
2. Provide thorough and complete written or electronic documentation of patient care (*eg*, progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible, timely and use

appropriate medical terminology;
3. Demonstrate proficiency in use of verbal and nonverbal skills in interactions outside of the context of patient care.

ii. DPR: R1 residents should be able to:
1. establish rapport with patients from a variety of backgrounds;
2. perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses;
3. effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates.

iii. Ethically sound relationships: R1 residents should follow the tenets of ethics in patient care. Please refer to the Professionalism Competency Curriculum.

iv. Working within teams: R1 residents should be able to:
1. work as team members with senior residents, other first year residents and attending physicians, including the communication skills outlined above and the coordination of patient care.
2. observe medical students' clinical performance as an evaluator, demonstrate skills, and give constructive feedback.
3. communicate effectively with nursing and other ancillary staff to enhance patient care in hospital and clinic settings.

f. R2: The successful R2 resident meets all R1 learning objectives and in addition, has further mastered the following:

i. Patient Communication:
1. engage patients in shared decision making for ambiguous or controversial scenarios;
2. conduct family meetings as in the setting of end of life decision making;
3. successfully negotiate most "difficult" patient encounters, such as the irate patient.

ii. Team Work:
1. R2 residents should progressively assume a leadership role, including:
a. facilitating interactions between team members
b. establishing expectations for performance
c. overseeing patient care
d. ensuring participation in academic discussions, etc.
2. R2 residents leading general medicine and ICU teams are responsible for ensuring successful inpatient-outpatient provider communications to maintain appropriate continuity of patient care.