

**Coaching Communication using Simulated Patient
Encounters (CCSE)
to Improve Doctor-Patient Communication**

“Orientation Manual”

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Coaching Communication using Simulated Patient Encounters (CCSE)

About this Manual...

This orientation manual is designed to assist clinicians and physician educators in coaching therapeutic communication. It is assumed that the physician educators and coaches who use this have extensive clinical and supervisory experience. CCSE training is tailored for family physicians and allied health professionals. This manual is meant to be used as a shared template of activities and values that will guide the process of the coaching and learning.

All materials involved in the coaching/research processes are open to all participants. Both coaches and trainees/participants are given a copy of this manual.

RATIONALE, SUMMARY AND GOALS

Rationale:

The role of the physician as defined by the CanMEDs 2000 Project requires fundamental competencies in the areas of professional, communicator, scholar, collaborator, advocate and manager (CMA Policy 2000). Communication problems in medical practice are common - the patient and the doctor do not often agree on the presenting problem (Starfield et al., 1979, 1981; Street & Haidet, 2011); outpatient visits are often considered difficult by clinicians (Hinchey & Jackson, 2011); and communication deficiencies by trainees and practicing physicians exist that can contribute to these difficulties (Davis, Mazmanian, Fordis, Van Harrison, Thorpe, & Perrier, 2006; Sargeant, Mann, van der Vleuten, & Metsemakers, 2009).

Managing difficult treatment situations is a well-recognized but mostly unaddressed problem in health care. Non-therapeutic responses in these situations can jeopardize the positive physician-patient relationship that is an essential component of effective care. This medical education research project aims to foster improved communication with difficult patients and places its focus on the patient-physician relationship.

Main Study Goals:

The overall goal of CCSE is to improve *therapeutic communication skills* in difficult patient situations. If CCSE succeeds in this goal, participants will improve:

- interviewing competence,
- empathic communication skills, and
- therapeutic alliance with their patients.

As well, we believe this will lead to an improved sense of therapeutic efficacy.

We predict that improvements will be greater than changes with training as usual or with clinical experience in practice for the same participant over an equivalent preceding period of time and that these changes will be sustained at follow-up.

THE CCSE EDUCATIONAL MODEL

CCSE Educational Model:

Two assumptions guide this research initiative and the CCSE educational model:

- “Difficulty” arises out of the interaction of patient’s symptoms, context, and response style, along with the physician’s skill and resilience;
- Physicians can be trained to understand this interaction and to use this to better manage difficult situations.

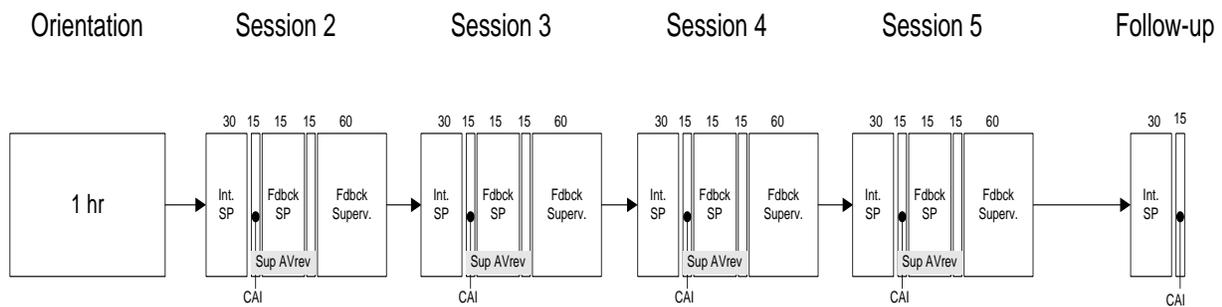
The CCSE educational model is developed with the following aims:

1. to improve complex communication skills that are essential in caring for patients, particularly challenging patients;
2. to create an optimal learning environment for trainees;
3. to avoid exposing actual patients to therapeutic errors during the learning process, and;
4. to condense the learning process to make it feasible for healthcare providers to attend.

The individual components of the package are established and accepted elements of medical education training programs: (a) the use of actors to portray standardized patients; the use of videotape feedback; (b) the coaching function; (c) problem-based experiential learning; and (d) structured evaluation.

The intervention is innovative in combining these components into *one practical 9-hour training package* that includes 4 weekly individualized coaching sessions based on a review of videotaped interviews between the trainee and standardized patients (SPs) (see figure 1). SPs are trained to portray commonly encountered clinical difficulties. Each half hour interview session between the participant and standardized patient is followed by a videotape-review and coaching session (60 minutes) with an expert clinical supervisor. In addition there will be 2 follow-up videotaped interviews with SPs: the week following completion of training and 3-6 months later at which time we will also conduct a qualitative feedback interview with each participant. It is important to monitor whether participants’ short-term learning translate into sustained improvements in their practice and to receive feedback for ways to improve CCSE.

Figure 1. [CAI=computer-aided self-evaluation; SP=standardized patient]



CCSE Components:

- *Simulated Interviews;*
- *Scripted Scenarios with Embedded Difficulties;*
- *Standardized Patients;*
- *Coaching with Videotape Review*

Simulated Clinical Interviews:

The simulated clinical encounters are scripted in such a way as to provide learning opportunities and exposure to a variety of commonly encountered clinical difficulties over the course of training including depression, anxiety and personality problems. The scenarios each have embedded therapeutic challenges and 'empathy prompts' of difficult-to-respond to phrases. Also included in the script for each simulated patient are background, family context, culture, coping style, and value systems.

The Scenarios

In creating the scenarios, we scripted levels of variable difficulty.

"Difficulty" is implemented in two ways:

1. through the complexity of the problem domain; and
2. the manner in which the problems are communicated.

In addition, there are identity and *content themes* that can cause discomfort in some trainees. These include: suicide, terminal illness, and discrimination based on aspects of identity such as race, age, class, gender or sexual orientation.

Communication difficulties can also arise when patients are help-rejecting, demanding or manipulative, aggressive, impulsive, interpersonally hypersensitive, angry or minimally responsive and withdrawn (Gallop et al 1993; Lancee et al. 1995; Lancee 2001).

One means for scripting difficulty is through the manner in which the presenting problems are expressed, for example with intense anger or non-responsiveness. Each simulated patient encounter has embedded 'difficult-to-respond-to' phrases which are intended to be *empathy challenges*.

Standardized Patients (SPs)

The benefits of using standardized patients instead of actual patients are:

1. the presentation of difficult treatment elements can be controlled;
2. the reviewed interview is part of a learning context, avoiding direct criticism of applied skills;
3. actual patients are protected from clinical errors occurring during training;
4. videotaping of SPs rather than actual patients is more feasible;
5. the SPs, in providing feedback to the participants, are more likely to be able to evaluate the physician more objectively, in contrast to a real patient who is more affected by the patient-physician power differential. This contributes to real patients' reluctance to be critical for fear of offending or losing one's doctor. Difficulties, when not revealed, can remain both unrecognized and unremediated.

One possible drawback of using actors instead of actual patients is if skills learned in artificial situations are not transferred to the field. However, we have used standardized patients extensively and have found that the interviewers report the experience to be very representative of real practice. The 3-6 month follow-up session will assess whether participants' improvements are felt to be generalized in their subsequent clinical practice.

The proposed training model can be adapted to different settings. While the use of standardized patients (actors) is an essential element of the training package, alternative approaches such as using actual patients or simulations by peers are also viable.

Learning with videotape review of simulated clinical interviews

Videotape feedback provides opportunity for more comprehensive examination of the interviews in contrast to naturally selective narrative accounts of clinical encounters (Hays 1990; Premi 1991). It also provides data on the content, process, organization, emotional, verbal, para-verbal and non-verbal aspects of communication, that are often beyond conscious awareness. During the coaching sessions, joint reviewing of the video is intended to engage the trainee to reflect *on* action so that they can develop their capacity to reflect *in* action (Brown et al. 1989; Binder 1999; Schön 1983, 1987).

Coaching:(see pages 15-16)

LEARNING OBJECTIVES

Learning objectives for the trainees that coaches will help to facilitate include:

- Improving the doctor-patient alliance
- Improving communication skills
- Improving empathic understanding and expression
- Expanding the field of enquiry
- Improving the sense of therapeutic efficacy

Specifically, we anticipate that:

1. Reviewing the videotapes, both trainee/participant and coach should detect an improvement over the training period (i.e. comparing the follow-up interviews with the baseline interview) in the following areas:
 - greater interviewing competence through improved alliance building skills
 - empathy in difficult situations
 - communication skills: clarity, logic, verbal expression repertoire, non-verbal expression, affect tracking, showing of genuine interest, care and concern, affect tolerance, recovery from errors, judgment, timing, flexibility, narrative skills, and frame reflection
 - ability to acquire knowledge and synthesize this into an understanding of the patient
2. Self-observed improvements in the above skills should correlate with an improved sense of mastery in difficult care situations.
3. The 3-6 month follow-up interview is intended to determine whether participants of CCSE maintain or acquire further improvements over time and to collect qualitative feedback on the process, experience and perceived applicability of what has been learned.

FINDINGS FROM PHASE ONE OF THE STUDY

Summary of Findings from Phase One of the Study (2001-2003)

In the first phase of the study, we conducted over 50 coaching sessions on videotaped simulated interviews with standardized patients by residents in family medicine and psychiatry.

In follow-up interviews, trainees highly valued the following aspects of their experience with CCSE:

- the use of videotape feedback
- the immediacy and individualized aspects of the coaching
- the focus on therapeutic engagement rather than diagnostic interviewing, and
- the use of standardized patients.

Here are some of the comments from follow-up interviews with participants from phase 1 of the study:

“This helped me to feel more prepared and to deal with psychiatry patients when other residents were freaked out.”

“I think my patients now leave with a better sense of being understood, of having connected.”

“This project actually motivated me. Seeing how my coach taught helps me in my teaching. I found that he was able to break things down in concrete aspects & he gave me lots of options & didn’t tell me that any 1 approach was best but that there were many.”

“Having the video was good. You can see your own reactions, your posturing. In medical education, it’s rare to have that level of feedback.”

Analysis of the pre-post measures of interviewing competence on the Counseling Self-Estimate Inventory (Larson et al., 1992) revealed significant improvements ($p < 0.001$).

PRELIMINARY FINDINGS FROM PHASE TWO OF THE STUDY

Summary of Findings from Phase Two of the Study (2004-2007)

In the second phase of the study we conducted a single-subject AB research design across multiple subjects, with change measured during three time periods: the one month control period (immediately preceding the intervention); the month of the CCSE educational intervention (four separate measurements); and two separate follow-up sessions (one week after the end of the intervention, and then again three to six months later).

Twenty-six family medicine residents (9 PGY1, 11 PGY2, 6 fellows) from five university-affiliated hospitals conducted four, once-weekly thirty-minute videotaped interviews with ‘difficult’ standardized patients. After each interview residents received one hour of individual coaching (including self-observation and skills teaching) from experienced training psychiatrists. Two

follow-up interviews with standardized patients occurred 1 week and 3-6 months post-intervention.

Results showed that participants experienced significant improvements in both self-efficacy and communication competence that were sustained for 3-6 months. There was no such improvement associated with training-as-usual during the month prior to the intervention (i.e., the control period).

DEFINITIONS AND TERMS OF REFERENCE

Therapeutic Communication

1. *What do we mean by 'Therapeutic Communication' and why is it so hard to teach and learn?*

Therapeutic Communication is the cornerstone of all clinical encounters in health care. It serves to forge working alliances between patients and healthcare providers. When working with severe or chronically mentally ill patients, therapeutic communication becomes central to the difficult work of sustaining therapeutic relationships. When there are difficulties in the alliance or poor communication, this can lead to misunderstandings, rupture in the helping relationships and ultimately compromised health care resulting from inadvertent, potentially iatrogenic or adverse consequences of therapeutic errors.

Therapeutic Communication is a clinical skill that requires the integration of multiple tasks: cognitive and emotional processing, tolerance of intense affect and arousal in both the clinician and the client, accessing knowledge, flexibility, skillful questioning, empathy, and verbal and non-verbal communication of engagement. The clinician develops an understanding of the patient's difficulties and carefully observes what unfolds in the therapeutic encounter. All of these skills help the physician to communicate a clinically reasoned understanding of the client's experience in a therapeutic and timely manner.

Trainees and staff often report feeling overwhelmed in the face of these challenges, which can be amplified when working with patients who present in difficult care situations.

2. *Difference between diagnostic interviews and interviews based on a therapeutic communication approach.*

In contrast to diagnostic interviews, *therapeutic communication does not rely on concrete diagnostic checklists*. Therapeutic communication seeks to engage the patient rather than focus from the start on clinical management of presenting problems or on effecting immediate change. Learning therapeutic communication offers an enriching educational experience that stands apart from the learning of other clinical skills. The 'art and science' of therapeutic communication can especially, when beginning as a novice expert health profession, feel elusive, ambiguous, non-specific and in short, frustratingly difficult for trainees.

Countertransference

1. What is 'Countertransference' and why is it so important to therapeutic communication?

It is fairly common that, during the interaction between the patient and the interviewer, the patient expresses wishes, expectations, or feelings toward the interviewer, that are based on the client's earlier experiences with another person. For example, a patient may fear that the clinician will act punitively, not because the clinician has given any indication that he or she is judging the patient harshly, but because the patient has had difficulty experiences in the past related to a punitive response from someone in authority. These feelings, expectations and wishes may be communicated consciously or unconsciously, verbally or non-verbally, through words or through actions. This phenomenon is called *transference*. Transference feelings may be positive or negative.

Transference is often not recognized by the interviewer who may automatically react directly to these wishes, expectations, or feelings. For example, the interviewer's reaction may include distressing feelings of fear, anger or helplessness. This reaction, called *countertransference*, can also be conscious or unconscious, verbal or non-verbal, involve words or actions, and be positive or negative.

Transference and *countertransference* are omnipresent in clinical encounters and not restricted to psychiatric or 'therapy' settings. They are important psychological concepts in understanding difficult care situations, as it is this very phenomenon that often impedes effective therapeutic communication and contributes to doctor-patient alliance difficulties.

However, *awareness* of transference and countertransference is one of the clinician's most valuable tools. Clinicians can use awareness of their countertransference experience to understand the patient's unconscious wishes, expectations, and feelings. Safran and Muran (2000) suggest that the interviewer's task is "not one of avoiding or managing countertransference feelings, but one of using [these feelings] to come to understand who the patient is in the world." This requires awareness by the care provider of his/her own emotional responses *along with* an awareness of what was happening in the encounter with the patient that evoked a particular response. The desired awareness requires reflection. Reflection takes a little time and a safe space in which to think. Rather than reflexively reacting to the patients, the clinician who is aware of countertransference feelings will often choose to use these feelings as a springboard for reflection upon the patient's world. The difficulties experienced by the interviewer are most likely also experienced by others in the patient's life. Reacting to these feelings reflexively often serves to repeat a vicious interpersonal cycle that is familiar to the patient and may well be the crux of the reason that he /she is seeking help.

Countertransference feelings can also provide insight into the care provider's vulnerabilities. It is important to distinguish between objective countertransference reactions that are generated by the patient and subjective countertransference reactions that are more idiosyncratic to the clinician. Discussion of countertransference during the coaching sessions can be a very effective method for examining and processing obstacles to therapeutic communication in difficult situations. If care providers can understand the interpersonal forces that shape their patients' lives, then they will be better able to avoid repeating the vicious cycle of ruptured relationships that perpetuate their patients' isolation and distress.

Empathy

a) *What is our definition of 'Empathy'?*

Empathy is about understanding the emotional experience and the perspective of another person. Empathy is difficult because it involves many clinically therapeutic tasks. One way of understanding difficulties with empathy is to examine difficulties with these tasks: engaging, accurately perceiving and communicating understanding and, finally, generating a clinically reasoned and therapeutic response with appropriate maintenance of professional boundaries.

For example, when presented with something a client says or does, the care provider may become more engaged or more distanced. Empathic engagement requires that the clinician keep the communication progressing either by inquiry into content, inquiry into affect or an expression of care and concern (verbally or non-verbally). This indicates to the patient that the care provider has understood and is interested in hearing more. However, if the clinician is tired or anxious, or has stereotyped views about the patient, or if the patient is hostile, or demanding or withdrawn or other obstacles intervene, then the clinician may avoid engagement and inadvertently close down the empathic process.

- Empathic engagement is facilitated when clinicians:
 - Explicitly acknowledge the patient's emotions,
 - Express care and concern or interest,
 - Recognize and acknowledge the patient's feelings of isolation, confusion, helplessness, worthlessness, hopelessness, or fear of being disappointed or hurt.
- Empathic engagement can be inhibited when clinicians:
 - Make the patient feel defensive (belittling, negating or minimizing)
 - Make the patient feel at the mercy of the system or a larger power (i.e. by being pessimistic or uncertain about one's ability to help)
 - Use clichés/platitudes rather than individualizing the patient's experience
 - Offer solutions that can't be reasonably acted upon

b) *How can identity differences, related to cultural background, race or sexual orientation complicate therapeutic communication or interfere with empathic engagement?*

Cultural and identity elements can also impede the empathic process in a variety of ways. For example, through the failure of the engagement process, through misunderstanding, or through inappropriateness of response.

- Failure of the Engagement Process
Difficulties can occur from failures to recognize engagement and disengagement cues due to misinterpretation of vocabulary, metaphor, non-verbal communication including facial expression and eye contact, formality of discourse, brevity of response, meaning of silence, agreeableness and flattery, and somatic expression of symptoms.
- Misunderstanding
Lack of shared experience can lead to misunderstanding of the experience of the patient. One must consider the individual's and cultural values and beliefs related to: the priority of family over individual needs; self-determinism versus deity, fate or destiny; tolerance for

competition versus co-operation; open disclosure versus family privacy; meaning of the ancestral past; and the role of belief and intuition.

- Inappropriateness of response
Assumptions that are founded in cultural norms about client expectations, can lead to failure to respond in a helpful manner. Important preferences should be taken into account. For example: preferences in relationship with caregiver; preferences for participation of family and community; preferences in traditional versus modern treatments; present needs versus long-term goals; preferences for solutions that are directive versus exploratory; preferences in proximity, bodily stance, tone, manner, dress; and preferences for acceptance and compromise versus confrontation.

Participant/trainees should be reassured that, with respect to the gathering of information, the expectation is that they might only gather a small percentage of all relevant data in the first half-hour of contact. The emphasis and primary purpose is to engage and establish a therapeutic alliance. Note that even very experienced clinicians find 'difficult' patients or situations 'difficult'. The goal of this study is to create opportunities to facilitate discussion, improved understanding and learning of clinical skills. Participants should be aware that there are many 'right' ways to respond. Also, 'empathic failures' in themselves provide potentially powerful therapeutic opportunities in their repair.

THE CCSE COACHING MODEL

Philosophy and Principles of Coaching

The CCSE model is based on adult learning theory, performance coaching, principles of effective teaching (Argyris 1997; Binder, 1999; Brown et al. 1989; Regehr, Hodges et al. 1996; Schön 1983, 1987; Tiberius & Tipping 1990; Wood 2000) and recommended psychotherapy supervision ideals (Alonso and Rutan 1998; Binder & Strupp 1993, 1997; Cameron et al. 1998; Ladany, 2005; Shanfield et al. 1993; Stoltenberg, McNeil, & Delworth, 1998; Watkins 1997, 1998) The educational role of the teacher/supervisor/coach is to *confer skill in seeking, appreciating and evaluating clinical data and to engender a curiosity* that will motivate self-learning/reflection/interpretation. An attitude of curiosity, spontaneity, and respect will model for the trainees the importance of a safe dyadic frame for reflection and questioning in which one can flexibly revise and adapt theory to action. *Constructive descriptive feedback* on both achievements and errors with joint generation of alternative courses of action will provide a template for coaching therapeutic communication (Shermin 1987; Tiberius and Tipping 1990).

Although *our primary aim is to engender a 'process-focused' intervention* for a 'process-rooted' problem, the therapeutic engagement is influenced by background, culture, help-seeking, beliefs, locus of control, attachment style, explanatory models, treatment expectations and other individual characteristics of patients. Therefore inquiry into these areas is essential.

While we urge the coaches to help trainees expand the sphere of inquiry, the coaching process itself remains primarily focused on process: effective questioning, non-judgmental listening, reflective thinking aloud, modeling, and feedback. This will provide trainees with an increased capacity for self observation and can help generate alternatives and options for change.

The following is a summary of *coaching and supervisory principles*:

- **Engage:** The goal is to engage in a collaborative, non-threatening relationship in which both observation and feedback unfold in such a way as to facilitate a *safe learning environment* in which the trainee can learn to be more effective in therapeutic communication.
- **Genuine Curiosity and Caring:** Engender a flexible, open, authentic, concerned, and interested approach. Model and emphasize the importance of *curiosity and caring*.
- **Observation of the Self & Self-Assessment First:** Model through the parallel 'learning alliance' the reflective stance that includes *observation* of the self, the patient, and the therapeutic encounter through both verbal and nonverbal communication. Teach to listen and watch for subtleties. Ask for a self-assessment, i.e. 'What do you think went well' and 'What did you struggle with?'
- **Give Positive Feedback:** Underlying capacities and strengths of the trainee will be acknowledged and when applied, reinforced by highlighting and discussing specific, observed sequences and describing the desired, achieved therapeutic behaviors.
- **Address Concerns:** *Address concerns*, finding ways to bridge into the coach's concerns (if and when they differ). Shanfield (1993), from his research of psychotherapy supervision, observed that "excellent supervisors" allowed residents to develop stories about the patient

encounter, tracked central and affectively charged concerns, deepened understanding, and invited speculation.

- **Use Specific Examples to Give Feedback and Generate Alternatives to Expand Therapeutic Repertoire:** Ascertain that the trainee understands the difference between an identified ineffective, concerning, or problematic therapeutic behaviour and more effective therapeutic behaviours. This should include a discussion that elaborates on plans, strategies, and ideas for ways to identify and specifically improve upon the identified 'untherapeutic' behaviour in subsequent clinical encounters.
- **Construct Meaning:** '*Reflect-on-action*' in a way that will hopefully lead the trainee to be able to '*reflect-in-action*' (Schön 1983, 1987). Expand and enlarge on constructed *meaning* and understanding from the reported experience of the SP along with the clinical encounter. Invite trainees to share both their own self-assessment along with the feedback they received from the SP. Shanfield (1993) believes that new knowledge is constructed in the supervisory interaction and that this is felt to be at the heart of the learning process.
- **Tolerate Ambiguity & Affect:** Engender and model *tolerance of ambiguity and tolerance of affect*.
- **Metabolize Shame & Generate Alternative Responses to Empathic Failures:** 'Difficulties' in the encounter in which embarrassment or *feelings of vulnerability* are to be discussed in an open, non-judgmental way. If there has been an empathic failure, frame this as a learning opportunity. Begin by acknowledging the trainee's potential sense of vulnerability and collaboratively explore alternative responses (+/- potential role-play).
- **Tend to Cultural Issues:** Ensure explicit discussion of questions that arise around values, beliefs and expectations that may be mediated through *language, culture or ethnicity*. Be open about what you don't know and invite the patient to elaborate and help you to better understand differences in cultural beliefs. These might otherwise impede the alliance or lead to false assumptions or misinterpretation of data. (See "Definitions and Terms of Reference")
- **Expand the Field of Enquiry: Information Acquisition** – Although process factors such as empathy and alliance building will be the focus of these encounters, there is a realistic expectation that essential data and background will be gathered and that this comprises part of what happens in good interviews. Encourage an expanded field of inquiry to include not only illness related information but also descriptors of cultural identity, trauma history (i.e. torture, war), social supports including the roles of family and community, coping repertoire (help-seeking behaviour), hopes, fears, expectations, and treatment preferences.

Deliberate and systematic attention to both process and content of coaching sessions is embedded into the design of the project. Education and supervisory principles will be discussed with the coaches, emphasizing the fundamentals of teaching, including effective questioning, listening, and dialogue on clinical reasoning along with the provision of meaningful and instructive feedback (Regehr, Hodges et al. 1996; Tiberius & Tipping 1990; Ende 1983). Coaching performance will, in a parallel process, be examined as part of the research study.

DETAILED PROCEDURE

Schedule and Structure of Sessions

Orientation Session – 60 mins

The objective of this first meeting between coach and participant/trainee: establish a *learning alliance* in which the coach can begin to get to know the trainee, discuss the learning objectives of the project, review the logistics, and address any questions or concerns. All interactions are one-on-one and each participant/trainee will have the same coach for all subsequent coaching sessions.

Trainees will meet for a preliminary orientation session with their coaches to establish an educational alliance and discuss the goals and process of the videotaped simulated patient interviews along with the overall project. During this first meeting, coaches will emphasize that the goals of the encounters are to engage in an empathic process and try to gain an understanding of the 'patient,' rather than making a diagnosis or management plan. Stress that these are not diagnostic interviews but rather 'engagement' interviews. Instruct participants to gather enough identifying data to be able to understand who the patient is, what their difficulties and experiences are, who their important supports might be, what they do to cope when in difficulties, and establish a therapeutic alliance so that the patient will be willing and motivated to return for follow-up.

Prior to the orientation session the trainee will have completed the Interpersonal Competency Questionnaire and the Experiences in Close Relationships scale (15-30 minutes).

Videotaped Interviews with Simulated Patients and Coaching Sessions:

1. Sessions 2 to 5

Session length: 120 min

- 30 min interview with SP
- 15 min SP feedback
- 15 min CAI & Research Questionnaire
- 60 min coaching

Session Outline

- a) Project coordinator meets with trainee
 - takes trainee to interview room
 - gives trainee a synopsis of the simulated scenario
 - sets up video camera and microphone
 - when ready gets the actor
 - does sound check
 - project coordinator leaves room

- b) Participant interviews SP for 30 minutes (research coordinator will knock on door 5min & 1min prior to the end of the interview)
- c) SP and participant go to separate rating rooms.
 - SPs score SP Evaluation Form and SP Session Feedback Form (15 minutes)Simultaneously, trainees score Self-Evaluation Form, Trainee Post-Session Self-Assessment, and complete computerized measures about reflection and interviewing competence
- d) SP joins the participant in his or her rating room and they meet for 15 minutes:
 - to review their experience
 - to compare ratings
- e) During step c and d the coach has been in the interview room to review the videotape set up by the research project coordinator; to mark salient clips for feedback.
- f) The SP is now finished with this participant and leaves.
- g) The participant joins the coach in the interview room for a 60 minute coaching session that includes review of salient segments of the video-taped interview with the simulated patient.
 - Research coordinator sets up and does sound check for audio taping of coaching session
- h) Following the coaching session, the participant and the coach both rate the coaching session using the Trainee Coaching Session Evaluation Form and the Coach Self-Evaluation Form, respectively.

2. Sessions 6-7

Note that for the two final follow-up interviews, Session 6 (60 minutes including 30 minute interview followed by SP feedback and completion of research questionnaires) and Session 7 (90 minutes including 30 minute interview with SP, followed by SP feedback and qualitative feedback interview with research staff), coaching is not included. However feedback is offered by the SP with a debriefing and qualitative feedback interview conducted by non-coaching staff from the research team (Above steps a-d).

Suggested Structure of Coaching Session for Coaches (60 minutes)

The following are meant as guidelines rather than rules to adhere to. Do what you think is best and try to keep a record of what you did differently and why.

1. Check-in

“How are you today? How do you think it went? What do you think went well? What did you struggle with?” Address indicators of anxiety, depression, and concerns in a supportive manner.

2. Agenda setting.

“Are there particular elements of this (just completed) interview that you would like to review and discuss today? Are there things that you thought about since the last session which you would like to discuss?”

If you and the trainee have developed a personal objectives list, ask if there are things on this list that the trainee would like to focus on

3. Bridge from previous session.

“Can you recall what we talked about in our last session? Is there anything that you were able to apply, noticed or found useful in your work this week?”

4. Review of salient video segments.

For each segment, jointly view segment without comment and invite the participant to reflect upon their observations and experience of the interview and to examine the interpersonal process taking place.

This can include discussion of: What the trainee was noticing, feeling and thinking at the time; what the trainee thinks that the SP was expressing, thinking, feeling, and needing at the time; imagining how s/he might have felt in the actor's place.

Invite further observation based on videotape review on how things went and discuss how this segment might exemplify a specific therapeutic challenge.

Use the observed, undesired or ineffective therapeutic interchange to get the trainee to identify the gap between what happened and a hypothetical improved outcome to generate reflection and discussion of alternative, more effective therapeutic behaviours or alternative responses that s/he would change the next time.

Ground discussion of theory from this specific example to jointly generate and discuss principles of effective therapeutic communication (“what do think this illustrates? - how would you advise a novice?”)

5. Summarize trainee's strengths and areas that need improvement.

6. Elicit feedback and session summary from trainee.

“What did you think of today's session? How can we improve how we approach things? What have you learned today?” Address conflicts or tensions directly through clarification of intention and reiteration of training goals - but avoid interpretations which may make the trainee have to defend him/herself. If appropriate, guide the trainee to reading or audiovisual materials.

Final Coaching Session on 4th Interview with Simulated Patient

In the fourth and final coaching session, in addition to providing coaching on the simulated patient interview, coaches and trainees will need to provide feedback on their impressions of the overall trajectory of change and progress, identifying strengths along with areas that might need continued attention. At the same time, it will be important to put closure on the trainee-supervisor relationship in this final meeting where some time should be spent reflecting on the joint experience of the coaches and participants and the overall process of learning.

Maintaining confidentiality

Each participant/trainee will be assigned a project folder (with a security flap). This folder has only a number on the outside flap and will be stored in a locked cabinet. The master list of names linking names and numbers will be kept locked in a separate place. As a trainee arrives at the project site, she or he will be given his or her folder by the project coordinator. In the spirit of openness, the trainee will have full access to all elements in the folder, and is allowed to choose which elements to share with actor or with coach. Trainee, actor, and coach produce assessment elements that are all added to the folder. Before the trainee leaves the project site, all elements are returned to the folder and the folder is given to the project coordinator. At the end of the training, the elements in the folder are entered into a computer database, with the folder number as the only identification information.

The coach chosen for a given trainee will not to have any direct administrative or supervisory influence over that trainee. All coaches have agreed to provide a confidential training process.

The audio and video materials will only be used for rating by an independent rater following a confidential protocol. After these ratings are completed the recorded material will be destroyed.

Feedback, Evaluation, Surveys and Measures

Standardized Patients (SPs) will provide feedback to the trainees after each interview. SPs will switch from being in 'role' portraying the patient in a scripted scenario to provide constructive, relatively objective feedback from the point of view of a potential patient. SP's will be instructed to give feedback in a descriptive rather than evaluative way that conveys their experience of the trainee and the interview, focusing their feedback on specific communicative behaviours of trainee/learner with the goal of sharing information rather than giving advice.

The purpose of SP feedback is two-fold. It serves to establish the safety of the context by reinforcing that this is a learning situation in which there are actors rather than real patients, thus the trainee needn't worry about the real impact of potential therapeutic errors. However the feedback from actors exemplifies the potential impact on actual patients, thereby emphasizing the importance of the exercise. By sharing information trainees benefit from impressions of their potential impact from the client's perspective. We believe it is an important and unique opportunity to receive transparent, honest, open, and informed feedback that exemplifies the perspective of the client.

The evaluation of the coaching process is achieved through ratings by the trainee and the coach along with subsequent qualitative analysis by independent raters of the audio taped coaching sessions. Assessment tools will include a checklist of critical supervisory elements.

Research Team

Paula Ravitz, M.D., the principal investigator of the project, has over 20 years of teaching experience, which informs her work as an educator of medical students, residents and physicians. She is an associate professor of psychiatry at the University of Toronto, director of the Mount Sinai Psychotherapy Institute and holds the Morgan Firestone Psychotherapy Chair at Mount Sinai Hospital. She is the head of the Psychotherapy Program for the University of Toronto, Department of Psychiatry. She has a special interest in dissemination of evidence-based psychotherapy and educational research and has been course director and faculty for numerous international CME workshops.

Jon Hunter, M.D., is the Head of the University of Toronto's Department of Psychiatry, Health, and Disease Program and Deputy Chief of The Department of Psychiatry at Mount Sinai Hospital. His clinical practice centers on the psychiatric care of cancer patients, with particular emphasis placed on psychotherapeutic interventions. His research interests include psychological management of chemotherapy side-effects, group psychotherapy in women at high risk for breast cancer, and the role of early life experience in adaptation to disease. He has won numerous Postgraduate Teaching Awards from the University of Toronto.

William Lancee, Ph.D., Director of Research in the Department of Psychiatry at Mount Sinai Hospital, has a long-standing interest and a number of publications on therapeutic communication, the doctor-patient relationship, empathy, the measurement of empathy, teaching medical students therapeutic communication, setting limits without exacerbating anger, the difficult psychiatric in-patient, educating cultural communication, knowledge and attitudes of staff towards AIDS patients, and training standardized patients to evaluate trainees.

Molyn Leszcz, M.D., is the Psychiatrist-in-Chief at Mount Sinai Hospital and Professor and Head of the Group Psychotherapy Program, Department of Psychiatry, University of Toronto. Dr. Leszcz's clinical work and academic scholarship has focused on broadening the applications of group and contemporary psychotherapies within psychiatry, geriatrics and with the medically ill. Dr. Leszcz has recently completed a multi-site clinical trial in the application of group psychotherapy in the treatment of women with metastatic breast cancer. His research also involves psychological interventions for individuals with genetic predisposition for breast cancer and for colon cancer. Dr. Leszcz has been the recipient of many teaching awards and has published broadly in the group therapy literature. He co-authored with Dr. Irvin Yalom the 5th edition of *The Theory and Practice of Group Psychotherapy*.

Robert Maunder, M.D., is associate professor at the Department of Psychiatry at the University of Toronto. He has carried out Canadian Institute of Health Research funded projects in stress in ulcerative colitis. He is actively involved in research and supervision of residents. He was supervisor for doctor-patient communication programs, teaching interview skills for 1st year and 2nd year medical students and family medicine and psychiatry residents.

Nancy McNaughton M.Ed., PhD.(abd) is a health professional researcher and educator and Associate Director for the Standardized Patient Program at University of Toronto. She is also an Affiliated Scholar with the Wilson Centre for Research in Education and an Academic Educator with the Centre for Faculty Development, at the Faculty of Medicine, University of Toronto. Her area of research is the epistemology of emotion and the place of emotion and affect in health professional training and practice.

Clare Pain, M.D., is an Associate Professor at the Department of Psychiatry, University of Toronto, and Director of the Psychological Trauma Program at Mount Sinai Hospital, Toronto. She is on the board of, and is a part-time psychiatrist for, the Canadian Centre for Victims of Torture (CCVT). She is also the co-project director of the Toronto Addis Ababa Psychiatry Project (TAAPP; www.utoronto.ca/ethiopia), and coordinator of the Toronto-Addis Ababa Academic Collaboration (TAAAC; www.taaac.ca). She has published a number of articles including two books: "Trauma and the Body: a Sensorimotor Approach to Psychotherapy" with Pat Ogden and Kekuni Minton Norton (2006) and "The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic" an edited book with Eric Vermetten and Ruth Lanius, Cambridge University Press 2010.

Andrea Lawson, Ph.D. is the Research Coordinator for the Department of Psychiatry at Mount Sinai Hospital. Her training is in quantitative research design and analysis.

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The Instruments

The evaluation was carried out using ratings from study participants (residents and family physicians) and compared with ratings from supervisors, standardized patients and independent raters. We used a computerized questionnaire, which is an amalgam of the paper and pencil tests. A computerized version is more interactive, and allows for immediate feedback to the trainees. We administered it at the same assessment times as the original paper and pencil tests so that we can determine reliability and validity. The objective is to replace the paper and pencil tests with the computerized assessment tool in the future.

The following domains will be measured:

- 1) Measurement of communication skills using *the Physician-Patient Interaction Checklist (Lehmann, et al 1990)* completed by trainees, supervisors and SPs after each session.
- 2) Measurement of Interviewing Competence using a modified version of the *Counselling Self-Estimate Inventory - Form 8 (COSE) (Larson et al., 1992)* by trainees at baseline and post-intervention. Supervisors score quality of trainees' SP interview using *the Video Review Log*.
- 3) Measurement of empathy using *The Staff Patient Interaction Response Scale (SPIR) (Gallop et al, 1990)* completed by trainees at baseline and post-intervention.
- 4) Measurement of Therapeutic Alliance using *Session Feedback Form Completed (modified from the empathy scale, Burns 1996)* by the SP.
- 5) The *Global OSCE Rating* instrument (Hodges, 2003) completed by supervisors after each session.
- 6) The experimental instrument, *Evaluation of Reflective Competence (ERC) (Gallop and Lancee 1990)* completed by trainees after each session.

Description of instruments

Measurement of communication skills

Physician-Patient Interaction Checklist (Lehmann, et al 1990) is a 41-item checklist (dichotomous scale) to be completed by SPs and expert raters/coaches which evaluates the quality of medical interview using videotapes, focusing on politeness, respect and communication. The scale provides objective feedback to resident participants and its reliability and content validity were demonstrated.

Measurement of interviewing competence

Counselling Self-Estimate Inventory - Form 8 (COSE)(Larson et al 1992) is a 37-item scale. The measure was modified by computerizing it, eliminating three items that referred to longitudinal counselling that didn't apply to the single session model of the CCSE, and modifying the wording of the anchors so that the trainee-rated scale was directed towards learning goals. The resident participant rates the items according to the extent to which they agree that the items reflect their actual estimate of how they would perform in a counselling situation at the present time. Rather than rating items on a six-point Likert scale (*strongly disagree* to *strongly agree*), in this modified version trainees indicate that they (a) "need improvement in this area," (b) "need only minor improvement in this area," (c) are "satisfactory, no improvement needed"; are "knowledgeably with confidence," (d) are "exemplary," or (e) "no evaluation possible." Higher scores reflect stronger perceptions of counselling self-efficacy. A factor analysis (N=213) yielded 5 factors that reflect trainee's confidences in using micro skills, attending to process, dealing with difficult client behaviours, behaving in a culturally competent way, and being aware of one's values. The inventory is reliable (alpha = .93). Initial validity estimates show that the

instrument is positively related to trainee performance, self-concept, problem-solving appraisal, and satisfaction.

Measurement of empathy

The Staff Patient Interaction Response Scale (SPIR)(Gallop, Lancee, & Garfinkel, 1990). The SPIR scale is an analogue scale that uses the written responses to hypothetical patient stimuli to assess the expressed empathy of staff. The stimuli are referred to within contexts that incorporate the independent variables under consideration. Each of the 4 pages of the scale reveals a context and 5 statements. The 4 pages are equivalent forms, but the phrasing of the statements is not identical. These 4 parallel forms allow for repeated assessment while minimizing practice effects. The 5 patient statements on each page are presented in a random order. Resident participants are given 30 minutes to complete the scale and the answers are scored according to a prepared manual.

Therapeutic Alliance

The Empathy Scale (ES) (Burns, 1996) (referred to in this proposal as the Session Feedback Form [SFF]) is a 12-item questionnaire to be completed by SPs. SPs rate how warm, genuine, and empathic their clinicians are during the session. They record how strongly they agree with each scale item with response options ranging from 'not at all' to "a lot" on a 4-point Likert scale. The first five items are written so that strong agreement indicates a good therapeutic relationship. The second five items are worded so that strong agreement indicates a poor therapeutic relationship. A total ES score can be obtained by adding the five positively worded items and subtracting the five negatively worded items. Range between -15 (the lowest possible empathy rating) and a +15 (the highest possible rating).

The Global OSCE Rating Instrument (Hodges, 2003)

This instrument has been widely used at the University of Toronto, Faculty of Medicine, in performance evaluations of medical students, psychiatry residents and foreign medical graduates in OSCE's. It has been shown to be a valid and reliable instrument, which allows us to evaluate and compare the outcome of our educational interventions with samples from other studies. We have attached some references of educational research in which this measure has been used.

Evaluation of Reflective Competence (ERC)

This experimental instrument is based on the literature that supports reflection as an important element of competence. Reflective practice is "consciously thinking about and analyzing what one has done." Applying a reflective approach to clinical interviewing fulfills several functions. (1) It improves the validity of the analysis of the interaction between a client and the interviewer. (2) It encourages critical thinking and promotes a questioning attitude that encourages continued engagement. (3) It promotes professional competence by encouraging the recognition of mistakes and weaknesses. (4) It provides documentation of an individual's progression in thinking and deeper understanding. The ERC is applied as an interactive computerized interview. The content of the instrument is attached in the appendix.

Three-six month follow-up measurement

Three months following the intervention, each participant will be assessed for longer term effects of the intervention using 1 SP encounter along with the following instruments: SFF and ERC for empathy and reflective capacity, PPIC and COSE for communication skills, IPS for interpersonal skills and PSQ for therapeutic alliance. A series of open-ended questions will be used to capture overall satisfaction with the training program, perceived impact on clinical practice, and suggestions for improvements.