2014

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Stokes, Theophil A.; Watson, Katie L.; and Boss, Renee D., "Teaching antenatal counseling skills to neonatal providers" (2014).
Uniformed Services University of the Health Sciences. 160.
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Teaching antenatal counseling skills to neonatal providers

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ARTICLE INFO

Keywords:

Antenatal counseling
Communication
Medical education
Periviable neonate

ABSTRACT

Counseling a family confronted with the birth of a periviable neonate is one of the most difficult tasks that a neonatologist must perform. The neonatologist's goal is to facilitate an informed, collaborative decision about whether life-sustaining therapies are in the best interest of this baby. Neonatologists are trained to provide families with a detailed account of the morbidity and mortality data they believe are necessary to facilitate a truly informed decision. Yet these complicated and intensely emotional conversations require advanced communication and counseling skills that our current fellowship-training strategies are not adequately providing. We review educational models for training neonatology fellows to provide antenatal counseling at the threshold of viability. We believe that training aimed at teaching these skills should be incorporated into the neonatal-perinatal medicine fellowship. The optimal approaches for teaching these skills remain uncertain, and there is a need for continued innovation and outcomes-based research.

Published by Elsevier Inc.

1. Introduction

Counseling a family confronted with the birth of a periviable neonate is one of the most difficult tasks that a neonatologist must perform. Such counseling sessions typically occur between a family in crisis and a neonatologist whom they have never met before. The neonatologist's goal is to facilitate an informed, collaborative decision about whether life-sustaining therapies are in the best interest of this baby.

Neonatologists are trained to provide families with a detailed account of the morbidity and mortality data they believe are necessary to facilitate a truly informed decision. Neonatology fellowship programs thus place a heavy emphasis on ensuring that fellows have acquired this knowledge. Yet the facilitation of a literal life-and-death decision requires a great deal more. These complicated and intensely emotional conversations require advanced communication and counseling skills that our current fellowship-training strategies are not adequately providing. This was highlighted in a

2009 web-based survey of U.S. neonatal-perinatal medicine fellows in their last month of fellowship training: 41% had never received any type of formal communication training, and 75% had never participated in any types of role-play or simulated patient encounters.¹

In this article, we will provide evidence demonstrating an essential need for advanced communication and counseling skills when providing antenatal counseling at the threshold of viability. We believe that training aimed at teaching these skills should be incorporated into the neonatal-perinatal medicine fellowship and will describe a variety of methods to address these needs.

2. The prevailing educational model

Each year at the Uniformed Services University of the Health Sciences, neonatology fellows are observed in a variety of simulated encounters with actors playing the role of NICU

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parents. A faculty observer (outside the room) watches a live video feed of each encounter and gives the fellow feedback upon completion of the scenario. A video recording of each scenario is also available for subsequent review. In one recent scenario, the actor played the role of an expectant mother at 25+ weeks' gestation, and the role called for her to appear nervous and afraid; she was also alone, as her military spouse had been deployed overseas. The faculty observer was instructed that the fellow's primary objective was to lead a discussion of risks to the infant, including short- and long-term risks. The faculty observer was asked to note whether the fellow discussed the following:

- (1) mortality and morbidity accurately;
- (2) respiratory, nutrition/GI, infectious, and neurodevelopmental morbidities;
- (3) anticipated interventions (e.g. intubation, ventilation, and umbilical lines); and
- (4) all risks and benefits of procedures while obtaining informed consent.

These goals and objectives were based on a model of antenatal consultation that is common throughout neonatology.^{2–6} During the simulation, the fellows dutifully presented, from “head-to-toe,” a detailed and accurate description of the common risks facing an infant born at this gestational age, including intra-ventricular hemorrhage, respiratory distress syndrome, chronic lung disease, patent ductus arteriosus, and necrotizing enterocolitis. They discussed umbilical lines and blood transfusions. Mortality rates were quoted, as were the possibilities of lifelong impairment including cerebral palsy or blindness. Fellows clearly felt pressured to get through their “script” within the time allotted, and the scenario became more of a lecture than a discussion. The words heard from the mother in these encounters were softly spoken and few in number. She frequently sighed loudly and stared distantly, and at times became tearful. Her non-verbal cues suggested she was too emotionally overwhelmed to comprehend a lecture on the perils of her baby being born prematurely, yet the fellows generally did not (and perhaps felt they could not) deviate from their pre-determined script for the encounter. The script seemingly had to be delivered.

In one illustrative example, the expectant mother straightened in her chair and pushed it back against the wall behind her as if trying to escape. This cue went unrecognized as the fellow continued with her description of common NICU morbidities. In the end, all of the fellows spoke knowledgeably about the topics listed as the objectives of the encounter. Yet post-encounter feedback from the standardized patients (Table 1) suggested that these conversations often did not meet the patients' expectations. The standardized patients reported feeling overwhelmed, unsupported, and even bullied. The fellows knew the data, but they had not been equipped with the advanced skills necessary to effectively *communicate* under such difficult circumstances.

3. Inadequate antenatal counseling in practice

The mismatch between physician counseling practices and parents' expectations can also be found in the literature on antenatal consultation. Much of this literature has focused on families confronted with the option of non-resuscitation in the face of extreme prematurity or severe congenital anomalies. Multiple studies suggest that these discussions tend to revolve heavily around the data neonatologists believe is necessary to facilitate literal life-and-death decisions.^{2,3,6–8}

Yet qualitative research exploring the needs of parents confronted with these situations demonstrates that they often need more than just data from their doctors. Parents who were interviewed after receiving neonatal consultation prior to the birth of an extremely premature infant consistently stressed the importance of establishing a trusting and hopeful relationship with the physician.^{9–11} They also commonly expressed doubts about their ability to rationally process so much information during a time of intense emotional stress.^{4,10} Parents commonly expressed a wish that their physician had been able to convey to them a sense of hope and compassion,^{7,12,13} and felt abandoned when physicians seemed to be “following protocol” or “acting by the book.”¹⁰ Women reported feeling “mistrustful” of physicians who communicated only bad news, and perceived such

Table 1 – Representative standardized patient comments following simulated antenatal counseling sessions with neonatology fellows.

Encounter 1:

“I didn't feel that I got empathy throughout. She did use a warm tone of voice, but I felt overwhelmed with constant eye contact and no break in the conversation for me to absorb information.”

“I felt a little bullied and although (she) had a warm tone of voice and was looking right at me, she was not on my side. I felt distrustful that she may do something without my consent. I felt powerless.”

Encounter 2:

“I felt challenged and looked down on by the fellow. I felt ignored, as I had expressed my opinion several times and felt disregarded. I felt uncomfortable when the student used lots of medical jargon.”

Encounter 3:

“The fellow expressed empathy by saying I did nothing to cause this in a supportive tone, but nothing like ‘I'm sorry this is happening to you’.”

“I felt overwhelmed after all that information. I felt unsure of what was really important and what ‘may’ happen. Everything seemed to have the same level of importance. Perhaps if the fellow modified her tone I might have felt less unsure?”

“I felt lost in the jargon.”

physicians as having “given-up.”¹⁰ In the words of one parent:

...the doctor comes, gives information, and leaves; it's like there is no relationship, someone you could rely on. If you are ill, you need to rely on someone and say “help me.” There you want to say “help me” (but) he/she just comes, gives information, and leaves.⁷

Neonatologists and families often have divergent goals at the outset of such conversations, and discordant views of what was actually said during them.^{7,8} Taken as a whole, this literature suggests that the current model of antenatal counseling suffers from a lack of communication skills, a lack of shared goals, and a neglect of the important role that emotions play in all of these. These are the critical issues that must be addressed when training neonatal practitioners to provide antenatal counseling.

4. Emerging models of education

Several models to train neonatology clinicians in communication and counseling skills can be found in the literature. Boss et al.¹⁴ recently published their evidence-based communication training model “Neonatal Critical Care Communication, NC3” for neonatology fellows and neonatal nurse practitioners. This model is based on OncoTalk, which has been successfully adapted to train fellows from multiple disciplines including adult oncology, geriatrics, palliative medicine, adult intensive care, and pediatric intensive care.^{15–17} The structure of the NC3 training is a 3-day retreat involving two primary learning activities: (1) didactic sessions targeted at discreet communication skills relevant to conversations with NICU families and (2) deliberative skills practice via small group, longitudinal role-plays with actor “parents.” The communication skills emphasize responding to emotion, eliciting family goals and values, engaging families in discussion, and ensuring that families understand the information delivered. The longitudinal case studies for the role-plays involve common NICU clinical scenarios, and learners practice the targeted communication skills with the same “family” at different points in their infant's NICU course. The actors are carefully trained to identify the targeted communication skills during the role-play, and they will either escalate or moderate their behaviors based on how well the learner performs the skill. Feedback from faculty and peers is focused on what the learner did well. NC3 builds on the fellow–nurse practitioner collaboration that is common in many NICUs. Participants rated the training as highly successful, both immediately after and one month following NC3 training.

Meyer et al.¹⁸ have reported their success with the Program to Enhance Relational and Communication Skills (PERCS). This model incorporates broader NICU staff, from social workers to chaplains to medical interpreters, during 6-hour workshops. Participants share their experiences with successful communication strategies and view a video of parents talking about their child's end-of-life experiences. The model also incorporates trained actors as parents, and focuses on the context of an interdisciplinary team meeting with the

family. Regardless of discipline or years of experience, participants reported improvements in their self-perceived competence and preparation for difficult conversations. These improvements in perceived competence appeared to be sustained for as long as one year following the workshop.

Cuttano et al.¹⁹ describe ongoing development of a simulation model for training of NICU clinicians that focuses on safety and error prevention, and includes communication skills training. Multiple communication training models that have proven successful in other scenarios involving high-stakes medical decisions might also be adapted for use in training neonatal–perinatal clinicians. The Kalamazoo Consensus Statement synthesizes the common elements of several different communication training models, all of which emphasize relationship-building with patients/families, understanding the family's perspective, and collaborative decision making.²⁰ Several professional accrediting organizations, including the Accreditation Council for Graduate Medical Education, have integrated communication skills into trainee competencies.

5. Incorporating improvisational theater training techniques

In improvisational theater, actors work without scripts. Improvisation teaches people to quickly create relationships, dialogue, and scenes by connecting with their scene partner and developing a shared story through deep listening and clear information delivery. Both physicians and improvisers must learn to recognize and respond to new circumstances in the moment. The overlap between improvisational theater skills and medical communications skills led one author (K. W.) to develop “medical improvisation,” a teaching method that tailors improvisation exercises to the communication needs of physicians.²¹

This approach is grounded in the observation that young clinicians struggling to remember medical information regurgitate scripts, but mature clinicians with a firm grasp of the medical facts can better serve their patients by going off-script. “Going off-script” does not mean throwing away the goals of the encounter or skipping critical information. Instead, it is the advanced communication skill of spontaneously reformatting how information is delivered to meet a particular patient's needs. As trainees' medical knowledge, skill, and responsibility increase, their communication capacity needs to increase accordingly.

In 2012, two authors (T.S. and K.W.) designed a 3-hour medical improvisation workshop for neonatology fellows and attendings. The workshop addressed several skills and concepts relevant to a prenatal consult for premature labor.

The experiential portion of the workshop was created to explore the expression of empathy in response to non-verbal cues of patient distress. A pair of participants was given a non-medical scenario between roommates (such as coming home to a roommate who has just suffered a romantic heartbreak) and was asked to improvise two conversations: first, the person entering the home was instructed to respond to the roommate's tale of woe unempathically, and second, to improvise an empathic response. Afterward, everyone in the

workshop discussed what statements, silences, tones of voice, and non-verbal cues in these scenes read as “empathy” or “lack of empathy” to them. Participants made several interesting discoveries. For example, one was surprised that those observing his scene perceived his attempts to fix the problem as dismissive of the roommate’s sadness, rather than supportive or helpful as he intended. (“Wow! That’s what I’ve been doing with my daughter!” he later exclaimed.) Another participant learned that her natural inclination to reframe the roommate’s problem as “not so bad,” which she intended as an expression of empathy and support, had the opposite effect—her scene partner experienced the cheery reframe as an undermining message of “stop being sad” or “you shouldn’t be sad, that’s not the right reaction.” The discussion that followed explored the difficulty of co-existing with another’s sadness. Other improvisation exercises in the workshop specifically targeted recognizing, expressing, and responding to a range of emotions, collaborative partnering, and delivering information in short manageable chunks rather than long monologues.

In the discussion portion of the workshop, participants were invited to brainstorm truthful positive messages that might be helpful when faced with parents who perceive that a doctor who only communicates only bad news is uncaring. The group generated statements that might convey comfort and support that could be shared alongside upsetting medical facts, such as:

- “You’re in a good hospital—I wish you weren’t going through this, but given that you are, the good news is everyone here knows how to handle premature labor and we’re going to take excellent care of you.”
- “You and I are a team—I’m going to do everything I can to save your baby’s life (or help you have the healthiest baby possible, or keep your baby comfortable) and help you get through this.”
- “You can change your mind—we’re flexible and we understand it takes time to process all this information; you can revisit these decisions anytime before delivery.”
- “We want to help you in any way we can—what else can we do to help you deal with this difficult situation?” (Offers of practical assistance with a patient’s non-medical priorities, such as “Can we call the support people you need here to get through this unexpected delivery?,” “Can we help you set up the childcare for your other children you need so you can give this delivery your full focus?,” and “Would you like me to ask a hospital chaplain to come see you?”).

The 2012 workshop demonstrated that medical improvisation training could help create the kind of communications skills that parents want—neonatologists who are not just “following protocol,” but who share necessary medical information while also connecting with parents as individuals in crisis. Medical improvisation training could improve neonatologists’ advanced communication skills in areas such as emotional presence, establishing trust, reading non-verbal cues, recognizing what information one’s “scene partner” (i.e. the patient) has received, and learning what information they want or are able to hear. Three hours seemed to be enough time to make helpful shifts in participants’ perspectives on

prenatal consults, but more work is needed to determine how much medical improv training is needed to facilitate lasting behavior changes. Plans to incorporate medical improvisation training into an existing neonatology communication workshop series are ongoing.

6. Conclusion

In a paper titled “Doctoring as Leadership: the Power to Heal,” physician philosopher Edvin Schei argues that the medical establishment’s efforts to strengthen patient autonomy may have inadvertently “harmed the patient–doctor relationship by causing physicians to shun care-taking or counseling behavior that can be interpreted as paternalism.”²² This may well be the case with the model of antenatal counseling currently being taught. In agreement with Schei, the counseling process should instead be viewed as an endeavor in “relational competence, where empathic perceptiveness and creativity render doctors capable of using their personal qualities, together with the scientific and technologic tools of medicine, to provide individualized help, attuned to the particular circumstances of the patient.”²² To paraphrase, physicians must accept and cultivate their role as counselors.

These are emotionally stressful, complicated conversations. Families are different, and a standardized, check-the-box approach to these encounters will not work. We must accept this, and recognize that *training* neonatal practitioners to provide antenatal counseling will also be an emotionally stressful, complicated process. Neonatologists are different too, and a standardized, check-the-box approach to teaching them these skills will not work. The methods discussed in this paper are suggested strategies that we believe hold promise, but continued innovation and exploration is needed. Neonatologists should avoid trying to do all of this on their own. Nurses and NICU parents and trained behavioral health counselors should be engaged in this process. There remains a great deal of work to be done, but a recognition that our old models are not working is a critical first step.

The views expressed in this article are those of the authors and do not necessarily reflect the official policies or positions of the Departments of the Navy, Army, Defense, or the US Government.

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