A Wider Use for the Uncertainty Communication Checklist

de Carvalho Filho, Marco Antonio; Jaarsma, Debbie; Strazzacappa, Marcia

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regularly tested on the medical decisions they would hypothetically make, they should be assessed on how they would convey and execute those choices. Theoretical frameworks like MEET could help students build a more reality-rooted confidence in their abilities, improve their communication skills, and assimilate techniques to implement in their future clinical practice.

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Yuri Yin-Moe Aung
Final-year medical student, Imperial College School of Medicine, Imperial College London, London, United Kingdom; yuri.aung15@imperial.ac.uk; ORCID: http://orcid.org/0000-0002-3138-5797.

Eri Yin-Soe Aung
Final-year medical student, Imperial College School of Medicine, Imperial College London, London, United Kingdom; ORCID: http://orcid.org/0000-0003-4113-3881.

Rishabh Hariharan
Final-year medical student, Imperial College School of Medicine, Imperial College London, London, United Kingdom; ORCID: http://orcid.org/0000-0003-3230-006X.

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In Reply to Aung et al: Receiving the comments from Aung and colleagues was a moment of joy and reinforced our trust in Medical Education Empowered by Theater (MEET) as a meaningful pedagogy. We wanted to seize the opportunity to expand on some of the authors' reflections.

The transition to practice is indeed a moment of profound discomfort. Early-career doctors often feel ashamed, awkward, and abandoned when facing suffering and death in real-world situations in which they are responsible for clinical decisions.[1] The cursed words "what if" when pointing to the past are terrible: "What if I had done *this* instead of *that*?" The resulting intense emotional reactions often drive early-career doctors away from engaging in meaningful reflections about their performance. Reflections should be focused on preparing for future experiences and not on finding who was guilty of a bad outcome. On the stage, early-career doctors and medical students not only have the opportunity to revive and reflect on the experience, modulate and relive their emotions, but they can also help supervisors become aware of their struggles.

Moral, racial, and sexual harassment by supervisors is inadmissible, but there are other ways of sabotaging the good spirit of novices. Some (well-intentioned) supervisors believe that they are preparing the newcomers for the reality of practice by pointing out the downsides of the medical profession. These supervisors work in a complaining mode, repeating ad libitum how miserable a doctor's life can be, and how difficult patients are, draining the soul out of early-career doctors and medical students. The stage may become a place to reenergize and learn that although doctors encounter sad situations, the profession itself is not sad. Having the means and opportunity to help others may be a source of joy and fulfillment.

Finally, as the authors stated, several modern medical schools count on professional actors in various simulated activities, from training to assessment. However, these actors often do not participate in devising the learning goals—actors do not have space to bring their learning tradition and culture to the medical education table. We have been working with this question in mind: How can we empower actors as autonomous medical teachers? MEET invites Aung and colleagues and *Academic Medicine* readers to join this conversation.

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Marco Antonio de Carvalho Filho, MD, PhD
Associate professor, emergency medicine, Life and Health Sciences Research Institute (ICVS), University of Minho, Braga, Portugal, and Senior Researcher in Medical Education, University Medical Center Groningen, The Netherlands; macarvalhofilho@med.uminho.pt and m.a.de.carvalho.filho@umcg.nl; ORCID: https://orcid.org/0000-0001-7008-4092.

Debbie Jaarsma, PhD
Full professor of medical education, director, Center for Education Development and Research in Health Professions, and research leader of LEARN (Lifelong Learning, Education & Assessment Research Network), University Medical Center Groningen, Groningen, The Netherlands; ORCID: https://orcid.org/0000-0003-1668-2002.

Marcia Strazzacappa, PhD
Actress, clown, and associate professor of education, and Laborarte coordinator, University of Campinas, São Paulo, Brazil; ORCID: https://orcid.org/0000-0002-4118-6572.

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A Wider Use for the Uncertainty Communication Checklist

To the Editor: We would like to commend the authors of "Development of the Uncertainty Communication Checklist: A Patient-Centered Approach to Patient Discharge From the Emergency Department."[1] Not only do Rising and colleagues address the important issue of how we can support doctors to develop the skills to communicate diagnostic uncertainty to patients, but they also offer a rare example of how to involve patients in teaching and in learner assessment. We were also pleased to see that the checklist will continue to be refined based on the experience of its use in teaching emergency department residents. However, we would have appreciated some further detail on the refinement process the authors plan to use.

It strikes us—a psychiatrist completing a PhD in the field of ambiguity tolerance, and a professor of medical education—that such a checklist could have far wider use. As the authors indicate, diagnostic uncertainty is common within medicine, and this issue is not unique to the discharge process within the emergency department. For example, there is limited evidence regarding the best way to support and train clinicians in communicating to patients the challenging concept of medically unexplained (i.e., persistent physical) symptoms. Within the United Kingdom, this is a huge challenge within both the community (primary care) and the acute hospital (secondary care) settings.

We are in complete agreement that involving patients to improve the doctor–patient interaction approach is the "next frontier" for public engagement. Involving patients would

be particularly useful for interactions where there are likely to be medically unexplained symptoms, as we know that patients are often not satisfied with the explanations or care they receive.[2] As suggested by Rising and colleagues,[1] if tools such as the uncertainty communication checklist are developed, then monitoring patient outcomes would be crucial, and there might well be a subsequent desirable change in health care utilization.

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Jason Hancock, MBChB, MRCPsych, MSc
Consultant psychiatrist, Devon Partnership Trust, Exeter, United Kingdom, and honorary clinical lecturer, University of Exeter Medical School, Exeter, United Kingdom; jason.hancock@nhs.net.

Karen Mattick, PhD, MSc
Professor, medical education, University of Exeter Medical School, Exeter, United Kingdom.

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In Reply to Hancock and Mattick: We thank the authors for their comments on our checklist and address a few questions they raise regarding next steps for use of this checklist.

At this time, we have completed our trial across 109 emergency medicine residents at 2 academic institutions and are in the process of analyzing the impact of our curriculum on outcomes of the simulated encounters. We obtained detailed feedback from residents about the usability of the checklist, which we will use to refine any unclear checklist elements. We then plan for a trial in which we will apply the finalized checklist in real, rather than simulated, patient encounters to assess its effect on patient outcomes, including subsequent care utilization, as we agree with the authors that this is a crucial component for assessing the ultimate impact of our work.

Although we have not yet planned work to investigate the realm of medically unexplained symptoms, we agree that acute care diagnostic uncertainty and medically unexplained symptoms share common challenges and likely have overlapping solutions in addressing uncertainty and ambiguity tolerance. We currently have work underway to extend our uncertainty focus to include other relevant domains (e.g., uncertainty related to COVID-19) and to expand more broadly across medical trainees outside of emergency medicine.

COVID-19 has brought uncertainty to the center stage for patients and providers alike, and thus there has never been a more important time to focus on how to facilitate effective patient–provider communication about uncertainty. While we cannot remove the uncertainty, we hope that with such communication, we can remove the insecurity that often accompanies uncertainty. We must prioritize learning how to make uncertainty understandable, acceptable, and tolerable to the patient—and we believe that this is best done through work that actively engages patients throughout the development process.

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Kristin L. Rising, MD, MSHP
Associate professor and director, acute care transitions, Department of Emergency Medicine, Sidney Kimmel Medical College at Thomas Jefferson University, Philadelphia, Pennsylvania; kristin.rising@jefferson.edu.

Danielle M. McCarthy, MD, MS
Associate professor and vice chair of research, Department of Emergency Medicine, Northwestern University Feinberg School of Medicine, Chicago, Illinois.

Important Consults Are Not Always "Perfect"

To the Editor: We read with interest Pavitt and colleagues' article[1] in which the authors evaluated resident and fellow perceptions on ideal communication for inpatient consultations. They identified that "the way residents frame the initial consult affects the resident–fellow relationship, teaching, learning, and patient care." Additionally, "fellows emphasized that if a resident can articulate a well-formulated, specific consult question and include the pertinent patient information, it can positively affect the interaction," while "residents commented that when consult questions were vague, they felt uncomfortable calling the consult and often received pushback." We would like to comment on these findings from within the context of our *Academic Medicine* article outlining a framework on consultation types.[2]

We defined 7 consult types as ideal, obligatory, procedural, S.O.S, confirmatory, inappropriate, and curbside. The value of categorization is that framing a consult type may positively impact provider communication and patient care. Pavitt and colleagues have now provided evidence for our theoretical perspective, identifying that residents and fellows do prefer when consults are "ideal"—when there is a clear question that undoubtedly falls within the expertise of the consultant. This is not surprising as "ideal" consults are the cleanest type for both caller and consultant. It is easy for each party to see the consult as important and that helps to avoid friction and positively impact the learning environment. Residents and fellows would prefer all consults be "ideal."

However, not all consults valuable to patient care and teaching fall into the "ideal" category. The best example of this is what we labeled "S.O.S. consults," in which the calling team is unable to formulate a clear question, but they believe that the consultant taking an overall look and providing advice would nonetheless be valuable. Although learning how to ask the right question of a consultant is a valuable skill, residents and fellows should recognize that S.O.S. consults are common, important for patient care, and often a valuable teaching opportunity. Forcing an S.O.S consult into a "clear question" can be detrimental if the question is off-mark. As Pavitt and colleagues have clarified,[1] these types of consults may be higher risk for interteam friction. However, we believe the described pushback from consultants could be largely mitigated with an improved lexicon by using the consult-type framework. If the confused practitioner were to highlight they were calling with an S.O.S consult, that framing could help the consultant focus on the need, rather than the frustration of receiving a vague question.

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