Best Practices in Relational Skills Training for Medical Trainees and Providers: An Essential Element of Addressing Adverse Childhood Experiences and Promoting Resilience

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ABSTRACT

Medical providers' ability to form strong therapeutic alliances with patients is an essential clinical skill that is associated with a higher quality of care and improved provider well-being. However, comparatively few medical providers exhibit adequate relational skills, which serve to convey respect, communicate caring, and build trust between the medical provider and the patient. A growing number of medical training programs and continuing medical education programs have begun to incorporate relational skills training, but the results have been highly variable in terms of training methods and effect. To support administrators who are considering the implementation (or improvement) of relational skills training in their organization, we provide a set of best practices for relational skills training, in the basis of a review of the literature and on our experience as clinical educators, and show the application of these best practices through a case study. We conclude with a discussion of challenges for implementing a high-quality relational skills training program, policy-level solutions for these challenges, and recommendations for future research.

KEYWORDS: best practices; communication; education; patient; relational; relationship; skills; trainee

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THE ABILITY TO form strong therapeutic alliances with patients is an essential clinical skill that is associated with a higher quality of care,[1,2] including higher rates of returning for follow-up visits, taking medication as prescribed, and adhering to recommendations for lifestyle changes.[3] Patients reporting better relationships with their medical provider tend to disclose more about themselves to their provider,[4] assign higher satisfaction ratings,[5] and are less likely to pursue litigation for provider malpractice.[5,6] Complementarily, providers who are routinely able to form strong therapeutic alliances experience higher levels of well-being and less burnout.[5]

Forming strong therapeutic alliances is especially important when providers are caring for patients who have experienced physical, psychological, and/or social trauma, because these alliances help providers learn of the trauma, avoid retraumatization, work with it, and help with its healing. Providers who are able to show interest, to communicate having time for discussing these issues, and to withhold judgement encourage patients to disclose such traumatic experiences,[5,7] thereby making it possible to offer the necessary treatment, referrals, and sensitivity in ongoing encounters. Trauma-informed services prioritize building a relational collaboration that is founded on safety and trust,[8] to promote healing and prevent retraumatization. It is not surprising, therefore, that building respectful and equitable therapeutic alliances helps to improve traumatized patients' adherence and engagement in outpatient[9] as well as inpatient[10] settings.

Certain patient populations, such as those with substance abuse[11] or chronic pain,[12] are more likely to have experienced a traumatic experience in their past, whereas other patient populations (eg, oncology, hospice) are likely to experience aspects of their current medical experience as traumatic. Pediatricians as well as geriatricians, who frequently communicate not only with the patient but also with family members of varying ages and levels of comprehension, manage complex relational systems in service of offering the best possible care for their patients. It is therefore especially important for providers who serve patients from such populations to be highly skilled at forming and maintaining strong therapeutic alliances with the patients and families they serve.

Forming strong therapeutic alliances with patients requires the consistent application of excellent communication and interpersonal skills,[5,6,13] which we call relational skills. The application of these skills conveys respect, communicates caring, and builds trust between the medical provider and

the patient. Relational skills are foundational to every interaction with a patient, from the basic activity of eliciting information to diagnose and treat a patient's illness and all the way to emotionally intense conversations such as sharing bad news, disclosing a medical error, or discussing end of life and goals of care. The consistent application of relational skills becomes even more important when interacting with patients who have experienced trauma; the provider's ability to sensitively inquire, listen, and address previous trauma can help patients feel less alienated and more empowered, and prevent the compounding of trauma in the course of medical treatment.[14]

Despite the vital role that relational skills play in the formation of effective therapeutic relationships, comparatively few medical providers exhibit adequate relational skills, as judged by patients[13] or by external observers.[15] Indeed, the attrition of relational skills might begin early in medical training, because medical students appear to lose empathy over the course of their training.[16] As a result, a growing number of medical training programs and continuing medical education programs have begun to incorporate relational skills training, and such training has been shown to be effective.[3,17,18] Over time, as relational skills training became more prevalent in medical education programs, a number of issues have emerged, including great variability in training methods and in the magnitude and persistence of the effect of training.[17] We believe that those responsible for designing and implementing relational skills training programs would benefit from a concrete list of best practices in teaching relational skills. To this end, we reviewed the literature on existing training programs and experimental interventions to identify practices that consistently contributed to sustained improvement in relational behaviors, and related these practices to our own experience as clinical educators who design and provide relational skills training. We list best practices (and examples of how we have been applying them) for educating medical trainees and providers in the consistent application of relational skills in service of building stronger therapeutic alliances.[19]

BEST PRACTICES IN RELATIONAL SKILLS TRAINING FOR MEDICAL PROVIDERS

EXPERIENTIAL

Training can generally be classified as didactic (ie, passive, abstract, and/or hypothetical) and experiential (ie, active, concrete, and applied). After a relatively brief didactic introduction of guiding principles and techniques, the bulk of the training should be experiential.[17] Experiential learning[20] can be achieved through interactions with peers, practice with standardized patients, and supervised patient encounters. We have found the "flipped classroom" model[21] (ie, learning material individually and meeting to practice, as opposed to the traditional classroom model of learning new material in a group and practicing individually) particularly helpful in this regard: Didactic content is provided to learners in a standardized way via customized online training modules, which learners can go through at their own pace, while starting to practice the skills through quizzes and simulations. After going through the didactic materials on their own, learners participate in experiential learning workshops, in which they practice the relational skills they were introduced to through progressively more lifelike contexts. When practicing relational skills experientially, we have found small group work and individual work to be most effective,[18,22] because these formats allow for high rates of active participation, individual feedback, and comfort with experimenting with new communication skills in a more intimate and safe setting.

DATA-DRIVEN FEEDBACK

Learning requires opportunities for deliberate practice combined with performance feedback.[23,24] Feedback becomes more effective the closer it is delivered to the performance to which it pertains.[25,26] Immediate feedback can be delivered in a variety of methods, including a "time out" method during simulations (eg, with standardized patients), or by using auditory (eg, ear buds) or visual (eg, text messages on smart watches) channels, which allow a trainer to communicate with a learner in real time. Using multiple sources of assessment and feedback is essential, because providers' self-report differs from that of their supervisors, trainers, and patients.[17,27]

CONTINUOUS

Acquisition and maintenance of relational skills are 2 separate challenges facing medical providers, especially because of the increasing cynicism and loss of empathy over the years of medical training.[16] Training must be incorporated into all stages of a medical trainee's education, because the application of relational skills tends to diminish without reinforcement and supervision.[17] Training should ideally begin with the first year of training and continue through clinical years and on to postgraduate years, including continuing medical education and incorporation into the maintenance of certification requirements.

After an initial intensive training, ongoing assessment and training can help maintain and strengthen relational skills, requiring a relatively small time investment: In preclinical settings, maintenance can be provided by brief online modules, as well as by incorporating relational behavior feedback after encounters with standardized patients. In clinical settings, incorporating feedback about relational behavior into formal evaluation checklists helps supervisors as well as trainees remember to apply the skills and to think about them, whereas online modules and grand rounds can introduce more advanced skills appropriate for specialized or complex situations.

COHERENT

Teaching relational skills requires integration across the entire educational enterprise, to maximize the benefits of constant social learning[28] (adopting behaviors implicitly condoned by the social milieu), situated learning[29] (learning through sociocultural immersion), and experiential learning[20] (learning through direct application and

engagement). Such coherence can be achieved by using consistent language for training, assessment, and feedback by all supervisors and trainers who come into contact with a learner (eg, course instructors, standardized patients, residents, attending physicians), and not only those whose primary responsibility is to offer training in relational skills. Thus, we found it helpful to include standardized patients in the training, to ensure that they use standardized language when providing relational feedback to medical students, and to make the content of the training available to instructors of other courses.

Comprehensive

Viewed through the lens of the theory of planned behavior,[30] behavior change requires holding a positive attitude toward the behavior (ie, seeing it as beneficial and worthwhile), experiencing normative pressure to perform the behavior (eg, believing one's supervisors expect one to perform the behavior), and having self-efficacy regarding the ability to perform the behavior. Training must target all of these elements, in addition to ensuring competence in the actual performance of relational behaviors. We have found that positive attitudes can be nurtured through case studies and reviews of the state of scientific evidence; positive normative pressure can be conveyed by having a senior representative of the organization (eg, vice dean for medical education) stating explicitly that excellent relational skills are expected of every student by the end of their training; and self-efficacy can be developed through increasingly complex experiential learning[20] exercises that include accurate and encourage formative feedback.

Competent Teachers

Training must be delivered by individuals who are competent at applying relational skills as well as at coaching others on the application of relational skills, because social learning theory dictates that much of learning occurs as a result of observing and imitating behavior that is sanctioned and rewarded.[28] Whereas this point might seem self-evident, we have found that educational administrators often assume that their faculty members are competent relational skills trainers simply because of their seniority or their roles. This is not always the case, and great care must be taken when selecting the faculty and trainers who will provide the actual relational skills training to learners. We have found it especially useful to provide training to designated faculty and trainers,[17] to review the relational skills as well as the methods of coaching relational skills.

Case Study: Implementation of Comprehensive Relational Skills Training Program for Medical Students

Incorporating the full list of best practices described previously requires a multicomponent curriculum that involves training not only medical students, but also their faculty and other trainers (eg, standardized patients). The Table shows a training program that embodies these best practices using a variety of training activities. This training program is the actual relational skills training curriculum we have been implementing at the University of Pennsylvania's Perelman School of Medicine over the past few years, and shows how each component corresponds to one or more of the best practices in relational skills training.

The program is integrated into the students' curriculum immediately upon entering medical school, and students have opportunities to practice the supervised application of relational skills in a preclinical setting, while discussing sensitive self-relevant topics such as race, class, sexual orientation, and privilege. Facilitators, who were trained as relational skills coaches, encouraged students to apply the relational skills they had learned while having these conversations, to form good relational habits in a preclinical setting. The skills emphasized in the curriculum focus

Table. Example of a Comprehensive Relational Skills Training Program for Medical Students (Current and Planned Components)

	Experiential	Data-Driven	Continuous	Coherent	Comprehensive	Competent
Coaching skills						
Coach: online module					×	×
Coach: experiential workshop	×				×	×
Coach: self-assessment		×				
Students: coach assessment		×				
Relational skills						
Students: online module		×			×	
Students: experiential workshop	×					
Students: peer practice (coached)	×		×	×		
Students: SP practice (coached)	×		×	×		
Students: self-assessment	×	×				
SP: online module				×		×
SP: experiential workshop						×
SP: student assessment		×				
Coach: online module				×		×
Coach: experiential module				×		×
Coach: student assessment		×				

SP indicates standardized patient.
"Coach" can refer to faculty member, senior student supervisors (eg, course facilitators, residents), etc.

heavily on providers' ability to inquire sensitively, listen empathically, and offer advice and opinions respectfully. These skills serve clinicians well when they interact with patients who have experienced traumatic events, because they help ensure that patients believe they are heard and are in control of their narrative and of their treatment, by intentionally minimizing the power differential in the doctor-patient relationship. To this end, medical students are trained to evaluate the level of "emotional charge" their interaction partner experiences, and to apply nondirective supportive listening techniques to help their partner release their emotional charge before transitioning respectfully into a more reciprocal conversation.

The program has been extremely well received by students, faculty, and standardized patients, who have been actively involved in its development and implementation. Consequently, the program continues to expand in scope, extending beyond first-year medical students, up to and including house staff and faculty.

COACH PREPARATION

The training begins by identifying potential coaches (faculty and senior students), who are invited to serve as facilitators in the initial doctoring course. Coaches are trained on coaching skills using an online module and an experiential workshop: The online module introduces fundamental concepts in coaching methods (eg, creating positive motivation, providing constructive feedback, successive approximation methods), whereas the experiential workshop provides coaches with opportunities to discuss these skills and practice them with each other while receiving constructive feedback on their coaching techniques.

STUDENT PREPARATION

On their first week of medical school, as part of the initial course on doctoring and humanism, first-year students complete an online module that introduces fundamental relational skills (eg, cultivating the right mindset, listening skills, respectful communication skills) through a combination of didactic text, video examples, and quizzes. The module also clarifies institutional expectations for the consistent application of relational skills, delivered via a video introduction by the vice dean for medical education, which emphasizes that "relational skills are as important as anything else you will learn in med school," "your relational skills will be part of the skill set we evaluate as we determine your potential to become a world-class physician," and that "we are emphasizing these relational skills because they will affect every aspect of your professional life."

After the completion of the online module, students attend an experiential workshop in small groups, with each group facilitated by 1 or 2 relational skills coaches, who have undergone preparation as described in the section, *Coach Preparation*. Groups work in separate rooms, to allow for a more intimate environment that enables a greater sense of privacy and safety. The experiential workshop provides students with an opportunity to discuss the relational skills and to practice them with each other in a structured way, while receiving constructive feedback from the coaches. Attitudes toward and proficiency with relational skills are assessed before and after the introductory training, as described in the section, *Ongoing Practice and Assessment*.

STANDARDIZED PATIENT PREPARATION

Standardized patients provide students with simulated clinical experience, which takes place as part of a different course than the one that introduced students to relational skills. To ensure that medical students receive relational feedback using coherent language across courses, we invited standardized patients to go through the relational skills training. Standardized patients completed the online relational skills module and participated in the experiential relational skills workshop, by forming their own small group and going through the same exercises as the students.

ONGOING PRACTICE AND ASSESSMENT

Relational skills must be assessed regularly, with feedback provided to learners and practitioners on a regular basis, to ensure the improvement and maintenance of skilled relational behaviors. We conduct a baseline 10-minute assessment before the start of training, using a theory of planned behavior framework,[30] which measures learners' belief regarding the importance of relational skills, perceived norms regarding institutional requirement of the application of relational skills, control beliefs regarding their ability to apply skilled relational behaviors, and intention to apply relational skills in clinical and collegial contexts. Repeating this assessment at regular intervals allows us to evaluate the effect of initial training and of ongoing coaching, and to tailor booster training to address specific deficits as needed.

In addition to this self-report approach about attitudes toward relational skills, we collect self-report and peer-report assessments about the actual application of relational skills in a variety of settings. Students rate themselves, their peers, and their clinical coaches on the application and modeling of relational skills, whereas coaches rate themselves and their students on their application of relational skills. These data are presented to students and to coaches to discuss and guide their practice of relational skills. We are unable to provide assessment materials and results in this report, because we are preparing to submit them for publication. Interested readers are welcome to contact the authors directly to discuss approaches to assessing relational skills and relational skills curricula.

DEVELOPMENT PLANS

We are now working toward implementing an integrated relational skills assessment system, that would allow students to reflect on their performance, and would allow supervisors and trainers in various capacities (eg, standardized patients, faculty, supervising residents) to input and

view feedback about students' relational skill. In addition, we are developing booster online training for students beyond the first year. We are collaborating with residency programs to develop specialized training for specific populations (eg, physiatry, pediatrics, family, gerontology).

CONCLUSIONS AND RECOMMENDATIONS FOR NATIONAL AGENDA

Incorporating relational skills training and review as a requirement for ongoing education will ensure that as providers further their careers, they retain strong communication skills and the ability to connect with their patients. This is especially true for specialties that care for patients with current or previous trauma, whose quality of care has been shown to improve after undergoing training for inquiring about adverse childhood experiences and sensitively responding to any patient disclosures.[31,32] In light of the critical importance of relational skills for medical providers as they interact with patients, and especially patients with a history of trauma, we recommend that relational skills training be considered part of the core set of clinical skills, and therefore provided to all medical trainees, at every stage of their training, across all specialties.

The challenges for implementing relational skills training in medical training programs are significant. A number of forward-thinking medical training programs are already incorporating high-quality relational skills training into their formal curriculum, but this practice is far from universal.[33] The biggest challenge to implementing effective relational skills training, grounded in the principles outlined previously, is likely to be the securing of sufficient institutional resources to support continuous, comprehensive, coherent, and competent training. Despite its acknowledged importance, the integration of relational skills into medical training will have to compete for a secure place in medical school curricula. To ensure that adequate resources are devoted to relational skills training during medical training, we recommend that well specified relational proficiencies be incorporated into accreditation standards, board examinations, and licensure requirements. Whatever the motivation for implementing high-quality relational skills training, we believe that incorporating the best practices we have outlined in this article will help maximize the magnitude and duration of the effect of relational skills training for medical trainees and providers, and serve them in establishing strong therapeutic relationships with their patients.

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