INDIANA UNIVERSITY SCHOOL OF MEDICINE
Department of Family Medicine

Counseling Practicum: Curriculum Description, Goals and Objectives

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Counseling practicum is an intensive, small group learning experience during which a resident counsels one of his/her own patients for an hour-long session, while receiving live observation and supervision from behavioral science faculty preceptors and a small group of three or four peers. Each counseling practicum session entails a 15-minute pre-session during which the resident gives a brief presentation of the patient and identifies the goals for the session. The group of residents and behavioral science faculty then observe the session in real-time via a closed-circuit television system. Approximately 25 minutes into the session, the counseling-resident takes a mid-session break and joins the observing team. This break has two goals: 1) to allow faculty and peers to provide some brief feedback and direction; and 2) provides an opportunity for the learner to briefly process his or her personal reactions and thoughts about the patient. The resident then resumes the counseling session. Afterward, a 15-minute post-session is conducted with the entire group to discuss the session, identify skills learned and areas for improvement, and to discuss continued treatment planning that includes an integration of both biomedical and psychosocial aspects. Specific feedback is given regarding the strengths and

areas for improvement in the physician's competence in communication, counseling, and relational skills, according to the ACGME competencies.

ACGME Competencies Addressed:

- Patient Care
- Medical Knowledge about social/behavioral sciences
- Interpersonal and Communication Skills
- Professionalism

Counseling Practicum Goals and Objectives

Goal: To increase communication and counseling skills through the practical experience of counseling of one's own patient and receiving immediate feedback by peer observer(s) and behavioral science preceptor(s).

Objectives:

- Residents will increase knowledge of
    - Basic counseling skills and methods
    - Evidence-based behavioral medicine
- Residents will increase skills in
    - Responding to patient emotions
    - Assessment of psychosocial and family context
    - Integrating biomedical and psychosocial aspects into treatment
    - Developing empathy and understanding patients' experiences
    - Building relationships and empowering patients to take charge of their own health

- Residents will demonstrate attitude change toward
    - The importance of behavioral care in their practices
    - Greater self-confidence in counseling skills and their ability to address psychosocial issues in practice

Implementing the Curriculum

The counseling practicum is one component of the Indiana University Family Practice Residency behavioral science curriculum, which includes both longitudinal components and a block rotation. Practicum is first introduced during a two-week behavioral science block rotation in the fall of PGY II, during which residents receive intensive teaching in small groups on a variety of topics, including a didactic session on basic counseling skills. For the duration of the longitudinal practicum calendar, which spans the next 18 months prior to graduation, resident behavioral science cohort groups are excused from their office or rotation schedules for one half-day for a practicum afternoon approximately every other month. Residents choose a patient from their panel and schedule him/her (and family as appropriate) for a one-hour counseling visit. They are instructed to invite patients that are experienced as difficult or frustrating, are noncompliant, medically or psychosocially complex, or about whom they have a "gut-feeling" that more is occurring psychosocially than they are aware of (i.e., family violence, family distress, addictions, or previous psychological conditions). Each resident must complete a minimum of six counseling practicum sessions prior to graduation.

Resources Requirements

This curriculum requires access to unobtrusive live observation, either through an observation window, a closed circuit television system, or other means. Our program has 10 rooms wired with VCRs and a closed circuit television system, two of the rooms are specifically designated for counseling and family meetings. Such equipment can be expensive to purchase and install.

Another necessary resource is faculty preceptor(s) with expertise in psychosocial medicine and/or communication competency assessment. The first two authors of this submission are Approved Supervisors of the American Association for Marriage and Family Therapy, which is an intensive faculty development program for clinical teachers of counselor-trainees, and the third author is the Indiana University School of Medicine statewide Communication Competency Director. While each program does not need to have this level of expertise available to undertake this curriculum, this is offered as an example of extra training in the clinical teaching of these areas. Faculty wishing to adopt this curriculum are strongly encouraged to participate in faculty development in the areas of communication, competency assessment, psychosocial/behavioral medicine, and general clinical teaching skills.

Planning and Training Timelines

As stated above, practicum curriculum begins in the fall of PGY II, and continues longitudinally over the next 18 months until graduation. Residents are scheduled for one-half day of counseling practicum approximately every other month until they meet the minimum number required (6 sessions).

To plan the implementation of this curriculum from the beginning would take approximately 6 months to a year or longer, depending on the existing level of expertise of the faculty preceptors (i.e., whether any would need to complete any faculty development programs), and whether or not the equipment exists to enable live observation or not (seeking approval and ordering/installing the equipment could be a lengthy process).

The remainder of the time would likely be spent obtaining issues such as program director and faculty buy-in, resident participation, (see below) and negotiating scheduling issues. Protecting the curriculum time can be a challenge within the complex graduate medical education system, bearing in mind clinic schedules, rotation requirements, and duty-hours limitations.

Approach to Promoting the Project

Essential to the success of this curriculum is support of the residency program director and other residency faculty. Approaches to promoting this project to the director and program faculty include: discussing the importance of direct observation as the gold standard of assessment, how the ACGME core competencies are addressed via this curriculum, and offering a summary of the importance of communication skills and psychosocial and behavioral counseling skills for better patient health outcomes, reduced malpractice complaints, and increased patient and physician satisfaction. Learners are hard-pressed to achieve such skills without experiential learning opportunities with real patients, and without specific, focused feedback based on direct observation. One key issue in our process of initiating this curriculum was to receive a grant to study the process and which provided some resources. The study was

funded by an Educational Development and Research Grant, from Medical Education and Curriculum Affairs, Indiana University School of Medicine.

A significant barrier can be resident anxiety and resistance. It is to be expected that many learners are uncomfortable with being directly observed, and feel unskilled at addressing behavioral and psychosocial issues. However, resistance tends to lower significantly as learners become familiar with the format and experience the process as occurring within a spirit of educational support rather than criticism. Residents often view psychosocial issues as less important, which is where the support of the faculty and program director is essential, as is a minimum required number of sessions to complete prior to graduation. In the beginning, we offered a "2 for 1" deal with willing residents in which we counted one counseling session as meeting both a counseling requirement as well as a video-tape review requirement (residents are required to review videotaped encounters of typical patient visits as routine parts of their training). Our first cohort of learners participating in this curriculum thus received this added incentive. Once it was running smoothly and became a regular required feature of the behavioral science curriculum, this incentive was no longer offered.

Evaluating the Curriculum

The study referred to above is evaluating the impact of the curriculum on residents' relationships with patients, communication skills, and empathy. A research assistant obtains consent to participate from both the resident and patient. Prior to the counseling session, the resident completes an assessment of their confidence in counseling skills (developed for use in this study, attached), an assessment of the quality of their relationship with the patient, the Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998; see

references for availability), as well as a measure of empathy toward the patient, the Jefferson Scale of Physician Empathy (HP Version-R, 2001; see references for availability). Pre-session, the patient also completes a version of the Agnew Relationship Measure and rates their stress on a scale of 1-10.

Post-session, the resident completes a self-assessment of his/her communication skills using the 4-Habits scale (Frankel, Stein, & Krupat, 2002; see references for availability), notes any "key moments" that occurred (important insights, moments of connection, etc), and completes the Agnew Relationship Measure and Jefferson Scale of Physician Empathy again. Post-session, the patient completes a version of the 4-Habits communication skills measure as well as the Agnew Relationship Measure, rates his/her stress level again, and notes any "key moments" from his/her perspective. Videotaped sessions are also later coded by the research assistant using an observation coding format of the 4-Habits scale, as well as the Pais Physician Rating Scale (attached). This scale was developed for use in this study and contains constructs important in psychosocial counseling. While these measures were used primarily for the research study of this curriculum, the 4-Habits scales and the Pais Physician Rating Scales are frequently used as springboards for feedback to the resident as well as for evaluation and learner assessment purposes. These scales could be easily used for this purpose primarily, rather than for research, should another program want to adopt this curriculum.

References

1. Agnew-Davies R, Stile WB, Hardy GE, Barkham M, Shapiro D. Agnew Relationship Measure. British J Clin Psychology, 1998 May, 37(2): 155-72.

2. Frankel RM, Stein T. Getting the Most out of the Clinical Encounter: The Four Habits Model. J Med Pract Management, 2001 Jan-Feb, 16(4): 184-91.

3. Hojat M, Mangione S, Nasca TJ, et al. The Jefferson Scale of Physician Empathy: Development and Preliminary Psychometric Data. Educ Psychol Measurement, 2001 61:349-65.

Pais Physician Rating Scale

Date: _____ Site: _____
Physician: _____
Patient: _____
Coder: _____

Physician Counseling Skills:

1. Support	1 Low	2	3	4	5	6	7	8	9	10 High
2. Acceptance	1 Low	2	3	4	5	6	7	8	9	10 High
3. Empathy/ Understanding	1 Low	2	3	4	5	6	7	8	9	10 High
4. Genuineness	1 Low	2	3	4	5	6	7	8	9	10 High
5. Provide Information	1 Low	2	3	4	5	6	7	8	9	10 High
6. Help Acquire Coping Skills	1 Low	2	3	4	5	6	7	8	9	10 High
7. Collaborative	1 Low	2	3	4	5	6	7	8	9	10 High

Patient Response Rating

1. Patient Affect	1 Low	2	3	4	5	6	7	8	9	10 High
2. Patient Cooperation	1 Resisting	2	3	4	5	6	7	8	9	10 Cooperative
3. Patient Disclosure	1 Low	2	3	4	5	6	7	8	9	10 High
4. Patient Engagement	1 Passive	2	3	4	5	6	7	8	9	10 Active

CONFIDENCE IN COUNSELING QUESTIONNAIRE

Please rate the following questions:

	Strongly Disagree							Strongly Agree
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. I am confident that I can help my patients with their psychosocial problems								
2. Family doctors should not be expected to intervene in patients' psychosocial problems								
3. I have good psychosocial counseling skills								
4. I am good at integrating psychosocial issues and medical issues in my patient care								