# Remediation of Interpersonal and Communication Skills

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**Abstract**

Learners may present with deficits in communication and interpersonal skills because of lack of knowledge, unfavorable attitudes, low skill level, or a combination of these factors. Overemphasis on the biomedical interviewing model, learners' psychological and psychiatric factors or issues of cultural or language diversity may also contribute to communication difficulties. For learners who need remediation in communication and interpersonal skills, the authors describe how they have achieved success by modeling their approach on seven principles of relationship-centered care, coaching, and effective feedback. They also present cases that illustrate these principles.

## 4.1 Introduction

*A psychiatrist-educator colleague pulls you aside and tells you of a third-year student with whom she is working and about whom she has concerns. She has noted that the student's interactions with patients are awkward, and he appears to make patients uneasy with his manner. Your colleague knows that you will be seeing this student in his next clerkship and hopes that you can help.*

The challenges in identifying and then remediating trainees who have difficulty in interpersonal communication are wide and varying. Occasionally these students are identified on clinical skills examinations, but often the need for remediation becomes evident while observing the trainee in everyday clinical situations. Despite what we may

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observe in their outward behaviors, many of these students wish desperately to connect effectively with others; however, most do not have a single identifiable correctable "lesion" or deficiency. We will first enumerate the most likely obstacles that learners encounter in achieving excellent patient–provider interactions, and then the strategies that we have used to try to surmount them.

Learners often face obstacles to successful communication in several areas. One key aspect to helping remediate these learners is to identify the area or areas on which to focus. To help with this identification step, the faculty member can use real-time clinical observation, using a tool such as a mini-clinical evaluation exercise [1] or a Brief Structured Clinical Observation [2], and/or simulation case scenarios to identify the learner's strengths and areas requiring more skill.

We divide suboptimal communication skills into knowledge, attitude, and skills deficits. Furthermore, clinical reasoning skills deficits and issues such as diverse backgrounds and interaction styles, as well as psychological and psychiatric factors, can manifest as communication skills difficulties.

## 4.2 Potential Causes for Challenges in Communication and Interpersonal Skills

**Causes for Challenges in Communication and Interpersonal Skills**

1. Knowledge deficit
   (a) Approach to patient-centered interviewing
   (b) Clinical fund of knowledge
   (c) Inability to balance communication skills with clinical reasoning
2. Attitude deficit
3. Skills deficit
   (a) Identification of nonverbal or emotional cues
   (b) Development of rapport
4. Psychological/psychiatric factors
5. Interaction style
6. Diversity issues

### 4.2.1 Knowledge Deficit

The learner may not have a systematic approach to patient-centered interviewing although most clinical trainees in the current era have had exposure to one of many available structured approaches (see Table 4.1). Since clinical fund of knowledge that informs the content and organization of the interview a poor knowledge base will undermine interviewing skills. Students early in their clinical immersion experiences (e.g., medical students on their first clinical clerkship) sometimes become so mired in or completely distracted by getting their clinical reasoning and diagnostic process correct that they do not focus on the patient's concerns, or they lack skills to balance listening and empathy skills with clinical reasoning.

### 4.2.2 Attitude Deficit

Given that most trainees have had exposure to basic communication skills principles, a learner may perceive that patient–provider interaction skills are less important than other areas of clinical competence (see Sect. 4.10.3, Specialized Case).

### 4.2.3 Skills Deficit

The learner may lack skills to identify nonverbal or emotional cues, or may lack skills needed to build rapport.

### 4.2.4 Psychological and Psychiatric Factors

Learners may have clinical depression or too much anxiety (either generalized or about performance) in clinical settings to interact well. In these instances, empathically hearing the learner's perspective, followed by referral to a mental health professional, is key.

**Table 4.1** Selected models for learning and teaching interpersonal communication skills

| Model | Components of the model | Features |
|---|---|---|
| 3 Function [12] | Establish rapport<br>Obtain information<br>Inform and educate the patient | Simple to remember; more intuitive approach |
| Four Habits [13] | Invest in the beginning<br>Elicit the patient's perspective<br>Demonstrate empathy<br>Invest in the end | Explicitly includes patient's perspective<br>Data in both inpatient and outpatient settings that corroborate utility of model |
| SEGUE [14] | Set the stage<br>Elicit information<br>Give information<br>Understand the patient's perspective<br>End the encounter | Sequential approach<br>Lack of explicit naming of emotion |
| Calgary-Cambridge [15] | Initiating the session<br>Gathering information<br>Providing structure<br>Building relationship<br>Explanation and planning<br>Closing the session | Specific, sequential steps within the model include suggestions |
| Kalamazoo Consensus Statement [16] | Build the doctor–patient relationship<br>Gather information<br>Open the discussion<br>Understand the patient's perspective<br>Share information<br>Reach agreement on problems and plans<br>Provide closure | Summary of large group of researchers<br>Combines strengths of several models |
| NYU Macy Initiative [17] | Prepare<br>Open<br>Gather<br>Elicit and understand patient's perspective<br>Communicate during the exam<br>Patient education<br>Negotiate and agree on plan<br>Close | Comprehensive, sequential |
| Smith [18] | Set the stage for the interview<br>Elicit chief concern and set agenda<br>Begin the interview with non-focusing skills that help the patient to express themselves<br>Use focusing skills to learn symptom story, personal context, and emotional context<br>Transition to the middle of the interview<br>Obtain a chronological description of the HPI<br>Past medical history<br>Social history<br>Family history<br>Review of systems<br>End of the interview | Very specific, sequential steps<br>Detailed explanation of each step of the interview, including biomedical aspects<br>Patient outcome data in internal medicine residents that support its use |

### 4.2.5 Interaction Style

It is important to recognize when learners are highly introverted or on the continuum of autism spectrum disorder (see Chap. 13).

### 4.2.6 Diversity

Learners with cultural or language diversity may not follow or understand social norms implicitly understood by indigenous groups or native language speakers.

## 4.3 Step 1: Establishing a Supportive Learning Environment

*When the student arrives on your clerkship, you observe his interactions with patients, and indeed you see that his mannerisms are distracting and awkward. Generally, the student has poor eye contact and stammers when interacting. After a patient completes a series of statements and awaits the student's responses, there is an uncomfortable pause. When a patient says something with emotional valence, the student does not detect these and moves forward with review of systems questions.*

*Review of previous coursework showed that there had been no prior concerns about knowledge base; he had performed at the class mean on the majority of pre-clerkship written exams. Comments from faculty observers in his pre-clerkship interviewing skills course showed no glaring deficits. However, some comments from standardized patients in the end-of-second-year OSCE reflected a sense of awkwardness but did not specifically describe the deficits.*

(continued)

*You arrange a meeting with the student to discuss these observations, saying, "I'd like to help you be more effective with patients. Can we meet tomorrow afternoon to talk about this further?"*

**Your initial steps in this meeting will include these goals:**

Step 1. Establish a supportive learning environment
Step 2. Demonstrate your expertise on the topic and process of communication skills by modeling those techniques with the learner
Step 3. Listen to and acknowledge the learner's emotions and understand his/her perspective
Step 4. Encourage reflection on strengths
Step 5. Share one or more objective observations of learner performance and encourage self-reflection
Step 6. Emphasize that it is important for the learner to initiate the development of his/her own learning plan that is based on both self-reflection and feedback
Step 7. Determine a period of time for implementation followed by checking in on progress, revisiting learning plans, and modifying learning goals for continual improvement

We strongly recommend that conversations about remediation begin with getting to know the learner as a person—the equivalent of taking a social history with a patient. Showing genuine interest in the learner maximizes the possibility of establishing a strong foundation of partnership, trust, and "unconditional positive regard" [3]. In addition, stating an explicit commitment to work with the learner and to speak as nonjudgmentally as possible can enhance the learning climate in this delicate time period.

Sample statements: *"As we begin our work together, it is important to me to get to know you as a person. What kinds of activities do you do that you love? What influenced you to choose medicine as a career? If you were not in the medical profession, what would you be doing?"*

These questions are not idle cocktail party conversation. Answers to these questions can reveal the learner's underlying passions, motivations, and strengths. Eliciting learner strengths in this appreciative manner can often help remediators link personal attributes to potential goals.

## 4.4 Step 2: Demonstrating Expertise About the Topic and Process of Communication by Modeling

It is essential that remediators of communication skills exhibit fluency and flexibility themselves in one or more models of communication (Table 4.1) and use those same principles when interacting with struggling learners. The process of remediating communication skills depends as much on modeling exemplary behaviors as it does on teaching and facilitating learner behaviors. To explicitly apply principles of patient-centered communication skills to the remediation process, we favor an iterative process of interactional "AART" (see box). Too often, struggling learners are subject to passive learning practices, where remediators merely tell their perspective without first eliciting the learner's thoughts. This approach may result in the learner playing a less active role in his/her own learning.

**Iterative, Interactional "AART"**

**A**sk and frequently elicit the learner's thoughts

**A**ctively listen and reflect the content of the learner's words

**R**espond with empathy

and only then:

**T**ell new insights from the remediator's perspective

## 4.5 Step 3: Listen to and Acknowledge Emotions and Understand the Learner's Perspective

*You learn that this student felt great shame about his poor performance. He knew something was wrong but could not identify exactly what by himself. He knew that he felt anxious whenever interacting with patients, and this anxiety was heightened during observations (as with his psychiatry clerkship). He felt that all of his classmates were "superstars," and that he could never compete with them.*

Learners whose patient–provider interaction skills are judged to be lacking often feel a wide range of emotions, including embarrassment, frustration, sadness, awkwardness, and defensiveness. Many equate poor performance with not being a nice person, or worse yet, being devoid of compassion—for most, a very condemning self-judgment that exactly contradicts the reason why they chose medicine as a career. Often learners will say, in self-defense, "when I'm in a *real* clinical situation [as opposed to a standardized or observed encounter], my patients like me."

Therefore, it is usually helpful to plumb the emotions behind the learner's reactions. Parallel to the process of emotional partnering with patients in clinical encounters, connecting emotionally with a learner undergoing remediation helps to build trust in the relationship. By expressing empathy and forming a connection, the work of remediation is more of a collaborative partnership and less of a required imposition. Rather than reacting only with statements like, "Well, you need to perform on this exam," or, "I can only evaluate you on what I observe," empathic statements such as those patterned after the mnemonic "PEARLS" (see box) [4] can be very helpful:

**"PEARLS"**

- **P**artnership: "I want you to know that I am committing to work with you on this."
- **E**motions: "I imagine it is frustrating to feel that you are being judged on situations that may feel inauthentic to you."
- **A**pology: "I'm sorry you're having to go through this process."
- **R**espect: "You have done a lot of work; I'm glad to hear that your patients work well with you."
- **L**egitimization: "These exercises can feel contrived. Anyone might feel awkward about having to go through this learning experience."
- **S**upport: "We can use your strengths to build skills and help lessen your frustration."

Getting on the same page and fully empathizing with the learner is highly powerful: from that stance, a remediator can more easily explore additional topics, such as

*"I'd like to hear your ideas of how you might succeed on this exam, given that it doesn't feel completely real to you."*

A word of caution: just because you may acknowledge the learner's emotions initially doesn't mean they will remain dormant for the remainder of the remediation process. The emotions arise again and again. Continuing to work on emotional connection with empathy skills will reap continued rewards.

## 4.6 Step 4: Encourage Reflection on Strengths

Once the emotional connection begins to develop, supporting the learner's strengths and passions can restore some of his/her confidence. Often in remediation, the tendency is for both remediator and learner to focus on deficit detection and elimination—what the learner is not doing well, and behaviors that the learner most wishes to change. An alternative approach is to turn instead to Appreciative Inquiry [5], a learning process that builds on success rather than focusing on deficits (see Chap. 18). The premise underlying the appreciative inquiry model is that all learners have strengths upon which they can build. Focusing on behaviors that encourage positive outcomes allows the learner to start from a place of known strength and comfort, which enhances the chance of further success. Additionally, having the student reflect on ideals of performances they have seen may also be helpful; this exercise serves as a point of inspiration for learners who find difficulty seeing anything laudatory in their own performances.

*"Based on the video of your interaction with this patient, I'd like to hear from you about areas that you believe you are doing effectively."*

*"I agree that you use steady eye contact when introducing yourself to the patient."*

One caveat, however, is that low-performing learners may overestimate their abilities; deft handling of these situations, without reinforcing behaviors that should not be reinforced, is key.

(In discussing an area of possible disagreement): *"I am hearing that you think your eye contact with the patient effectively communicated caring."*

*This student desperately wished to connect with patients and was highly motivated to learn specific techniques to bring him in connection. He thinks he had been an excellent test-taker throughout college and the first part of medical school; he just buckled down and forced the information into his head.*

*"It sounds like one of your strengths is not only to take tests but also to assimilate information in a way that makes sense to you. I am also glad to hear that connecting with patients is very important to you, and I am excited to work with you to develop those skills."*

## 4.7 Step 5: Observe the Learner's Performance, Encourage Self-Reflection, and Give Direct Feedback

Direct observation—whether it be in real time or via review of video recorded encounters, using role play or with a real or standardized patient—provides primary data for analysis. We recommend following the same process of "AART" used previously at the time of getting to know the learner: begin with *A*sking the learner for his/her own assessment of performance, *A*ctively listen to the learner's responses and compare his/her self-assessment with your own impressions, and begin to determine if the learner's strengths can be drawn on to effect needed changes. Then, continue by *R*esponding with empathy, affirming those things she/he did well and demonstrating your understanding of the learner's self-assessment, and conclude by *T*elling your own impressions of the learner's areas of strengths as well as areas that need work, and discussing next steps for practice and improvement. As previously mentioned, struggling learners tend to assess themselves more positively than their actual level [6, 7]; therefore, developing an increasingly accurate self-reflective eye is the only process by which learners will continually improve. (See Chaps. 13 and 14 for more on reflection and metacognition.) Following the iterative "AART" process of eliciting self-assessment and providing reinforcing feedback early and often in the relationship can help the learner to gain that accuracy and achieve success.

> *Initially this student wished to work on skills using role play, with the faculty member playing a range of patient presentations. To the student, this felt much more manageable, and with the faculty member's understanding of the student's goals, exercises could be tailored specifically to this student's level of need.*

One central tenet in developing expertise is an emphasis on deliberate practice with structured feedback [8]. It is important to set the learner up for small successes that build on each other. For example, one can start with a controlled or simulated scenario that allows the learner to employ strategies highlighting one of his/her own strengths. As the remediator focuses feedback on the effective behaviors that the learner exhibited, the learner can start from a position of success. Subsequently, the remediator can construct incrementally more challenging practice sessions that present progressively more challenging obstacles for the learner. The confidence gained by recent successful experiences allows the student to discover successful behaviors in these more challenging sessions. The educator can then deliver specific feedback to enhance behaviors that hone in on the desired skills.

The skill of engaging in specific feedback is important for learners in remediation and can be anxiety provoking (see Chap. 15). Feedback sessions that are frequent, planned in advance, and initially focus on reinforcing behavior more than corrective behavior modifications reduce the anxiety for the learner and the faculty member. One simple format for feedback, using the "AART" framework noted above, is to follow these steps:

1. Create an environment that allows for privacy and comfort.
2. Take an emotional reading of the learner: "How do you think that went?"
3. Elicit the learner's perception of successful aspects of the interaction.
4. Confirm those items that actually added to success. Add any not noted by the learner.
5. Elicit the learner's perception of aspects of the interaction that did not add to success or that could be done differently.
6. Confirm those items that did not add to success. Add any not noted by the learner. Be careful to focus on a few items that are most critical. An overwhelming number of items may have a negative impact on learning.
7. Elicit from the learner any "take-home" items. Allow the learner to state back learning points in his/her own words.

Using a structure for feedback reduces the potential negative emotional impact and allows for collaboration (see Chap. 15).

*Upon initiating feedback after a simulated patient encounter involving a disengaged teenager, the student demonstrates frustration with the lack of progress toward understanding the patient's motivation and the amount of time "wasted" during the interview. The faculty member names the perceived frustration, indicates that teenage patients are often less able or unwilling to speak spontaneously during the interview (demonstrating understanding while respecting the student's frustration), and then supports the frustration as a positive indicator that this student was able to perceive a barrier to connecting with this patient. The emotion of the learner is validated and through creating the partnership, the ensuing corrective feedback or suggestions for future success are more likely to be accepted by the learner.*

## 4.8 Step 6: Emphasize Development of Personal Learning Plans

Effective learning plans are written documents with specific goals and interventions toward those goals. Learners often struggle at first to develop personal learning plans because they have previously had no active role in generating learning goals and how to reach them. Work by Knowles in adult learning theory suggests that learner-generated interventions and goals result in increased frequency of application of interventions and increased success toward goals [9]. (See Chap. 13 on the role of learning plans in metacognition.)

*"Tell me an area where you would like to improve."*

*"When you watch the video of that interaction, where did you feel that you struggled?"*

Often, learners name many goals that remediators have not considered, usually making those goals worth pursuing for learners' personal growth. After identifying several of the learner's own goals, the remediator can take the opportunity to ask for permission to add another goal or two.

*"Are you open to a suggestion or two from my perspective?"* [This is where pre-establishing expertise in this area can bolster your position.]

*"You mentioned earlier that your eye contact helped your communication with patients. I'd like to analyze those phases of these encounters with you more closely—I have a different perspective. Can we agree to put that on your learning plan?"*

Goals as part of learning plans are most effective when they are "SMART": specific, measurable, attainable, relevant, and time-bound [10]. The student can be challenged with beginning a draft of a learning plan based on the discussion of topics to be addressed. However, it is important and helpful for the faculty to revise the learning plan with the student in order to improve the utility of the plans. Some sample learning plans for this student might be:

"The next time I need to prepare a patient for hearing bad news in an encounter, I will change my tone of voice to be serious, not lighthearted, and I will make a statement that gives them a warning that the news is serious. I will say . . ."
"When the patient starts to cry, I will allow silence instead of continuing to speak. I will hand them tissues. After I count to 10 or when the sobbing has subsided, I will gently ask them to share their experience by saying …"

*Because this student's strengths were test-taking and a desire to connect, goals collaboratively developed included: using a structured, standardized approach to each encounter; making certain to use at least one empathic statement during each history of present illness; remembering to ask about the patient's explanatory model of illness; and using the technique of summary to check his understanding of the patient's illness.*

## 4.9 Step 7: Revisit the Learning Plan and Modify Future Goals

A learning plan is best used as a guide for continued intervention. Frequent review of the learning plan during remediation not only serves to verify intervention strategies but it also aids in recognizing progress. As the student works through the goals, new goals may emerge which are then used to update the learning plan.

## 4.10 Adapting the Approach to Specific Circumstances

### 4.10.1 Learners Who Lack Verbal Rapport-Building Skills

These learners feel compassion and empathy and possibly communicate them nonverbally but do not verbalize their empathy in a way that patients can appreciate.

**Remediator**: [after eliciting effective behaviors from the learner and other areas to improve] *I wonder if I could bring up an observation*.

**Learner**: *OK*.

**Remediator**: *I noticed that while your eye contact and vocal tone showed caring*, *I didn't hear a specific empathic statement*.

**Learner**: *But I was empathetic*.

**Remediator**: *I saw your intention*, *but I'm not certain that the patient did. I was guessing that you were feeling the patient's frustration*, *but a more precise tool to communicate empathy is an actual verbal statement*.

**Learner**: *They sound too touchy-feely*.

**Remediator**: *I'm hearing you feel uncomfortable saying words that communicate emotion. At the same time*, *did you know that for both surgeons and internists using a verbal empathic statement actually shortens their office visits*?

**Learner**: *No*, *I didn't*.

**Remediator**: *It's hard for patients to read our minds. I wonder if you could find expressions that would allow you to connect verbally with a patient without sounding too hokey*.

### 4.10.2 Learners with Intransigent Attitudes

One approach is to gain understanding of the learner's ultimate professional goals and to draw connections between these communication skills and those goals. For instance, succeeding in fields based on interactions between colleagues of different disciplines and professions invariably requires excellence in interpersonal skills.

**Learner**: *I don't need to learn this stuff. My patients will like me because I can save their lives*.

**Remediator**: *I'm glad to hear that you plan on establishing medical expertise. Tell me what areas of expertise you wish to achieve*.

Another approach uses appreciative inquiry (see above and Chap. 16): ask the learner what characteristics define the most exemplary clinicians s/he has seen.

**Remediator**: *Tell me of a time when you saw one of your role models do what you admired*.

**Remediator**: *And now tell me how that role model interacts with team members* [data gathering—potentially this role model does not interact well].

**Remediator**: *I'm wondering what your feelings and thoughts were when you first saw that role model in that interaction. Do you feel it is acceptable for that role model to scream in the operating room*?

After establishing the learner's perspective, use the opportunity to share knowledge about outcomes and pitfalls of ineffective communication skills for any practicing physician, including decreased efficiency, increased malpractice risk, poor patient outcomes and experiences of care, and poor provider well-being.

> *I'm curious if you know data on the relationship between the quality of interactions of exemplary physicians in your field and malpractice risk.*

### 4.10.3 Specialized Case: Adaptation of the Approach to a Residency-Level Learner

*The internal medicine residency program director asks you to meet with a first year resident because of poor performance on a standardized patient communication skills assessment. You view the videos of the interactions in advance of the meeting and observe a lack of empathy, the resident's inability to modulate his speedy and abrupt pace to the patients' emotional tone and tempo, and an insistence on adhering to his own agenda at the expense of that of the patient, to the point of being argumentative. In his initial meeting with you, he expresses that he prides himself on his interactions with his patients and is not sure he's going to gain much from working with you. He admits that there was "a lot going on" for him on the day of the assessment and that he feels that his performance on that day did not accurately reflect his skill level. He feels he develops good rapport with those around him.*

**How can you engage this learner in improving his skills?**

- Empathize with his difficulties on that day and with the artificial nature of an interaction with a standardized patient.
- Further establish a supportive learning environment by acknowledging his sense of his own strengths and suggesting that your time together will help him to be even better than he already is.
- Spend time getting to know the resident, such as where he is from, where he trained, why he chose internal medicine, and where his career aspirations lie, as this builds rapport and allows you as the remediator to assess his motivations.
- Appreciate those areas that he feels are his strengths.
- Ask for examples of times when he felt that he did well.
- Ask him for examples of when he observed or experienced excellent communication skills.

*He cites many positive influences for good communication, including how doctors took the time to meet with his family while his grandmother was a patient; a doctor in medical school who served as a role model for him in patient, colleague, and staff interactions; and an ICU attending during his internship year who took the time to understand patients' perspectives.*

*He also reflects on his experiences with a patient during an ER rotation who was viewed by everyone else as a "difficult patient." The patient, who was initially refusing to talk, finally began to open up when he took the time to empathize and listen to her concerns instead of only telling what he wanted.*

**At this point, what is your diagnosis/assessment of this learner's communication skill ability and confidence?**

- The resident's attitude toward the importance of communication skills is a positive one (although his attitude toward his need for work in this area is questionable). He agrees that empathy is an important aspect of patient care. However, his confidence about his ability to display empathy may outstrip his actual ability to do so.
- He does have a degree of self-awareness because he knew that the standardized encounters had not gone well; however, he may also have some blind spots if he believes that he is demonstrating empathy when he is not doing so.

**How else can you diagnose the learner?**

- In order to ascertain if his perception of his performance is congruent with reality, you can review the tapes with the resident and determine the accuracy of his self-assessment.
- You can also plan to spend some time observing the resident interacting with his patients and debrief these interactions with him in real time or afterward.
- Conversing with and reviewing evaluations from those who have worked with him in the past can also add important data.

**How would you go about reviewing an interaction with the resident?**

- Ask the resident for his own assessment of his performance first.
- Focus on strengths, asking him to name things that he did well.
- Once you have established some nascent trust and he is feeling more secure, then begin to explore areas that he can improve.

  **Remediator**: *Tell me what you feel you did well in this interaction*.

  **Resident**: *I think I showed compassion toward the patient*.

  **Remediator**: *Can you give me specific examples*, *for instance*, *phrases that you used*, *to demonstrate compassion*?

You point out that he may have felt for the patient, but that more of a demonstration of empathy is needed.

*He recognizes that he foucused excessively on achieving his biomedical agenda rather than acknowledging the patient's emotional needs. You commend him on his observation and point out that, rather than being a nuisance to have to manage the strong emotion from the patient, if handled well, it can serve as a means for understanding where the patient is coming from and ultimately gain the patient's trust and ultimately achieve the desired biomedical outcome.*

**How would you go about designing a learning plan with this learner?**

- Ask the learner to summarize what he has learned to date.
- Ask him to list what he feels he did well, and what he could do differently.
- Set up a follow-up meeting time to observe his skills, and ask the learner both what he wants to work on in the interim and what you will be looking for in the observed interaction at the next meeting.

*The resident identifies two areas that he wishes to work on: (1) negotiating an agenda with the patient, and (2) dealing with strong emotions during confrontational encounters with patients.*

**Remediator**: *I agree that those are good areas to focus on*. *Is there anything else*?

**Resident**: *No*, *I think that is about it*.

**Remediator**: *May I make a suggestion to add to your list*?

**Resident**: *Sure*.

**Remediator**: *I would be interested in seeing how you demonstrate the empathy that you feel for the patient's situation*.

- Ask the resident to remember how his mentors demonstrated empathy.
- Assess his knowledge and skill level for demonstrating empathy and review mnemonics for empathy (for example, PEARLS) if he is not aware of these approaches.

## 4.11 Conclusion

Remediation can be a challenging endeavor for the learner as well as for the remediator. We have found that this structured, seven-step approach can lead to major improvements in learners' communication and interpersonal skills [11]. Approaching the struggling learner from a perspective of coaching and unconditional positive regard, can be a challenging, especially if remediators find they have little in common with their

learners. Also the remediators must self-reflect and investigate one's own blind spots or issues of countertransference with a learner, and consultation with trusted colleagues and experts in these skills. Courses such as those held by the American Academy on Communication in Healthcare can also deepen skill sets and provide connections and feedback from these colleagues and experts.

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