

# Teaching Tool 7 - Coaching

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CanMEDS Communicator

## Resident coaching on common written communications

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As residents or learners develop their verbal and written communication skills they tend to experience many of the same pitfalls. If you have one or more learners that tend to experience any of these common pitfalls, consider using this tool as the basis for a one-on-one coaching session. Your learners will benefit from actively engaging in the development of their communication skills through deliberate practice that is observed and assessed both informally and formally.

Start your coaching session by asking the learner if he/she can identify his/her own strengths and weaknesses. Explore any relevant pitfall(s) identified by either you or the learner. Ask the learner to articulate the potential impact on the patient. Talk through suggested fixes and make a commitment to observe the learner on his/her approach. Commit to providing timely feedback and coaching.

### Instructions for Teachers:

- Have the learner select a written communication for review.
- Review it together discuss any areas of strength or areas for improvement
- If you identify any of the common pitfalls below discuss the impact and explore possible fixes

Type of written communication	Pitfall	Impact on patient or on referral source	Suggested fix
<b>CONSULTATION LETTER</b>	<ul style="list-style-type: none"> <li>• CONTENT</li> <li>• No attention to what information should be included in the letter: what is essential, important, or relevant is not considered</li> <li>• A lot of detail on the assessment, with little detail on the impression and treatment plan</li> <li>• Letter not written and sent in a timely fashion</li> <li>• Did not answer the referring physician's question</li> </ul>	<ul style="list-style-type: none"> <li>• The length of the letter is irrelevant as long as the content is organized discretely and clearly. However, learners need to reflect on what content is deemed essential, important, or relevant to the patient population they are managing</li> <li>• Without a working knowledge of what is important, essential information may be hidden in the letter, rendering it unhelpful to the referring source and the treating physician; as well, learners have wasted time producing an ineffective letter</li> <li>• Delay in patient care if information not provided in a timely manner</li> <li>• Referring physician frustration as referring question not answered; this may generate another referral</li> </ul>	<ul style="list-style-type: none"> <li>• Create templates for specific patient populations seen</li> <li>• Tell the learner to focus on the impression and plan as this is the area most physicians will review first</li> <li>• Provide samples of what a good consultation letter looks like in your specialty for your learner to review and compare and contrast with their own</li> <li>• Explicitly set expectations with the learner for when the letter needs to be done</li> <li>• Tell the learner to always answer the referring physician's question posed in the referral letter</li> </ul>
	<ul style="list-style-type: none"> <li>• STYLE</li> <li>• Disorganized content and lack of content planning</li> <li>• Wordy</li> <li>• No attention to visual layout with no white space</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of content planning, organization, and white space, making the letter difficult to scan by a busy clinician</li> <li>• Wordy letter filled with medical jargon and filler words that do not add to the meaning of the letter</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage the learner to use templates for conditions commonly seen</li> <li>• Tell the learner to review all dictations before sending so they can pay attention to the visuals of the letter (white space) and check for errors</li> <li>• Encourage the learner to use bullet points in the body of dictation (e.g. history of presenting illness, physical examination)</li> <li>• Encourage the learner to use numbered lists (e.g. past medical history, medications, plan)</li> </ul>

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			<ul style="list-style-type: none"> <li>• Encourage the learner to use tables to reflect a lot of information in a visually effective manner (e.g. table for muscle grading numbers)</li> </ul>
<b>DIAGNOSTIC IMAGING CONSULTATION REPORT</b>	<ul style="list-style-type: none"> <li>• Description of findings is poor, vague, variable, or inconclusive, with a lack of detail</li> </ul>	<ul style="list-style-type: none"> <li>• Frustration on referring physician's part</li> <li>• Potential for misunderstanding regarding diagnosis and next steps, leading to inappropriate use of resources (i.e. unnecessary additional tests)</li> <li>• Patient safety may be compromised if there is a delay in treatment because it was not clear additional tests were needed</li> </ul>	<ul style="list-style-type: none"> <li>• Variable approaches in diagnostic imaging are a common problem. Ensure the learner chooses one approach that they are able to articulate and routinely use</li> <li>• Create a template of acceptable phrases for common findings and opinions</li> <li>• Teach the learner to synthesize and consolidate clear findings, opinions, and management plans</li> </ul>
<b>LABORATORY REPORT, CONSULTATION REPORT</b>	<ul style="list-style-type: none"> <li>• Poor or vague impressions of the case with an unclear statement of reasons for the uncertainty</li> </ul>	<ul style="list-style-type: none"> <li>• Report reader may make incorrect assumptions, potentially impacting treatment recommendations</li> <li>• Delays in treatment</li> <li>• Requests for second opinion via clinician</li> </ul>	<ul style="list-style-type: none"> <li>• Provide templates for common diagnoses</li> <li>• Teach the learner to outline the key concepts to be transmitted before writing the draft report</li> </ul>
	<ul style="list-style-type: none"> <li>• Incomplete report (missing parameters)</li> </ul>	<ul style="list-style-type: none"> <li>• Delayed treatment</li> <li>• Requests for review of case (duplication of work)</li> </ul>	<ul style="list-style-type: none"> <li>• Rather than rely on electronic synoptic reporting systems, the learner may write a draft report, including all necessary parameters</li> <li>• Encourage reference to College of American Pathologists' cancer reporting protocols for draft writing</li> </ul>
	<ul style="list-style-type: none"> <li>• Incorrect use of language</li> <li>• Use of non-conventional terminology</li> </ul>	<ul style="list-style-type: none"> <li>• Improper grammar and ambiguities may lead to reader misunderstanding of the severity of findings</li> <li>• Delays in treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Provide a list of standardized (conventional) terminology</li> <li>• Teach the learner to outline the key concepts to be</li> </ul>

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		<ul style="list-style-type: none"> <li>• Requests for review of case (duplication of work)</li> </ul>	transmitted before writing a draft
<b>SURGICAL – OPERATIVE REPORT</b>	<ul style="list-style-type: none"> <li>• Abbreviations used without citing specifics (e.g. AVSS)</li> <li>• Missing pertinent information (e.g. intraoperative findings, blood loss, placement of drains, pathology pending, intraoperative complications experienced, etc.)</li> <li>• Incorrect or incomplete procedure recorded</li> </ul>	<ul style="list-style-type: none"> <li>• Using abbreviations that are not known can result in misunderstanding of patients needs and / or delaying further intervention or alterations in management due to confusion</li> <li>• Missing information that can direct and alter post-operative care, investigations, or monitoring</li> <li>• Incorrect drains, etc., may be removed (especially in cases of multiple drains)</li> <li>• Perception of patient having undergone incorrect procedure leads to miscommunication with the patient, family, and consultants, and creates potential for confusion and loss of faith in the system and team</li> </ul>	<ul style="list-style-type: none"> <li>• Teach the learner to look up and record the appropriate specific pertinent vitals (HR, BP, SaO2, Temp, urine output)</li> <li>• Teach the learner to ask for and record the various important surgical aspects</li> <li>• Teach the learner to clearly label and record positions of drains (use diagram if necessary)</li> <li>• Teach the learner to discuss procedure performed with MRP so that it can be adequately reported in the chart</li> </ul>
<b>SURGICAL CONSULTATION REPORT</b>	<ul style="list-style-type: none"> <li>• A diagnosis but no recommendations</li> </ul>	<ul style="list-style-type: none"> <li>• Further investigations</li> <li>• Improper follow-up</li> <li>• Inaccurate expectations around recovery process</li> <li>• Missed opportunity to educate the physician</li> </ul>	<ul style="list-style-type: none"> <li>• Teach the learner how to incorporate continuing professional development into consultation letters (e.g. include relevant references, summary of clinical practice guidelines; incorporate education paragraphs about specific treatment, etc.)</li> </ul>
<b>DISCHARGE SUMMARIES</b>	<ul style="list-style-type: none"> <li>• Lack of a discharge plan, with far too much focus on the details of what transpired and little information on the next steps and who is responsible for following up on the issues identified</li> <li>• Delay in discharge note</li> </ul>	<ul style="list-style-type: none"> <li>• Patient safety is compromised</li> <li>• Confusion and frustration for the primary care physician and community services providing follow-up</li> <li>• Delay in needed services</li> </ul>	<ul style="list-style-type: none"> <li>• Tell the learner that it is critical to summarize major medical and surgical issues that transpired during the course of admission — it is easier to review the details if they are organized in a format that can be readily scanned (numbered list of</li> </ul>

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			<p>issues, with bullet-point descriptions)</p> <ul style="list-style-type: none"> <li>• Explain that the discharge plan must be detailed enough to include the next steps post-discharge, who will do what, and what the patient has been told if the discharge plan isn't successful. Specifically, the discharge summary needs to clearly identify the expectations of the primary care provider</li> <li>• Provide clear guidelines for the completion and delivery of discharge notes</li> </ul>