# A Codeveloped Family-Faculty Curriculum to Improve Trainee Communication

Divya Lakhaney, MD,[a] Sumeet L. Banker, MD, MPH,[a] Annie O'Connor,[b] Julia Barugel,[b] Stephanie B. Gati, MD,[a] Hadley M. Bloomhardt, MD,[a] Cecilia Mo, MD[a]



Patient- and family-centered care (PFCC) describes an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.[1] This model of care is essential to pediatric practice and requires ongoing partnership and collaboration between physicians and families in which each party brings his or her expertise.[2] At the core of PFCC is effective, inclusive communication. Understanding the patient's perspective and expressing empathy are key features of patient and family-centered communication. Although effective communication is a core competency for pediatric residency programs,[3] current teaching methods are inconsistent and variable, and residents feel inadequately prepared.[4] In this article, we describe our collaborative effort with parents in our Family Advisory Council (FAC) to develop a curriculum to foster PFCC. This family-faculty curriculum aims to teach communication and empathy-building skills to pediatric residents using narratives delivered directly by parents.

## ANNIE O'CONNOR, FAC MEMBER

When I was 20 weeks pregnant with my third child, my family was told that the pregnancy was not viable without intervention. We were fortunate to have an in-utero procedure that extended my pregnancy to 31 weeks, at which time Matthew was born. Since then, we have had multiple hospital encounters, including a prolonged NICU stay, planned and unplanned hospitalizations, and emergency department visits, and we quickly became "frequent flyers."

Early on, we learned that our experiences do not always correlate with clinical outcomes. We have had good outcomes clouded by poor communication and feelings of disrespect or distrust. We have had challenging times buoyed by mutual respect and feelings of understanding and empathy. These experiences have taught me that creating partnership and mutual respect between providers and families is paramount, and much of that is established through bedside communication.

During one of Matthew's lengthier hospitalizations, I was approached by a medical student who had been in our room several times as part of teaching rounds. He had become familiar with our case, and he stayed behind to ask me if he could practice doing a patient intake and medical history. This was my first glimpse of the educational value that "real-life" interactions have for health care providers in training. That medical student opened my eyes to the fact that our "frequent flyer" experiences could be used to help improve not only training but, potentially, the care and experiences of others in the future. Early exposure to parent

[a]*Department of Pediatrics, Columbia University Irving Medical Center, New York, New York; and* [b]*Family Advisory Council, Morgan Stanley Children's Hospital, New York-Presbyterian Hospital, New York, New York*

Drs Lakhaney, Banker, Bloomhardt, Gati, and Mo, Ms Barugel, and Ms O'Connor conceptualized and drafted the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

**DOI:** https://doi.org/10.1542/peds.2021-051715

Accepted for publication Sep 21, 2021

Address correspondence to Divya Lakhaney, Columbia University Irving Medical Center, Department of Pediatrics, Division of Critical Care and Hospital Medicine, 622 West 168th St, VC4-417, New York, NY 10032. E-mail: dl2182@cumc.columbia.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).



**FINANCIAL DISCLOSURE:** The authors have indicated they have no financial relationships relevant to this article to disclose.

**FUNDING:** No external funding.

**POTENTIAL CONFLICT OF INTEREST:** The authors have indicated they have no potential conflicts of interest to disclose.

**To cite:** Lakhaney D, Banker SL, O'Connor A, et al. A Codeveloped Family-Faculty Curriculum to Improve Trainee Communication. *Pediatrics*. 2022;149(1):e2021051715

perspectives could influence communication, empathy, and bedside manner from the start of a provider's career.

## DEVELOPMENT OF FAMILY-FACULTY CURRICULUM CONCEPT

### Divya Lakhaney, MD, FAC Physician Advisor

Since joining our institution's FAC, I have been struck by our parent members' experiences with the health care system. What stood out the most was the recounting of conversations and interactions with medical providers, especially those that did not go as well as they hoped. These difficult interactions often stemmed from a lack of common understanding between families and the health care team because we often approach issues from different perspectives. I saw an opportunity to leverage these stories in an effort to bridge this gap and improve communication that patients and families receive from their health care team.

### Sumeet Banker, MD, MPH, Associate Program Director, Pediatric Residency Program

Effective communication with patients and caregivers is a core competency for pediatric residents[3] and is central to providing holistic PFCC. Conversely, miscommunications between families and providers are at the heart of many disagreements and conflicts. Traditional lectures led by physician-faculty can help residents list and recall principles of communication but, in the absence of the family voice, can be static and lack real-life context. We knew that these families' experiences would speak volumes, while allowing us to use higher-level educational pedagogy with case-based learning, role plays, and clinical experiences, rather than relying on lectures. We found an opportunity to harness the rich parent narrative by using parents' own voice by placing them in the role of faculty in a "family-faculty" curriculum.

## FORMATION OF STEERING COMMITTEE AND CURRICULUM DEVELOPMENT

### Divya Lakhaney, MD, and Sumeet Banker, MD, MPH

We engaged parent and resident stakeholders in the development and delivery of this curriculum. This partnership was important in connecting the perspectives of those receiving health care and those providing it. Using an established curriculum development framework,[5] we first performed needs assessments with both groups, which identified a number of gaps around communication and PFCC, including delivering bad news, practicing cultural humility, and navigating parent–provider disagreements. A steering committee including parents, pediatric residents, and physician-faculty met regularly to select topics, identify family-faculty, and plan the format for each session, while also debriefing and addressing feedback from attendees. The curriculum was iteratively refined to meet the needs of the family-faculty and the resident participants on the basis of session evaluations.

The curriculum consists of quarterly sessions incorporated into the resident conference series. Topics for each session were identified via needs assessments and rotate on a 3-year cycle (Table 1). Family-faculty for each session were initially identified from the FAC, and later expanded to include other clinical programs within the hospital, such as the Columbia Children's Complex Care Program. All family-faculty underwent 1 to 2 preparatory sessions with the physician-faculty and resident leaders, during which parents shared their stories around the session theme, key teaching points were identified, and learning objectives were jointly developed by the residents, physician-faculty, and family-faculty on the basis of the experiences and stories shared. Role plays and small-group discussions were used, although based on audience feedback, most sessions were formatted as facilitated interviews led by resident leaders followed by an open question-and-answer session.

### *Annie O'Connor, FAC Member*

Our program brought the recipients of the education (residents) and recipients of care (families) to the same table to plan educational sessions to be delivered by family-faculty. This role reversal naturally preconditioned us to be eager to hear from the residents at each steering committee meeting, seek understanding of their needs and goals, and create a partnership as we worked to plan and evaluate each session. We observed, over time, that the resident members of the steering committee became more comfortable with this behind-the-scenes collaboration with family members. Such collaboration can lead to a more natural and welcoming partnership with family members in their future roles as physician leaders and, most importantly, improve their skills at the bedside.

## EXPERIENCE OF A FAMILY-FACULTY MEMBER: JULIA BARUGEL, PARENT PARTICIPANT IN A FAMILY-FACULTY SESSION

My stepchild was born with biliary atresia and had his first liver transplant when he was 7 months old. After many years of surgeries, including a second liver transplant, multiple procedures, and transfusions, he developed significant behavioral health issues that manifested in troubling ways. We often found ourselves torn between treating his medical issues and his psychiatric challenges. As a parent, these experiences were isolating, so it was particularly gratifying to be asked to talk with pediatric residents on the intersection of behavioral and physical

**TABLE 1** Family-Faculty Session Topics, Format, and Brief Description

| Topic | Format | Brief Description |
|---|---|---|
| Breaking bad news | Family-faculty panel, question-and-answer session | Four family-faculty members reflected on past experiences receiving bad or unexpected news about their child, followed by question and answer with attendees. |
| Caring for children with medical complexity | Small-group breakout session | One mother and one mother-father dyad shared specific experiences around shared decision-making and transitions of care, with attendees split into small groups. |
| Communicating with families when things do not go as planned | Role play with family-faculty facilitators | Three family-faculty members served as simulated parents in small groups and provided feedback to attendees who simulated discussions around unexpected events, such as cancellation of procedures and need to redraw blood samples. |
| Understanding pain | Family-faculty panel, question-and-answer session | Two family-faculty members reflected on their children's experiences of acute and chronic pain, followed by question and answer with attendees. |
| Intersection of behavioral and physical health | Family-faculty panelist, facilitated question-and-answer session | One resident leader interviewed a family-faculty member with prepared questions about her experience navigating her son's physical and mental health challenges, followed by question and answer with attendees. |
| Parent–provider disagreements | Family-faculty panel, facilitated question-and-answer session | One resident leader interviewed 2 family-faculty members with prepared questions geared toward disagreements they had with medical providers, followed by question and answer with attendees. |
| The physician parent | Faculty panel, facilitated question-and-answer session | One faculty leader interviewed 3 faculty members about their experiences when their child was hospitalized, followed by question and answer with attendees. |
| Impact of coronavirus disease 2019 on families | Family-faculty panel, facilitated question-and-answer session (virtual) | Two resident leaders interviewed 2 family-faculty members with prepared questions to reflect on their experiences caring for their children with medical complexity during the first summer of the coronavirus disease 2019 pandemic, followed by a question and answer with attendees. |
| Cultural humility in family-centered care | Family-faculty panel, facilitated question-and-answer session (virtual) | Two resident leaders interviewed one mother and one mother-father dyad from different cultural traditions with prepared questions regarding the interplay between medicine and culture, followed by question and answer with attendees. |
| Working with Latinx families with limited English proficiency | Family-faculty panel, facilitated question-and-answer session (virtual) | Two resident leaders interviewed 2 Latinx family-faculty members about navigating the English language-dominant medical system. This was facilitated by a Spanish interpreter and followed by question and answer with attendees. |

health as part of this curriculum series.

During the preparation, I was able to share my story in its entirety with the pediatric resident leading the session and the physician-faculty leaders. Together, we worked on the flow of the narrative and picked out helpful themes and teaching points that we felt would be important for the audience to hear. We agreed on a format, objectives, and an outline for the session that would optimize the discussion. I appreciated the structure of the session in which the same pediatric resident that was involved in the preparation led the session itself.

Although the purpose of the session was to help the residents understand

the parent perspective, I, too, gained a tremendous amount by participating in the session. I have shared my son's journey with countless providers over the years, but sharing my story in this way was incredibly healing and validating to know that the trainees could learn from my experience. I may not be able to change my own family's experience, but knowing that I could use my story in a positive way to influence the practice of future generations of physicians is very meaningful. Additionally, I learned more about the trainee experience by hearing their stories and perspectives and by listening to their questions. When you are a parent at the bedside, you do not always think about those things. Most importantly, the open discussion away from the clinical setting removed the hierarchy that often exists at the bedside and made it feel like we were partners who could learn from each other.

### EXPERIENCE OF PEDIATRIC RESIDENTS: HADLEY BLOOMHARDT, MD, STEPHANIE GATI, MD, AND CECILIA MO, MD, PEDIATRIC RESIDENTS

We learned early in our training that pediatric patients should be treated in the context of their family. For many patients, parents are the ones who provide the history for a patient, assist extensively with the physical examination, and work with us to create care plans that align with their family's goals, beliefs, and backgrounds. However, we rarely hear about their experience with overwhelming hospitalizations, their perceptions of interactions with the medical team, and their recommendations for improving the partnership.

We valued the opportunity to meet with parents so that we can learn from their unfiltered stories about the triumphs and challenges that they have experienced within the medical system. These sessions have allowed us to speak with parents outside of the clinical setting and have given us the rare opportunity to learn about their experiences in a low-stress environment. Through these discussions, we have gained the skills and confidence to ask parents to share their insights on challenging topics using respectful and open-ended questions. In our daily clinical interactions, we draw from these parents' stories and use the skills that we have learned to help build rapport and encourage families to participate in shared decision-making. This curriculum has given us insight into many different aspects of the patient and caregiver experience, including caring for a child with medical complexity, navigating disagreements between parents and providers, and demonstrating cultural humility in family-centered care.

It can be challenging to hear about instances in which we have failed our patients and families or caused them unintended distress. During the session mentioned above, Mrs Barugel shared how traumatic it was for her hospitalized child to undergo physical examinations multiple times a day without being asked, particularly when his gown was moved for abdominal examinations. In hearing this, we reflected on the many examinations that we had performed and the distress that we may have inflicted on our patients. From this discussion, we were reminded of the importance of explaining to a child what to expect throughout a physical examination. Hearing from parents in this way had a certain sticking power that is otherwise not represented in our residency curriculum, and it will change how we practice in our careers. Additionally, partnering with parents both in these sessions and on the steering committee enhances our skills at the bedside by reinforcing that we must view parents as our partners.

## CONCLUSIONS

The development and delivery of the family-faculty curriculum has been a true partnership among parents, physician-faculty, and trainees. We learned that parent stories and experiences can be leveraged to help trainees develop a PFCC approach and learn important communication and empathy-building skills. Moreover, these lessons in communication can be more powerful when they come directly from parents rather than filtered by physician-faculty. The family-faculty members have also benefited from participating in these sessions because sharing their stories can transform difficult patient and family experiences into positive teaching moments. The power comes from opportunities for family-faculty and trainees to take the other's perspective, which fosters partnership and collaboration.


## ACKNOWLEDGMENTS

We thank the NewYork-Presbyterian Morgan Stanley Children's Hospital FAC for their collaboration in the development of this curriculum and for sharing their stories with us. We also thank the other resident and parent members of our steering committee, specifically our parent members, Missy Adriazola and Suzanne Chen.


### ABBREVIATIONS

FAC: Family Advisory Council
PFCC: patient and family-centered care

## REFERENCES


1. Institute for Patient- and Family-Centered Care. Patient- and family-centered care. Available at: https://www.ipfcc.org/about/pfcc.html. Accessed April 6, 2021
2. Kumagai AK. The patient's voice in medical education: the family centered experience program. *Virtual Mentor.* 2009;11(3):228–231
3. Accreditation Council for Graduate Medical Education. Program requirements for

graduate medical education in pediatrics. Available at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/320_Pediatrics_2020.pdf?ver=2020-06-29-162726-647. Accessed April 6, 2021

4. Reed S, Frey-Vogel A, Frost M. Look who's talking: a survey of pediatric program directors on communication skills education in pediatric residency programs. *Acad Pediatr*. 2020;20(1):9–13

5. Kern, DE. *Curriculum Development for Medical Education: A Six-Step Approach*. Baltimore, MD: Johns Hopkins University Press; 1998