

**Brief Report**

# NephroTalk: Evaluation of a Palliative Care Communication Curriculum for Nephrology Fellows



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**Abstract**

**Context.** Nephrologists care for a medically complex population that faces difficult decisions around treatment options and end-of-life care. Yet communication training within nephrology fellowship is rare. Prior work suggests that communication training in nephrology can improve perceived preparedness to engage in difficult conversations; however, it is unclear if this training results in improved clinical skills.

**Objectives.** The primary aim was to evaluate the efficacy of a three-day curriculum for nephrology fellows (NephroTalk) to improve communication skill acquisition for delivering serious news. We also measured self-reported preparedness for three additional communication tasks taught, including goals of care and transitions at end of life.

**Methods.** Thirty-three first- and second-year fellows from seven academic nephrology programs participated in NephroTalk from 2015 to 2016. Pretraining and post-training encounters to deliver bad news with standardized patients were audiorecorded and evaluated using a modified communication checklist. Fellow experience and self-reported improvement in communication tasks were measured using a five-point Likert scale.

**Results.** Skill use increased after training for seven of the nine skills measured ( $P < 0.01$ ). The average number of skills gained after training was  $3.6 \pm 1.8$  skills. With increased communication proficiency, post-training encounters were significantly shorter than pretraining encounters ( $P = 0.03$ ). Fellows reported improved preparedness to engage in all communication tasks taught in NephroTalk curriculum.

**Conclusion.** Our findings support NephroTalk as an effective communication skills curriculum for nephrology trainees. Fellows increased their communication skills significantly in delivering bad news leading to more efficient encounters. *J Pain Symptom Manage* 2018;56:767–773. © 2018 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

**Key Words**

Communication skills curriculum, palliative care, nephrology

**Introduction**

Communication skills are an essential component to caring for seriously ill patients with advanced kidney disease who often experience limited survival even with life-prolonging therapies like dialysis. Effective

communication improves patient and family member understanding and likely leads to more informed decisions that align with articulated values and priorities. Communication skills training, however, remains rare in nephrology fellowships despite a reported

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Accepted for publication: August 2, 2018.

need for palliative care within nephrology education.<sup>1,2</sup>

Patients report that communication with nephrology clinicians is unsatisfactory. In a survey of patients referred to nephrology, almost all desired prognostic information about their condition to be shared voluntarily by their nephrology clinician and felt this information would better prepare them for future treatment decisions.<sup>3</sup> Yet patients with advanced kidney disease, including those on dialysis, describe discussions of prognosis as rare.<sup>4,5</sup> The absence of these discussions may in part influence the disproportionately higher rate of dialysis initiation in seriously ill patients and increased health care utilization at end of life.<sup>5-7</sup> Conservative care without dialysis has emerged as a viable option for patients with limited prognosis whose goals support quality of life.<sup>8,9</sup> However, most patients, including those who stand to benefit the most from conservative care, tend to receive or prepare to undergo dialysis.<sup>10</sup>

Communication skills are teachable. Successful communication training programs have used simulated patients to teach palliative care communication skills to nonpalliative care medical specialists.<sup>11-14</sup> We previously published results of communication skills training for nephrology fellows that demonstrated improved preparedness in giving bad news and discussing goals of care.<sup>15</sup> The primary aim of the present study was to evaluate objective communication skill acquisition for delivering serious news after a three-day communication curriculum for nephrology fellows (NephroTalk). We secondarily assessed self-reported preparedness for three additional communication tasks taught.

## Materials and Methods

### *NephroTalk Curriculum*

The NephroTalk curriculum is grounded in adult learning principles incorporating experiential learning and deliberate practice.<sup>16</sup> NephroTalk began as a half-day workshop with a previously published description and self-reported preparedness results that measured two communication tasks: giving bad news and discussing goals of care.<sup>15</sup> We now present an expanded three-day NephroTalk for first- and second-year fellows held annually at the University of Pittsburgh Medical Center (UPMC).

The expanded curriculum comprises brief didactics, faculty demonstrations, and small group skills practice addressing four key communication tasks: giving bad news using the SPIKES framework (Setting, Perceptions, Invitation, Knowledge, Empathy, Summary and Strategy),<sup>17</sup> negotiating goals of care using VitalTalk REMAP (Reframe, Expect emotion, Map values, Align with values, and Propose Plan)

framework,<sup>18</sup> managing conflict using a three-step approach,<sup>19,20</sup> and addressing transitions at end of life with emphasis on support of the decision, assuring comfort and nonabandonment and addressing timing.<sup>21</sup> Table 1 describes the communication skills taught for each of these tasks. Within the bad news task, fellows are explicitly taught skills for how to respond to emotion including the NURSE acronym (Name, Understand, Respect, Support, Explore);<sup>22</sup> use of silence; and wish statements.<sup>23</sup> Much of the teaching time is spent in small group skills practice in which fellows interact with simulated patients. The small group skills practice is led by a facilitator pair comprising trained communication educators within the disciplines of palliative care and nephrology. The cases developed for skills practice focus on two scenarios commonly experienced in nephrology practice: 1) conservative care for an elderly patient with advanced comorbidities facing treatment decisions for advanced kidney disease and 2) a surrogate decision maker for a critically ill patient with oliguric acute kidney injury (Table 1).

### *Measurement*

Skill acquisition was objectively measured using standardized patient (SP) encounters before and after the three-day curriculum for giving bad news only. The other three communication tasks (negotiating goals of care, managing conflict, and addressing transitions at end of life) were measured using pre- and post-self-reported preparedness surveys (see Survey section). The SP encounters used actors distinct from the simulated patients used for the NephroTalk training to enhance clinical realism. One case involved giving a diagnosis of kidney disease to a new patient, and the other case involved giving news of worsening kidney function and impending dialysis initiation to a patient with known kidney disease. Each fellow randomly encountered one of the cases before training and the other after training. To ensure blinding, fellows were instructed not to discuss the case specifics with the other participants. Fellows were given 20 minutes for each SP encounter including five minutes to review the case before talking to the patient.

*SP Encounter Cases.* The SP cases were developed with and reviewed by a communication expert (R. M. A.) (Items S1 and S2). The cases were written with a consistent structure and three scripted emotion responses: 1) nonverbal negative emotion cue lasting five seconds after bad news delivered (e.g., after the news is given, the patient would express concern and look away from the speaker); 2) scripted verbal emotion cue after five seconds of the nonverbal negative emotion (e.g., "All of a sudden things are worse!"); and 3) scripted verbal emotion cue delivered

Table 1  
NephroTalk Communication Tasks and Practice Sessions

Communication Task	Skills Practice With Simulated Patient Scenarios	
	Scenario A	Scenario B
Giving bad news	Didactics With Communication Skills SPIKES (Set-up, Perceptions, Invitation, Knowledge, Empathy, Summary and strategize), nurse	Giving bad news to an elderly man with heart disease and Stage 4 CKD in clinic that his kidney function has worsened
Negotiating goals of care	REMAP (Reframe, Expect emotion, Map values, Align with values, and Propose Plan)	Three days later: Discussing forging dialysis or time-limited trial of dialysis in setting of clinical worsening
Addressing transitions at end of life	Support the decision; assure comfort and nonabandonment; address timing; explain what to expect; and consult others	Seven days later: Following up on time-limited trial and addressing dialysis in setting of serious illness and limited prognosis
Managing conflict	Create a learning conversation; negotiate common goals; strategize focused on common goals	Fellows identify and role-play difficult cases encountered with patients, families, or other professionals <sup>a</sup>

CKD = chronic kidney disease.

<sup>a</sup>Simulated patients were not used.

after fellow responded to second scripted verbal emotion cue (e.g., “I can’t deal with this!”). The cases were created to produce a similar emotional intensity, one demonstrating fear and the other frustration. Before the course, a training session was held with the two SPs that included a review and performance of the cases until consistency and reliability occurred.

SP encounters were audiorecorded, deidentified, and blinded as whether they were precurriculum vs. postcurriculum. Two evaluators with communication training expertise (J. W. C. and R. C.) reviewed and scored all encounters using a standardized communication skills checklist (see later). Evaluators scored each audiorecording independently, and consensus was reached on any disagreement.

*Communication Skills Checklist.* The checklist used by reviewers to assess fellows’ skills in the SP encounters was adapted from a previously validated Family Meeting Communication Assessment Tool (FaMCAT) used in geriatric communication skills training evaluation.<sup>12</sup> The FaMCAT checklist has 31 distinct communication skills that include a broad checklist of communication skills including the six-step SPIKES framework for giving bad news.<sup>17</sup> It includes a training manual with working definitions of each skill as a reference for evaluators completing the checklist.

The communication skills checklist for NephroTalk was adapted from FaMCAT to include the bad news skills only and then piloted to create the final checklist. Inter-rater reliability between the two evaluators was calculated using kappa statistic. Items that received a kappa >0.4, representing moderate agreement between the evaluators, were included in the final checklist. The summary item received a kappa <0.4 and was therefore omitted from the final checklist. The final version included nine specific communication skills for giving bad news (Table 2). Each skill was scored as a *yes* for a skill used and *no* for a skill not used. The checklist also asked reviewers to label whether the recording was before or after training. Evaluators underwent extensive training on using the checklist and training manual.

*Surveys.* Fellows completed a baseline survey that assessed demographics, previous palliative care education, and self-reported preparedness to engage in goals of care and end-of-life conversations with patients and their families. A postcurriculum survey was administered at the end of the workshop to assess satisfaction with the curriculum and changes in perceived preparedness using a five-point Likert scale (e.g., 1 = not at all prepared and 5 = very well prepared).

Table 2  
SP Encounter Checklist and Definitions

Step	Communication Skill	Definition
Setting	Greeting	Fellow appropriately gives name and explains role
Perception	Assess patient's understanding	Asked what patient understood or heard from doctors about kidney problem (must be an open-ended question)
Invitation	Asked if it was alright to tell the news	Asked permission before giving the news
Knowledge	Gave information in chunks	Gave information in simple phrases allowing patient time to process information. Credit given if three or less pieces of new information given
Empathy	Avoided medical jargon	Consistently avoided use of medical terminology
	Emotion cue 1: Nonverbal emotion cue	After giving news, patient has nonverbal emotion cue. Credit given if fellow is silent for five seconds
	Emotion cue 2: "All of a sudden things are worse!"	Fellow must respond with empathic statement with nurse or wish statement
Strategy	Emotion cue 3: "I can't deal with this!"	Fellow must respond with empathic statement with nurse or wish statement
	Checks in for understanding	Open-ended question to the patient that assesses her understanding of the information given

SP = standardized patient.

### Analysis

Data were collected for three consecutive years. Skill acquisition was measured using data from the second and third years (25 fellows), whereas data from the first year (eight fellows) were used to pilot and validate the final checklist. Self-perceived preparedness was analyzed for all 33 participating fellows.

Descriptive statistics were used for baseline characteristics of the participants, previous experience with palliative care education, and satisfaction with the curriculum. McNemar exact test compared skills used before and after training. Wilcoxon signed rank test was used to compare the median number of skills gained after training and to compare the length of the encounter in seconds before and after training. Paired t-tests were used to compare preparedness before and after training. This study was deemed exempt by the University of Pittsburgh Institutional Review Board. All analyses were conducted in Stata (Stata/SE Release 14; StataCorp, College Station, TX).

## Results

### Baseline Participant Characteristics

A total of 33 fellows from seven nephrology training programs (UPMC, Geisinger Medical Center, Henry Ford Health System, Medical University of South Carolina, Baylor College of Medicine, Allegheny General Hospital, and New York University Lagone Health) participated in three separate NephroTalk workshops at the UPMC between 2014 and 2016. Mean participant age was 33 years; the majority was males; and were in their first year of fellowship training (Table 3). Fellows reported little exposure to palliative care during their training with only three (15%) fellows undergoing a formal palliative care rotation. Seven fellows (35%) had received formal teaching

on how to discuss dialysis decisions including conservative care with patients with limited prognosis. Only four fellows (20%) had received teaching on dialysis withdrawal and end-of-life issues.

### Skill Acquisition

The primary outcome was skill acquisition in giving bad news. Skill use increased post-training for all nine skills measured (Table 4). The difference was significant for all skills ( $P < 0.01$ ) with the exception of two skills that were frequently used pretraining: greeting and assessing patient understanding. The largest percent improvement was for giving information in small chunks (36% pre vs. 96% post) and responding to emotion cue #2 (12% pre vs. 72% post). Fellows rarely checked in for understanding after

Table 3  
Baseline Participant Characteristics

Mean ± SD or n (%)	Total (n = 32 <sup>a</sup> )
Age	33.1 ± 4.0
Gender	
Male	20 (63)
Female	12 (38)
Fellowship year	
First year	19 (59)
Second year	13 (41)
Ethnicity	
Caucasian	8 (25)
African American	1 (3)
Asian or Pacific Islander	5 (16)
East Indian/Pakistani	14 (44)
Hispanic/Latino	1 (3)
Other	3 (9)
Prior palliative medicine rotation	5 (15)
Prior education about how to discuss conservative care without dialysis	10 (30)
Prior education about how to discuss dialysis withdrawal	6 (18)

<sup>a</sup>Total number of participants is 33 (8 in 2015 + 12 in February 2016 + 13 in October 2016), but one participant in February 2016 did not answer any of the demographic questions.

Table 4  
Skill Acquisition Before and After Training

Skill	Before Training (n = 25), n (%)	After Training (n = 25), n (%)	Percent Change	P <sup>a</sup>
Greeting	15 (60)	19 (76)	+16	0.289
Assessed patient's understanding	19 (76)	23 (92)	+16	0.289
Asked if it was all right to tell the news	1 (4)	14 (56)	+52	0.001
Gave information in small chunks	9 (36)	24 (96)	+60	<0.001
Avoided use of medical jargon	15 (60)	24 (96)	+36	0.004
Emotion cue 1: Patient silent with nonverbal emotion for five seconds after bad news given	15 (60)	25 (100)	+40	0.002
Emotion cue 2: "I can't understand this. I've never had kidney problems"	3 (12)	18 (72)	+60	<0.001
Emotion cue 3: "Will this kill me!"	7 (28)	20 (79)	+51	0.004
Checked in for understanding	2 (8)	10 (40)	+32	0.008

<sup>a</sup>McNemar's exact test.

delivering the news before training (8%); however, this significantly increased with training (40%).

Overall, 23 of 25 fellows increased the total number of skills used. Of nine measured skills, the average skill count improved from  $3.44 \pm 1.36$  pretraining to  $7.04 \pm 1.10$  post-training ( $P < 0.001$ ). The average increase was  $3.6 \pm 1.8$  skills with the largest individual increase of seven (range 1–8). Together, the two evaluators were 95% correct in identifying whether the audiorecordings occurred before or after training.

#### Duration of Encounters

With increased skill use, the average duration of all SP encounters was significantly shorter after training compared with before training (710 vs. 792 seconds;  $P = 0.03$ ).

#### Fellow Self-Reported Preparedness and Satisfaction With Training

After NephroTalk training, fellows reported improved preparedness to engage in communication tasks taught during NephroTalk curriculum (Table 5). Fellows were highly satisfied with the

curriculum. On a five-point Likert scale, almost all participants strongly recommended this training to other fellows ( $5.0 \pm 0.2$ ) and believed that it should be mandatory ( $4.9 \pm 0.3$ ). Fellows identified one communication skill to commit to practice. Most (73%) identified emotion skills, especially use of silence.

#### Discussion

Our data demonstrate that NephroTalk training led to objective skill acquisition in delivering serious news and self-reported preparedness in goals of care and end-of-life discussions. Fellows gained more than 3.5 new skills per encounter for giving serious news after NephroTalk training. Surprisingly, these added communication skills led to shorter SP encounter times. This finding adds to the evidence that proficiency in communication is associated with more effective and efficient patient encounters.<sup>24</sup> It also contradicts the common argument that time is a barrier to the use of communication skills.

To our knowledge, this is the first nephrology communication training program to demonstrate

Table 5  
Self-Reported Preparedness Before and After Training

"How Well Prepared do You Feel to ..." <sup>a</sup>	Before Training (N = 33)	After Training (N = 33)	P (Before vs. After) <sup>b</sup>
Deliver bad news	$3.0 \pm 0.6$	$4.4 \pm 0.5$	<0.001
Negotiate an agenda	$2.6 \pm 0.7$	$4.3 \pm 0.6$	<0.001
Respond to emotion	$2.8 \pm 0.9$	$4.5 \pm 0.5$	<0.001
Discuss prognosis of advanced kidney disease	$3.0 \pm 0.9$	$4.3 \pm 0.6$	<0.001
Discuss goals of care about treatment for advanced kidney failure	$2.9 \pm 0.9$	$4.5 \pm 0.6$	<0.001
Discuss conservative care without dialysis	$2.6 \pm 0.9$	$4.4 \pm 0.5$	<0.001
Discuss dialysis withdrawal with patient/family	$2.5 \pm 0.8$	$4.5 \pm 0.5$	<0.001
Respond to a patient (family) who wants dialysis initiated or continued when not doing well	$2.5 \pm 0.9$	$4.1 \pm 0.6$	<0.001
Discuss death and dying with a patient with kidney disease (or family) when death may be imminent	$2.5 \pm 1.0$	$4.4 \pm 0.6$	<0.001

<sup>a</sup>Mean (SD) response as indicated on Likert scale: 1 = not well prepared, 3 = somewhat prepared, and 5 = very well prepared.

<sup>b</sup>Wilcoxon matched pairs signed ranks test.



objective skill acquisition. We chose to measure objective skills in delivering serious news as this is an important task for nephrologists to ensure that patients understand their condition and make informed decisions about their care. This is especially important given this population has a high prevalence of limited health literacy and information needs.<sup>25,26</sup> After training, almost all fellows gave serious news using clear language in small chunks and were more likely to ask permission before giving the news. These specific skills are considered key clear health communication techniques to ensure that information is easily understood.<sup>27</sup>

Fellows were also explicitly taught and evaluated on the ability to recognize and respond to emotion. Patients with kidney disease report a high burden of emotional needs that influence how they cope with their illness, make decisions, and prepare for the future.<sup>28,29</sup> Fellows were more likely to respond to nonverbal and verbal emotion cues after training. Our findings buttress the evidence that responding to emotion, which has been shown to reduce patient distress, is a teachable skill.<sup>30</sup>

Our findings support current recommendations by the National Academy of Medicine that all clinicians learn primary palliative care skills, including conducting goals of care and advance care planning conversations.<sup>31</sup> This is particularly relevant to the care of older frail patients with advanced kidney disease whose priorities may focus on quality of life rather than life-prolonging treatments like dialysis. Fellows felt more prepared to engage in goals of care communication tasks after training. One fellow reported in the post-training survey a commitment to “align with the patient’s goals and values more than my goals and agenda.”

The positive findings of NephroTalk add to the growing data supporting the benefits of communication training that incorporates deliberate practice with simulated patients.<sup>11,13,32</sup> The three-day NephroTalk curriculum described here provides a framework for other institutions across the country to develop similar programs. NephroTalk has also been modified for shorter sessions at national meetings and has been shared with palliative care educators interested in teaching primary palliative care skills to nephrology fellows. These positive findings, however, are tempered by the lack of data demonstrating the effectiveness of these skills when applied to actual clinical care situations.<sup>33</sup>

The longitudinal data collection and rigorous methodologic assessment of the curriculum’s efficacy are important strengths. There are several limitations that are worth noting. First, given that this was a regional course complicated by travel logistics, skill acquisition was measured immediately after training. Thus, it is impossible to determine whether skill use

was sustained. Trainings with similar educational methods such as GeriTalk demonstrated sustained skill use through family meeting assessment an average of 68 days after training.<sup>12</sup> In addition, we only measured objective skills for delivering serious news with the other three communication tasks measured using self-reported preparedness. However, fellows reported improved preparedness for these three communication tasks. Even after training, most of them did not check in for understanding after giving news; yet with only 8% used pretraining, this significant improvement is impressive especially given previous findings with only 8% used after training.<sup>11</sup> Skill acquisition was measured using SPs and not real patients limiting our ability to generalize these findings to actual clinical practice. Finally, we measured skill acquisition using audio without video recordings, thus limiting our ability to capture participation of nonverbal communication skills such as body language and demeanor. To address this limitation, our checklist included a nonverbal cue for which fellows were given credit if they remained silent for at least five seconds.

In conclusion, NephroTalk training resulted in measurable skill acquisition for delivering serious news. These skills may also lead to more efficient encounters. Fellows reported improved preparation for basic palliative care tasks including those pertaining to goals of care and addressing transitions at end of life. Further research is needed to determine whether NephroTalk leads to skill acquisition for the other three communication skills taught and if these skills are retained and transferred from simulation to actual patient care.

### **Disclosures and Acknowledgments**

J. O. S. received funding for this project through the William and Sandra Bennett Clinical Scholars Program through the American Society of Nephrology and the Department of Medicine at the University of Pittsburgh Medical Center. The authors thank Dr. Amy Kelley at Mount Sinai Hospital for assisting with adaptation of FaMCAT.

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## *Appendix*

### *Item S1: Fellow Background Given to Fellow Before SP Encounter*

#### *Case 1: Fellow Background*

You are seeing Ned Taylor for a follow-up appointment in outpatient nephrology clinic. Ned is a 50-year-old gentleman with polycystic kidney disease who has been seen in nephrology clinic for 10 years. His renal function has been stable at Stage 4 CKD with creatinine 2.7 (27 mL/minute/m<sup>2</sup>). Ned was last seen six months ago.

Since then, he was hospitalized last month for diverticulitis with acute on chronic kidney injury with creatinine rising to 3.2 (18 mL/minute/m<sup>2</sup>). Blood work drawn yesterday confirms that creatinine remains elevated and is felt to be his new baseline.

He has seen education in the past, and the plan is for preparation for hemodialysis when his kidney function worsens. He is not a transplant candidate at this time given recent cancer, and the doctors have deemed his abdominal surgery as a contraindication to peritoneal dialysis.

He is mildly hypertensive (155/85) and had no edema on examination. Other laboratory reports are satisfactory.

Your task today: Tell Mr. Taylor the news that it is time to prepare for hemodialysis.

#### *Case 2: Fellow Background*

You are seeing Mel/Melanie Boroski as a new patient in outpatient nephrology clinic. Mel/Melanie is a 52-year-old man/woman with long-standing diabetes and hypertension who has been referred by his and/or her primary care doctor Dr. Miller for worsening renal function. Outside records demonstrate progressive CKD with creatinine 2.6–2.8 (~24 mL/minute/m<sup>2</sup>) during the past six months. Renal ultrasound is significant for small echogenic kidneys without signs of hydronephrosis. Urine dipstick is notable for 3+ protein and glucose.

His and/or her past medical history is significant for diabetes for past 12 years complicated by retinopathy and neuropathy, hypertension, and hyperlipidemia.

On examination, he and/or she is hypertensive (160/90) and has mild edema.

Your task today: Tell the patient the news that he and/or she has advanced kidney disease.

### *Item S2: Case Background for SP Encounters*

#### *Case 1: Case Background*

#### **Giving Bad News, Time for Dialysis Preparation**

Ned Taylor is a 50-year-old gentleman with polycystic kidney disease—kidney disease caused from abnormal production of cysts that leads to kidney failure. It was diagnosed 10 years ago after experiencing worsening low back pain. His other medical history includes colon cancer, which was resected followed by chemotherapy, hypertension, and anemia. His kidney function is moderate, creatinine 2.7 with estimated function of 26 mL/minute/m<sup>2</sup>. He has been treated with blood pressure medications and goes to the kidney doctor to be monitored every three to six months. At his last visit, the kidney doctor had told him things were stable, and he was happy to hear the news. He is scheduled for a return visit one month after recent hospitalization for diverticulitis. During the hospitalization, his renal function worsened to 3.2 with an estimated function of 18 mL/minute/m<sup>2</sup>. This was felt worse because of dehydration and low blood pressure. He had repeat laboratory tests yesterday that demonstrate the creatinine is the same. He is here for follow up of his blood work and does not know the result.

Key tasks for the fellow to do during the encounter:

1. Introduce him or herself to Ned
2. Ask the Ned what he knows about his kidney disease before giving the news that the laboratory reports have worsened
3. Ask permission to give the news
4. Give the news in small chunks
5. Respond to Ned's shock and frustration, which if done well can lead to fear and worry.

Three emotion opportunities:

- Emotion cue: nonverbal frustration and shock after hearing that kidneys are worse or word dialysis (SP should be silent for five seconds before moving on).



- Emotion cue: “You guys have been seeing me for 10 years and all of a sudden things have gotten worse. I can’t believe this is happening.”
  - Emotion cue: “How am I going to deal with this?”
6. Check in for understanding

Fellow will have 15 minutes to complete encounter.

### *Case 2: Case Background*

#### **Giving Bad News, New Diagnosis of Kidney Disease**

Melanie/Mel Boroski is a 50-year-old woman/man with diabetes diagnosed 12 years ago after a hospitalization for nausea and vomiting. Her/his diabetes has been difficult to treat, and she and/or he now suffers from many of the ill effects of the disease. Eyesight has been affected, and she and/or he has burning and decreased sensation in her legs. Her and/or his primary care doctor Dr. Miller referred Melanie/Mel to the kidney doctor (nephrologist) because kidney function has gotten worse. Melanie now has a serum creatinine of 2.4 with an estimated function of 24 mL/minute/m<sup>2</sup>. (Note if Mel, creatinine 2.8 with estimated function of 24 mL/minute/m<sup>2</sup>).

Key tasks for the fellow to do during the encounter:

1. Introduce himself or herself to Melanie/Mel
2. Ask Melanie/Mel what she and/or he knows about kidney disease before giving the news
3. Ask permission to give the news
4. Give the news that she and/or he has kidney disease in small chunks
5. Respond to Melanie’s fear and sadness: three emotion cues
  - Emotion cue 1: Nonverbal cue of fear lasting five seconds after bad news given
  - Emotion cue 2: “I can’t understand this. I’ve never kidney problems”
  - Emotion cue 3: “People die on dialysis ...”
6. Check in for understanding.

Fellow will have 15 minutes to complete encounter.