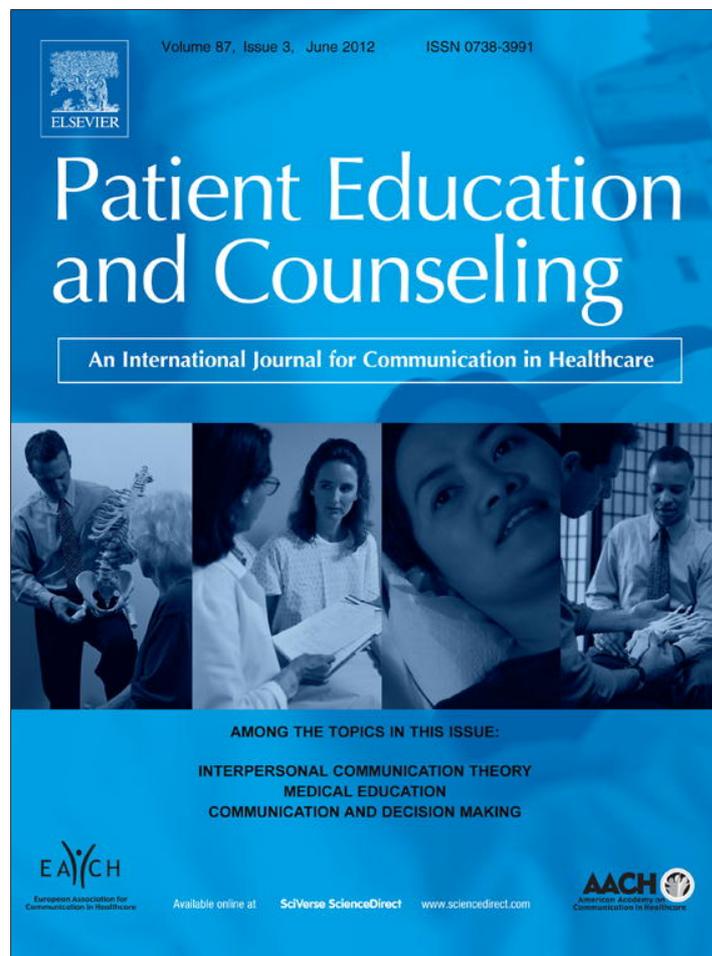


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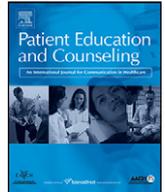
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## Medical Education

## Uncovering and validating clinicians' experiential knowledge when facing difficult conversations: A cross-cultural perspective

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## ABSTRACT

**Objective:** To explore clinicians' experiential knowledge when conducting difficult conversations; and to verify if experiential knowledge is culturally based.

**Method:** Data were collected in Italy and the United States during the Program to Enhance Relational and Communication Skills (PERCS) workshops. At the beginning of each workshop, during a whiteboard exercise, clinicians shared the strategies they had found helpful in difficult conversations. The strategies were analyzed in each country through content analysis. Upon completion of this primary analysis, the themes identified within each country were synthesized into second-order themes by means of aggregated concept analysis.

**Results:** We conducted 14 Italian and 12 American PERCS-workshops enrolling a total of 304 clinicians. The suggestions that were similar across both countries were related to: organizational aspects and setting preparation; communication and relational skillfulness; clinician mindfulness; interpersonal qualities and sensibilities; and teamwork and care coordination. Additionally, US participants identified attention to cultural differences as a helpful strategy.

**Conclusion:** Clinicians can access relational strategies, tied to their experience, that are typically unrecognized in medical education. The whiteboard exercise is an effective teaching tool to uncover and validate already-existing relational knowledge.

**Practice implications:** Communication training programs can foster clinicians' sense of preparation by building upon their already-existing knowledge.

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## 1. Introduction

Across the span of their professional careers, healthcare practitioners conduct thousands of conversations with patients and families [1]. However, when it comes to difficult conversations, clinicians often report that their training has not adequately prepared them for the job at hand [2]. The literature highlights the need for improvement in clinicians' communicative and relational practice [3], and documents apprehension on the part of clinicians who do not feel prepared for such conversations. The concern we address in this paper, however, is that educational strategies focused on improving communication can, in effect, collude with this sense of unpreparedness if they underestimate or neglect entirely the valuable store of experiential knowledge that

clinicians have accumulated prior to any formal learning in this area [4,5]. Too often, educational programs focused on improving clinicians' communication highlight and privilege the expertise and agenda of the instructors, implicitly sending the message that communication and relational skills are a realm of knowledge that must be taught to clinicians from the outside by experts who are more skilled [6–8].

There is growing recognition of the central importance of the experiential learning that occurs in everyday clinical practice [9–11]. Through their life experience and daily clinical interactions with patients and colleagues, practitioners test values, intuitions, and judgments; cultivate a body of experiential knowledge of what works and what matters; and adjust their practice accordingly [12]. Unfortunately, however, the knowledge that springs from clinicians' personal and professional experience is often unrecognized or devalued by the academic medical culture and by clinicians themselves. Despite a cultural movement towards more “learner-centered” medical education, concepts such as valuing participants' previous experience, considering the instructor as a facilitator and a resource person, and promoting self-directed

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learning are incompletely integrated into educational practice [13–15]. While continuing medical education programs are said to be crafted according to learner-centered principles, many of these programs fall short of these ideals [16–18].

Based on the assumption that clinicians' hard earned experiential knowledge provides a trustworthy and invaluable foundation for further learning about communication in clinical practice, the Program to Enhance Relational and Communication Skills (PERCS) was developed at Children's Hospital Boston and later at San Paolo Hospital, Milan. PERCS is an interdisciplinary program that aims to improve clinicians' preparedness and skills when holding difficult healthcare conversations [19]. The pedagogical design of the program is intended to promote the discovery and enhancement, through experiential learning, of these relational capacities. Consistent with the program's pedagogy, at the beginning of workshops, participants are invited to engage in an interactive whiteboard exercise to share their experiential knowledge about difficult conversations with patients and families.

The aim of this study was twofold: to explore clinicians' experiential knowledge in conducting difficult conversations; and to verify if experiential knowledge is culturally based. To accomplish these two aims, we explored experiential knowledge in an Italian and US cohort of clinicians and employed aggregated concept analysis to compare qualitative data cross-culturally. We compared Italian and US clinicians because they represent two very different medical cultures [20], and because of the ongoing collaboration between the two institutions.

## 2. Method

### 2.1. Participants

Participants of the study were interdisciplinary clinicians who voluntarily attended the Program to Enhance Relational and Communication Skills (PERCS) at Children's Hospital Boston, United States, and San Paolo University Hospital in Milan, Italy, from 2008 to 2010. Participants were adult clinicians in the Italian site and pediatric clinicians in the US site.

PERCS was developed at Children's Hospital Boston in 2002. After the first author (GL) apprenticed with the American program during a year-long Fulbright Scholarship, PERCS was implemented and adapted by the C.U.R.A. Research Center at San Paolo Hospital, Italy, in 2008 [21]. The American and Italian PERCS programs share the same pedagogical principles and format, emphasizing interdisciplinary and experiential learning. In day-long workshops, clinicians have the opportunity to introduce themselves, share their expertise during a whiteboard exercise, practice difficult conversations with actors in simulated encounters, observe others, and receive feedback from the actors, interdisciplinary participants, and facilitators. The program's pedagogy is based on validating existing relational capacities, emphasizing moral and relational dimensions of care, suspending hierarchy, creating safety for learning, and valuing reflection and self-awareness. Further details on the US and Italian PERCS programs are published elsewhere [22,23].

### 2.2. Data collection

At the beginning of each PERCS workshop, participants engaged in a whiteboard exercise. The aim of this exercise is to make explicit and affirm already-existing communication and relational knowledge in order to make it possible to draw upon this knowledge during the workshop. Participants were asked by a facilitator, "Imagine that a colleague who is preparing to have a difficult conversation with a patient and his/her family comes to you for advice. Thinking back on your experience what suggestions

would you give him/her?" Consistent with brainstorming sessions, all the participants were encouraged to contribute and a rapid generation of ideas was generated. Participants did not evaluate or comment on any of the suggestions offered. A facilitator documented each participant's suggestions on the whiteboard. The process of writing participants' suggestions on the whiteboard served as an aid to validate and represent concretely the experiential knowledge of the group. At the end of the exercise, the facilitator summarized the suggestions and acknowledged the breadth and depth of experiential knowledge shared by the group. The exercise generally lasted 20 min. The insights and ideas identified during this exercise were used by participants during the simulated encounters and were woven throughout the workshop by facilitators during the feedback sessions that took place after the simulated encounters. At the end of the workshop, the list of the suggestions generated during the exercise was e-mailed to all of the participants as a statement of the group's wisdom and as a reinforcement of the day's learning.

### 2.3. Data analysis

In the present study we used an aggregated concept analysis [24]. This analytical approach is used to compare qualitative results across studies that use the same research design in order to gain a higher level of abstraction of the phenomenon under investigation [25]. The aggregated analysis provides a common framework that supports the commonalities and specificities across each country. The data analysis was conducted in two steps. In the primary analyses, researchers from each country analyzed their own data following the principles of content analysis in order to identify first-order themes. In the secondary analysis, the themes that emerged from each country were compared and synthesized into second-order themes. These second-order themes reflected the commonalities and specificities of the themes from both countries. Details of the two steps are reported in the following section.

#### 2.3.1. Primary analyses

Transcripts of the whiteboard exercises were analyzed, within each culture, through content analysis [26]. To respect the contextual meanings of the data, transcripts of the Italian whiteboard exercises were analyzed by two Italian researchers (GL, SB), and transcripts of the US whiteboard exercises were analyzed by two US researchers (ECM, DMB). During content analysis, each set of researchers read the suggestions provided by clinicians independently and identified themes that described the content of the suggestions. Then, they met to share, discuss, and refine their themes. Once consensus on the themes and their labeling was reached, the researchers independently coded the suggestions offered by clinicians according to the themes identified. To document the inter-coder agreement, *K* coefficient was calculated separately within the sets of Italian and US data. The Italian (Cohen  $K = .73$ ) and US (Cohen  $K = .80$ ) inter-coder agreement was substantial. The disagreements that emerged between the raters during this analysis were then reconciled in face-to-face discussions between researchers, and the percentages of the themes' frequencies were computed.

#### 2.3.2. Secondary analysis

Upon completion of the primary analyses, the research team analyzed the results cross-culturally. The secondary analysis commenced with a reading of the findings of the two research groups. Through a series of 3 videoconference meetings, Italian and US researchers presented their themes and reflected about similarities and differences in the themes' content and categorization. The aim of the first two meetings was to generate second-order

**Table 1**  
Demographic characteristics of Italian and US participants.

	Italian participants N= 178	US participants N= 126
Discipline		
Physician	48 (30%)	34 (28%)
Nurse	73 (46%)	52 (43%)
Psychosocial professional	24 (15%)	3 (2%)
Medical interpreter	0	23 (19%)
Chaplain	3 (2%)	1 (1%)
Other	12 (7%)	9 (7%)
Valid N	160 (100%)	122 (100%)
Ethnicity		
White	153 (96%)	90 (75%)
Hispanic	0	17 (14%)
African	0	1 (1%)
Asian	0	10 (8%)
Other	7 (4%)	2 (2%)
Valid N	160 (100%)	120 (100%)
Previous learning experience		
None	29 (18%)	41 (34%)
Coursework	27 (17%)	6 (5%)
Practicum	29 (18%)	12 (10%)
Residency	8 (5%)	16 (13%)
Continuing education	13 (8%)	1 (1%)
Multiple previous learning	44 (27%)	37 (30%)
Other	11 (7%)	9 (7%)
Valid N	161 (100%)	122 (100%)
Gender		
Male	33 (21%)	23 (19%)
Female	127 (79%)	98 (81%)
Valid N	160 (100%)	121 (100%)
Age		
Mean (SD)	38.63 (12,329)	37.73 (10,058)
Valid N	156 (100%)	120(100%)
Years of experience		
Mean	12.97 (10,236)	10.89 (10,695)
Valid N	147 (100%)	120 (100%)

themes that could offer a common framework for the suggestions offered by participants while respecting the cultural specificity of the findings. When substantial similarities among themes were detected, a second-order theme was identified to capture the essence of the themes from both countries. If subtle differences were detected between countries, but the differences referred to the same second-order theme applicable for both countries, these were included and described within the same conceptual category. When themes differed substantially from each other, a different second-order theme was created to capture the cultural specificities. Two researchers (GL, SB) then coded all of the Italian and US suggestions according to the new second-order themes. In a third videoconference, the coding was reviewed by the entire research team for accuracy. Percentages of the suggestions belonging to each second-order theme were computed and examples of suggestions were chosen to illustrate each second-order theme.

#### 2.4. Ethical consideration

In Italy, the study was reviewed and approved by the Ethical Committee of San Paolo Hospital, Milan. In the US, the study was

reviewed by the Institutional Review Board of Children's Hospital Boston that determined the study met exemption criteria #1 under the Health and Human Services regulations 45 Code of Federal Regulations 46 (i.e., research conducted in established educational settings involving normal educational practices). In both countries, participants signed a consent form granting permission for data generated from workshop to be used for research purposes.

### 3. Results

Between 2008 and 2010, 14 Italian and 12 US PERCS workshops were conducted with whiteboard exercises, enrolling a total of 304 participants. Demographic characteristics of Italian and US participants are reported in Table 1.

During the whiteboard exercise, 398 suggestions were offered, of which 382 were able to be coded (189 by Italian participants and 193 by US participants). The remaining 16 suggestions were unable to be coded because they were either illegible or unclear. The first-order themes that emerged in the primary analyses are reported in Table 2. A summary of the first- and second-order themes is reported in Table 3. The common second-order themes, which incorporated similar suggestions and as well as subtle differences across countries, and the specific second-order theme, which emerged only in the US, are described below. Second-order themes that were similar in both countries focused on: organizational aspects and setting preparation; communication and relational skillfulness; clinician mindfulness; interpersonal qualities and sensibilities; and teamwork and care coordination. The suggestions specific to only one country (US) were related to the theme of attention to cultural differences. The frequencies of the second-order themes in both countries are reported in Table 4.

#### 3.1. Common second-order themes shared by both countries (Italy and US)

##### 3.1.1. Organizational aspects and setting preparation

Participants highlighted the importance of getting prepared for difficult conversations and identified practical suggestions regarding the setting and the organizational aspects such as: "Find a private space", "Turn off beepers and cell-phones. Try to minimize interruptions", "Prepare the environment for the difficult conversation: tissue, water, tea". Participants mentioned the importance of preparing not only the setting but also preparing themselves. Gathering updated information about the patient, verifying the patient's name, or thinking about who to include in the meeting were reported as useful strategies: "Read the patient's medical history before the meeting", "Consider if child should be included in the family meeting", "Plan the communication goal".

An important distinction between countries regarding the organizational aspects and meeting preparation was that the US participants adopted a team approach and highlighted the importance of team preparation and coordination prior to the meeting: "Plan ahead. Huddle, get team cohesiveness before sitting down with family" The team aspects of preparation were not specifically identified in the Italian suggestions.

**Table 2**  
First-order themes that emerged from Italian and US primary analysis.

Themes from Italian participants	N= 189 (%)	Themes from US participants	N= 193 (%)
Practical skills	54 (28%)	Preparation	27 (14%)
Patient-related skills	80 (42%)	Communication Skillfulness	64 (33%)
Clinician-related skills	37 (20%)	Perspective taking	42 (22%)
Qualities for a good practice	18 (9%)	Principles and sensibilities	41 (21%)
		Teamwork	19 (10%)

**Table 3**  
First and second-order themes that emerged from the primary and secondary analysis.

Primary analysis		Secondary analysis	
Themes from Italian participants	Themes from US participants	Common second-order themes, shared by both countries (Italy and US)	Specific second-order themes, present only in one country (US)
Practical skills	Preparation	Organizational aspects and setting preparation	
Patient-related skills	Communication Skillfulness	Communication and relational skillfulness	
	Perspective taking		Attention to cultural differences
	Teamwork	Teamwork and care coordination	
Clinician-related skills	Principles and sensibilities	Clinician mindfulness	
Qualities for a good practice		Interpersonal qualities and sensibilities	

**Table 4**  
Frequencies of the second-order themes in Italian and US suggestions.

Second-order themes	Italian suggestions N (%)	US suggestions N (%)	Total N (%)
Organizational aspects and setting preparation	19 (10%)	21 (11%)	40 (10%)
Communication and relational skillfulness	101 (53%)	91 (47%)	192 (50%)
Clinician mindfulness	30 (16%)	22 (11%)	52 (14%)
Interpersonal qualities and sensibilities	26 (14%)	17 (9%)	43 (11%)
Teamwork and care coordination	13 (7%)	25 (13%)	38 (10%)
Attention to cultural differences	–	17 (9%)	17 (5%)
Total	189 (100%)	193 (100%)	382 (100%)

3.1.2. Communication and relational skillfulness

Participants offered several communication and relational skills that had enhanced their conversations with patients and families. Participants identified verbal and non-verbal communication skills such as: “Listen, stay in silence with patients”, “Open-ended discussion”, “Eye contact”, “Touch”, “Attentiveness to seating”, “Pick up non-verbal cues”. Relational strategies were offered to foster the clinician–patient–family relationship during the meeting: “Make introductions at meetings. Patient, family members, staff, friends, all of us need to be recognized”, “Verify the patient’s awareness of the disease and his/her wishes”, “Start from the patient’s needs”, “Few things at a time”, “Don’t use too much medical lingo”, “Try to understand if the patient has understood”, “Facilitate the expression of the other’s feelings”, “Apologize if you have made a mistake”, “Offer silence, may feel awkward but it can be so important for the family to absorb the news”, “Make drawings to help explain”, “Explain what is going to happen next”, “Provide pen and paper for the parents for their questions”. The importance of being able to take the perspective of the patient or family was mentioned by clinicians of both countries as a general strategy to guide their behavior: “Put yourself in the patients’ shoes and think, what would I like to hear?”, “How you would like to be treated?”.

Subtle distinctions between countries were detected in the realm of perspective taking. Italian participants focused on the importance of perspective taking as it related to putting the patient at ease and reassuring him/her during a difficult conversation: “Don’t scare the patient”, “Be able to reassure the patient, take care of the emotions”. US participants offered many suggestions about the importance of eliciting, valuing, and respecting the patient’s and family’s perspective: “Remember to put yourself in the position of patient and family. Use your imagination for you to understand the patient’s and family’s perspective”, “Recognize and elicit the family’s perspective and agenda early in the meeting”, “Try to position yourself on the same level as patients and family”.

3.1.3. Clinician mindfulness

Participants offered suggestions relating to the importance of fostering and cultivating their own mindfulness and internal awareness. Participants recognized the importance of monitoring themselves and shared suggestions for cultivating mindfulness during difficult conversations such as: “Self-awareness”, “Be calm,

be attentive”, “Be open-minded”, “Don’t get too defensive”, “Be willing to change course”, “Stay balanced, maintain neutrality”, “Tolerate silence”, “Allow the suffering to come out”.

Some of these suggestions were specifically related to the ability to be in touch with oneself and one’s emotions, and to be able to identify with, but also to differentiate oneself from the patient: “Pace yourself”, “Listen to your own emotions”, “Be in touch with yourself and be yourself”, “Be able to differentiate from the patient”, and “Recognize if the conversations are getting routine for you”.

3.1.4. Interpersonal qualities and sensibilities

Participants identified general human qualities that were perceived as essential in order to create a positive relationship and climate with patients and families. These abstract qualities, recognized in both countries, included: “Respect”, “Compassion”, “Hope”, “Honesty and trust”, “Realism”, “Authenticity”, “Humility”, “Patience”. Participants also offered suggestions about how to enact these qualities in order to build a trustworthy clinician–patient relationship: “Be respectful”, “Try to provide realistic hope”, “Let the patient understand that s(he) is important”, “Be welcoming”, “Be spontaneous”, “Have confidence and presence”.

3.1.5. Teamwork and care coordination

Teamwork and care coordination were recognized by clinicians as vital assets when addressing challenging clinical situations. Participants acknowledged the importance of partnering with colleagues and allying with patients/families to both increase their effectiveness and improve the delivery of care: “Don’t go alone into a conversation”, “Enhance integration and communication between team, patients and relatives”, “Communicate with your colleagues”, “Form a team with parents”.

Other suggestions were related to the importance of paying attention to the aftermath of the conversation, both for clinicians and patients, and of maintaining the continuity of care whenever possible: “Debrief afterwards”, “Importance of follow-up”, “Sometimes it may be preferable to hold shorter, more frequent meetings than one single meeting with the family”, “Give business cards in order to promote continuity of care”, “Try for continuity of team members”.

An interesting qualitative difference was that the US suggestions were more focused on the importance of teamwork and

partnership between colleagues and patients (“*Communicate as a team. Need to respect other members*”, “*Acknowledge team members to work as a team*”), whereas the Italian suggestions were more focused on the importance of maintaining continuity of care between the clinician and the patient (“*Continuity of relationship and rapport*”, “*Give a primary phone number*”).

### 3.2. Specific second-order themes present only in one country (US)

#### 3.2.1. Attention to cultural differences

Paying attention to the cultural differences of patients and their families was a theme that emerged only in the US suggestions. The attention to cultural differences was highlighted with respect to the importance of gathering the patient's perspective. For US clinicians, the ability to recognize and address cultural differences through the interpreter service and team coordination was an important aspect of clinical practice: “*Recognize cultural differences*”, “*Be sensitive since culturally some people may not want to hear bad news and words such as cancer*”, “*Try to have an understanding of the cultural diversity for families*”.

## 4. Discussion and conclusion

### 4.1. Discussion

Despite literature reporting clinicians' inadequacies in communication [2], the findings of our study demonstrated that clinicians come to learning activities already possessing significant experiential knowledge about communication and relationships which is grounded in their clinical practice and humanity. This knowledge, that for the most part remains implicit, can become explicit and operational through the process of reflection generated through the whiteboard exercise [27]. By exploring the clinicians' experiential knowledge, we discovered that many of their suggestions were consistent with expert-driven recommendations in the literature on communication and conveying bad news [28–31], thus highlighting how everyday clinical practice can be a valuable source of knowledge [27].

Despite the different medical cultures of the participants involved, many suggestions were similar across countries. Participants recognized the importance of exploring patients' perspectives, offering information in manageable doses, cultivating respect, authenticity and trust, working in teams and providing closure. This finding suggests that there may be a trans-cultural common knowledge of what is important and relevant in relationships with patients in difficult clinical situations. We might further hypothesize that there is a core of relational skills and interpersonal qualities that transcends cultures and might be rooted in the common human and professional experience of uncertainty, grief, closeness and help [32].

Interesting qualitative differences were found between the suggestions offered by Italian and US clinicians. Attention to cultural diversity was mentioned by US clinicians as an essential skill for addressing challenging healthcare conversations, whereas this suggestion was not offered by Italian clinicians. This may reflect the greater multicultural composition of US society and diversity of the US clinicians who attended the PERCS program – including medical interpreters – compared to the more homogeneous Italian sample and population [33]. These thematic distinctions between Italian and US clinicians, suggest that the knowledge that is borne from everyday clinical practice is framed to some degree by the historical context of professional training and by the healthcare culture in which practice takes place. If this is indeed the case, exploring already-existing knowledge could be a productive avenue of research to capture the messages conveyed by the healthcare culture regarding what is important and valuable.

Finally, the educational strategy that we employed deserves some reflection. The whiteboard exercise not only allowed us to gather valuable information about clinicians' experiential knowledge, but also proved to be an effective educational strategy to validate participants' already-existing relational knowledge that often passes unrecognized by the academic medical culture [27]. Our findings suggest that educational programs could increase clinicians' preparation and confidence for difficult conversations by bringing to light and building upon already-existing experiential knowledge. In our previously published program evaluations, we have reported that healthcare professionals who participated in PERCS workshops identified the process of having their experiential knowledge validated to be one of the most powerful aspects of the paradigm [22,34]. In contrast to more prescriptive approaches that teach how to convey bad news, the whiteboard exercise might have contributed to alleviate learners' anxieties by reminding them that they already have a reservoir of communication and relational skills from which to draw, and that reflection might serve to unpack this knowledge and make it more readily available to them.

Some limitations of this study should be acknowledged. Our sample was composed of clinicians who voluntarily enrolled in the program and was not randomly selected. Participants' sensibilities and interest in the topic of communication may have prompted their enrollment and influenced the generosity and depth of their suggestions to the whiteboard exercise. The study was carried out with adult clinicians in the Italian site and pediatric clinicians in the US site. However, this difference seemed not to be reflected in the core themes that were identified. The US sample included medical interpreters that may have contributed, in part, to the emphasis on attention to cultural differences. As the whiteboard was conducted as a group exercise, the suggestions offered were not linked to the participants' discipline.

### 4.2. Conclusion

The results of this study prompt us to reflect on the abundance of communication and relational skills that clinicians recognize as important and the apparent gap between what clinicians already know, or feel that they should do with patients and families, and their actual practice. Future studies could investigate why this already-existing knowledge seems to get lost in clinicians' actual behaviors and relationships. Insufficient time with patients [35], the lack of feedback received on one's own behavior [36], and the impact of the hidden curriculum and organizational culture [37] have been identified as challenges to communication and relationship development, and could be promising avenues for future research.

### 4.3. Practice implications

This study captured clinicians' suggestions when facing difficult conversations, which are grounded in their lived experience. Our findings demonstrated that clinicians already possess a valid implicit knowledge on communication and relationships, and that this experiential knowledge can be made explicit, can be fortified with formal learning, and eventually refined or improved. Uncovering and validating clinicians' experiential knowledge could be a strategy to create an optimal adult learning environment.

Despite the different healthcare cultures, clinicians' experiential knowledge about difficult conversations presented similarities in relation to the core aspects of communication. Our findings suggests that there may be a trans-cultural common knowledge of what is important and relevant in relationships with patients in difficult conversations, which may constitute a valuable resource when delivering multicultural care.

The whiteboard exercise served as an educational strategy to better appreciate and unpack participants' experiential knowledge. The exercise increased active involvement in learning and personal ownership of learning, and contributed to collaborative thinking. As a group learning activity, it can be easily integrated into educational courses.

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#### Conflict of interest

None.

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