Our validation of the evaluation checklist supports the use of this curriculum as an objective measure of communication skills for ACGME clinical milestone assessment of residents for progression in their programmes. Trainees in consulting specialties requiring efficient communication with other health care providers could benefit from a similar curriculum. Future efforts will include surveying participants about their perception of how this simulation contributed to their ability to communicate with other physicians and expanding the simulation annually for both PGY-2 and PGY-4 trainees.

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Let’s talk about diet—Nutrition skills in medical education

1 | WHAT PROBLEM WAS ADDRESSED?

Doctors are recommended to support patients to improve their dietary behaviours to help reduce the prevalence of lifestyle chronic disease. The findings from a recent systematic review which investigated medical nutrition education throughout the world found that it was insufficiently incorporated into medical education, regardless of country, setting or year of medical education. Innovative and effective ways to increase students’ nutrition knowledge, skills and confidence to counsel are required without increasing overcrowded curricula.

2 | WHAT WAS TRIED?

A pilot intervention to improve Year-4 medical students’ knowledge and communication skills about nutrition and diet was developed and implemented by a multidisciplinary team from the University of Auckland, New Zealand. The pilot was included in the 1-week General Practice Observed Patient Simulation (GPOPS) teaching block primarily focused on communication skills development in the context of simulated general practice consultations. This was considered an ideal place to introduce and practice nutrition-related curriculum content and skills.

The education intervention included:

1. Online nutrition and Motivational Interviewing (MI) resources (MI guidelines and video demonstrating OARS(Open questions, Affirmations, Reflective listening and Summarising)
2. An introduction to the 5As (Ask, Assess, Advise, Agree, Assist) of Obesity Management
3. Healthy Conversation Skills (a patient-centred approach to support life behaviour change) including a video to enhance healthy conversations skills
4. An MI tutorial to practice skills-related to nutrition using role play with a peer
5. A simulation weight management/Pre-Diabetes case with a standardised patient (actor) to practise MI interviewing and nutrition counselling skills followed by a debrief with a tutor

3 | WHAT LESSONS WERE LEARNED?

On completion of each GPOPS teaching block, students were invited to complete a questionnaire to evaluate their perceptions of the resources provided and to canvas their opinions on the types of nutrition skills development that they would find useful. Additionally, students completed NUTCOMP, a reliable and validated questionnaire that assessed self-perceived competence of primary health professionals in providing nutrition care to patients with lifestyle-related chronic disease.

The MI resources provided to students in GPOPS were perceived most useful for increasing knowledge and confidence to counsel in nutrition. Similarly, observation of the patient simulation case increased students’ perceived confidence to counsel patients. Opportunities for naturally incorporating and reinforcing nutrition skills suggested by the students included small group activities during pre-clinical years involving problem-based learning and role-playing to strengthen communication skills. Students also suggested that consideration be given to the importance of interdisciplinary teaching and faculty collaboration to appropriately link, sequence and frame curricular content to create an integrated nutrition curriculum. Students’ self-perceived nutrition competence scores demonstrated
positive attitudes towards nutrition, lack of confidence in nutrition knowledge and skills and moderate confidence to counsel in nutrition.

The pilot intervention aimed to integrate a modest amount of nutrition content focused on communication skills relating to diet and nutrition within the time constraints of the GPOPS teaching block. It complemented without compromising teaching of other important related aspects of lifestyle intervention.

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Re-imagining death certification education

1 | WHAT PROBLEMS WERE ADDRESSED?

Death certification is a key part of a physician’s responsibility to patients, with far-reaching consequences. For patients’ families, death certificates have legal, financial and sentimental utility, while for society, death certificates are critical for understanding the epidemiology of disease and allocating public health resources. When caring for dying patients, clinicians are most often focused on extremes of physiology and biochemistry (e.g., shock and sepsis), known as mechanisms among pathologists. However, the underlying cause of death (e.g., coronary artery disease and COVID-19 infection) leading to those mechanisms is coded and used by local, state and federal agencies and is thus the most important part of the death certificate. A recent study of 601 death certificates reviewed by experienced pathologists revealed that 53% contained at least one major error and 60% had an inaccurate underlying cause of death. At our institution, internal medicine residents receive one brief training on death certificates prior to commencing training. We sought to address this knowledge gap with a focused didactic intervention.

2 | WHAT WAS TRIED?

We created a digital interactive 45-min session to build skills for completing death certificates. Our session highlighted differences between pathologists’ approach to cause of death and clinicians’ experiences caring for patients at the end of life. We started by describing the role death certificates play in local, national and international epidemiology. We then reviewed the parts of a death certificates and had participants practice categorising diagnoses as immediate causes of death, underlying causes of death and mechanisms. Finally, participants corrected actual erroneous death certificates (personal health information redacted). We assessed the efficacy of the intervention by having participants complete death certificates for two fictional patients before and after the workshop: a patient with advanced cancer who died on a comfort-focused care pathway and a patient with shock and respiratory failure. Responses were graded according to a previously described standardised scale.

3 | WHAT LESSONS WERE LEARNED?

Thirty-eight residents completed the workshop. During the pre-workshop assessment, 89% of death certificates had ≥1 error, compared with 46% after. Major errors, such as incorrect categorisation of a cause of death, decreased from 58% to 17% after the intervention.

While we expected improvement in the accuracy of death certificate completion, we were surprised by the degree of magnitude of the change, as well as the distress among learners about their lack of knowledge on completing death certificates, and recognition that they had frequently submitted erroneous certificates in the past. By clarifying the differences between underlying causes of death, immediate causes of death and mechanisms, the workshop provided learners the tools necessary to more accurately complete death certificates in the future. Participants reported that teaching on death certificates is best situated during the transition from the first to the second year of post-graduate training, when they have more context about caring for dying patients but before being responsible for independently completing death certificates as senior residents. Teaching on death certification is necessary, effective and desired by internal medicine trainees at our institution and should be mandatory for all providers.