

ONCOTALK | teach

A faculty development program

Teaching communication skills in clinical settings

Investigators

Anthony Back MD, University of Washington, Fred Hutchinson Cancer Research Center

Kelly Fryer-Edwards PhD, University of Washington

Bob Arnold MD, University of Pittsburgh

Walter Baile MD, M.D. Anderson Cancer Research Center, University of Texas

James Tulsky MD, Duke University

Contents

1. Introduction to Oncotalk Teach
2. Roadmap for a successful teaching encounter
3. Beginning: Setting useful goals
4. Middle: Balancing your commitments to learner and fellow
5. Middle: Using yourself as a role model
6. Middle: Feedback that engages fellows
7. Closing: Take-home messages that resonate
8. Facilitating group learning
9. How learners progress

This program is supported by the National Cancer Institute.

Version 1.0 October 10, 2007

Introduction to Oncotalk Teach

developing skills for teaching communication to oncologists

Our goal

The Oncotalk Teach program aims to provide faculty development for oncology faculty involved in teaching communication skills at their home institutions. We view the Oncotalk Teach program as part of a larger vision of establishing communication as a core skill for clinicians who care for patients with cancer—a vision that includes further development of a learning community within oncology, a clear delineation of expertise and milestones in acquiring expertise, and further research to establish an evidence base linking communication to patient- and family-level outcomes.

Why we designed Oncotalk Teach

A number of Oncotalk alumni have asked about further programs and training, and many have reported that they have done some communication teaching after returning home. Many quickly discovered that simply having the teaching materials (slides and modules) was not enough to prepare a really successful teaching session. We had not clearly defined what made the teaching work in a manner that could be shared with others

To define the teaching better, we analyzed about 100 hours of transcribed audiotapes of Oncotalk small group teaching, and out of that we defined a few core skills. These skills for teaching communication go beyond what is available in the literature now—particularly when teaching communication skills to more experienced clinicians who are on the frontline of life-threatening illness.

We specifically designed a program to enhance teaching skills because we decided that the most effective way to move communication to the front burner was to create a new cadre of oncology faculty who possess the core teaching skills. We are hoping that the Oncotalk Teach faculty will ensure that teaching communication is better integrated into the teaching of oncology fellows.

What you will acquire

In Oncotalk Teach, we will focus on skills for teaching better communication in the most common teaching settings in oncology training: outpatient clinic visits, and inpatient attending. We have placed the primary focus in Oncotalk Teach on these common settings rather than in a

specialized workshop like the original Oncotalk retreat for a couple of practical reasons. First, a specialized workshop requires more resources and commitment from your program. They are more likely to spring for a specialized workshop if they can see the skills as important and teachable. Second, the specialized workshop skills—while effective and memorable—require more faculty expertise. We honed our teaching skills in common clinical settings, and we all still do this kind of teaching much more commonly than in an Oncotalk-like workshop.

Important definitions

Oncotalk Teach will focus on foundational skills for communication teaching in common clinical settings. We will use the term “**learner talks**” to denote settings in which the learner is talking to the patient, and the teacher is observing. We will use the term “**teacher talks**” to denote clinical settings in which the teacher talks to the patient, and the learner is observing. We will use the term “**group talks**” to denote settings in which the teacher is trying to generate thinking, talking, and reflection in a small group of learners—typically during rounds, or an ad hoc meeting about a patient. We will use the term “**workshop**” to denote a setting that is specifically for education, such as a block of time in a fellows’ weekly educational curriculum, or a special 2-4 hour workshop aimed specifically at communication. Those of you who attended Oncotalk will probably notice that a workshop conducted away from the clinic has some important advantages, and we agree—that is why Oncotalk Teach is residential. There is no substitute for intensive face-to-face teaching. Once you have established some short-term teaching successes with common clinical teaching encounters, you should consider a workshop for your fellows.

What to expect with Oncotalk Teach

Virtually all the sessions in Oncotalk Teach happen in small groups. The small group format capitalizes on the experiential aspects of learning. As in Oncotalk, we will emphasize skills practice, and this will constitute the meat of the course. Because this program represents a unique opportunity we expect—as with Oncotalk—that we will attract an extraordinary group of clinicians who contribute a great deal to the learning that occurs for all of us.

We recognize that this format is unlike most medical education, especially CMEs designed for physicians. Medical education is built on the model of ‘see one, do one, teach one.’—and most CMEs consist of simply ‘see someone talk about one.’ Yet the empirical evidence demonstrates that acquiring complex skills, like communication, requires much more than watching someone once. And we think that by this point in your career, you’ve already seen enough power point for a lifetime.

Overarching principles

Here are some bedrock principles for teaching communication.

- Clinicians and teachers both use themselves as instruments
- Communication teaching requires attention to the cognitive **and** emotional data
- How teachers act (with students and patients) is as important as what they say
- What learners discover is more important than what they are told

How novices differ from experts

One of the problems with a lot of medical education, in our opinion, is that it fails to take into account how novices differ from experts. These differences can be especially perplexing in communication because previous work in communication has not clearly defined the skills or the milestones. The modules following this will define these differences in detail. At this point, we would simply like to point out the novices see the world differently than experts. To teach a novice, you must uncover and correct the novice’s explanatory model of how things work (or how a patient is responding, or what helps a patient understand) before you provide the new approach. Thus you will see our teaching put a great deal of emphasis on exploration—but not exploration simply to unearth detail. The exploration we are talking about for good teaching is tactical—you are looking for explanatory models. Correcting a learner’s incorrect explanatory

model is more likely change learner behavior. The learning sciences have identified this ability of a teacher to respond to complex and novel situations as ***adaptive expertise***, and that is what we are aiming to give you.

An overview of the modules

Basically, the modules will walk you through a teaching encounter—from the beginning, through the middle, to the end. You will notice that the “end” of an encounter is not simply when you have stopped talking. The real end occurs after you have done a bit of reflection on what happened. This kind of reflection, which we will do explicitly in Oncotalk Teach, is called **metacognition** within the learning sciences, and it is essential to building new levels of expertise. We will ask you to reflect on your teaching, and you will ask your learners to reflect on their communication.

References

Bransford JD, Brown AL, editors. How People Learn: Brain, Mind, Experience, and School. National Research Council, Washington DC, 1999.

Fryer-Edwards K, Back AL, Arnold RM, Baile W, Tulsy JA. Tough Talk, <http://depts.washington.edu/toolbox>

Kurtz M, Silverman J, Draper J. Teaching and Learning Communication Skills in Medicine. Radcliffe Publishing, Second Edition, 2005.

Roadmap for a successful teaching encounter

the master cognitive map

Learning objectives:

- Learn a master cognitive map that you can use for outpatient and inpatient teaching
- Understand how the Oncotalk Teach program is designed around the map

Introduction:

We think that teaching communication skills, whether inpatient or outpatient, whether teacher talks or learner talks, can be described in a single cognitive map. We've been using and refining this map for years, and find that as teachers it helps us mentally structure our work. The map is simple: a teaching encounter has a beginning, middle, and end. A couple of examples are in the table on the next page.

Beginning the teaching encounter: Setting useful goals

Opening a teaching session requires a few key activities that will set the stage for the rest of the entire session. Opening a session will be necessary whether you have worked together many times or whether it is a new relationship. How much time you spend during the Opening, and what you do, will depend on how long you have for the teaching session (3 minutes? an hour?) and how well you know each other.

A teaching session often comes in the middle of a busy day, or is set among competing demands. Your job as teacher is to prepare the fellow for the work that is to come. This requires engaging the fellow by asking about their goals, choosing a goal to work on, and ensuring that the fellow has a strategy to try that will enable him to succeed at some level. You can accomplish this surprisingly fast with the help of a little transparency and direct communication.

Master cognitive map	An outpatient 'learner talks' example	An inpatient 'teacher talks' example
Beginning: faculty ask fellows for their learning goals; and help fellows identify strategies that will enhance likelihood of success in the encounter	You (a faculty member) ask the fellow at the beginning of an afternoon clinic session to identify a skill that the fellow wants to work on that day. The fellow says he would like to work on trying to talk about prognosis with patients. He is worried that he often feels the patient is confused by the information. After a less than a minute of discussion, you and the fellow agree that he will try asking patients if they want to talk about prognosis today. You settle on a learning goal of identifying patient concerns before giving prognostic information. The fellow agrees to pull you into the room if a patient says he wants to discuss prognosis.	Before a family conference, you (a faculty member) ask the fellow what she would like to learn about doing a family conference. The fellow says she would like to watch to learn 'how to do it better' and that she doesn't feel that she really knows how. You suggest that an important first step is to ask about what the patient and family understand, and to observe how you do that.
Middle: the faculty sets up some type of skill practice, then gives feedback	You watch the fellow talk about prognosis to a patient with metastatic colon cancer. After the visit, during feedback, the fellows' self-assessment is that he thought it went pretty well. The faculty points out that the fellow did a great job understanding the patient's perception. You note that the patient seemed confused when the fellow talked about 'disease-free survival'.	You conduct the family conference. Afterwards, you spend 2 minutes with the fellow asking her what she observed about eliciting pt/family understanding. (The skill practice is observation in this case.) The fellow is able to remember your exact question, and expresses some surprise that the question was so simple but useful.
End: the teacher closes with one really good take-home point	You ask the fellow about his take home learning point. The fellow mentions the medical jargon he takes for granted. You reinforce this as an important learning for that day.	You ask the fellow about her take home learning point. The fellow cites the question to elicit the family's perception. You agree and suggest that the fellow conduct that part of the next family conference.

Middle: Practice with feedback

The Middle of the teaching session is where the bulk of the work occurs. This is the skill practice in a small group setting, or the bedside interaction in bedside teaching. The three key tasks for the teacher in this section are to: 1) help the learner gain an accurate sense of their skills; 2) help the learner see what strengths that they had in the encounter that they can build on in the future

and 3) help the learner see how they can build on these skills to be better at the task in their next encounter.

Closing: take-home points that resonate

The closing of a teaching encounter can get short-shrift because we often run short on time. The work of closing is important because it reinforces the learning that has taken place. Ask the learner what she is taking away from the session (e.g. "Having gone through this, is there a take home point for you?"). By naming a specific point, it reinforces it in the learner's mind and she will be more likely to carry it forward from the session. Depending on the learner's reply, you can either simply reinforce their assessment (e.g. "That is a great point to walk away with") or you can offer an additional point you think came from the session (e.g. "You know, I also thought you made great progress with using silence during this encounter. I can see that being a useful skill for you in the future.").

Table: The key teaching skills in the master cognitive map

Master cognitive map	What the teacher did to optimize learning	How the teacher knew she did it right
Beginning: faculty identifies learner goals	-Created a plan to observe a substantive conversation -Crafted a specific goal with the fellow	-Fellow names the goal -Goal has observable endpoint
Middle: faculty sets up some type of skill practice, then gives feedback	-Collect primary observational data about skill practice -Ask learner for self-assessment specific to goal -Link feedback observation to their learner goal -Builds on learner strengths in feedback	-Learner evaluates self using descriptive endpoints previously negotiated -Learner accepts feedback as clearly relevant to own learning goal -Learner feels like she can do better next time she practices the task
End: faculty closes with one really good take-home point	-Asks for 'the most important' take home point	-Learner names a take home point that is one of the key points from this encounter

Setting useful learning goals

finding the learning edge

Learning objectives:

- Develop strategies for eliciting effective learning goals from learner prior to a patient encounter;
- Identify goals which help learner work in their optimal learning zone (a balance of innovation and comfort).

Why is this module important?

Assessing learner needs and setting learning goals is a critical first step in a teaching encounter. Faculty and learners both need to think about goal setting, but in different ways. For faculty, setting goals for each teaching encounter helps you get clear about your expectations and priorities for the session. For learners, specific goals help guide them to where they want to focus during the skill practice encounter. Identifying specific goals also engages both faculty and learner as there is a purpose to the encounter that has relevance. Goal setting is both the starting point for all teaching encounters and also the map that points the way for future work.

Too often in teaching encounters, the faculty choose the learning goals and assume that the learner agrees with them. A better practice would be to negotiate: ask the learner for her learning goal, and then refine it. For example, an attending might feel that particular learner needs to focus on better monitoring of patient emotions. But if the learners' goal was to talk about management in the care of a sick patient in the middle of the night, learning is unlikely to occur. Forcing the learner to talk about empathy will leave the learner unheard and unengaged, feeling that the 'teaching' was merely the faculty's agenda.

Adult learning theory suggests that learning is most likely to occur if the learner is engaged in the problem at hand. Thus, we believe that assessing the learner's goals is a critical step as it allows the teacher to focus on something that the learner feels is important.

When do I use this skill?

Goal setting happens at the beginning of a teaching encounter. There may be broader goals for a course or a clinical rotation, or specific goals for a particular patient encounter. Faculty and program directors have already mapped out areas in which they want learners to work. These curricular goals provide an important framework within which to set learner specific goals. For example, if a curricular goal of the fellowship is to provide skills for giving bad news, that can

define the universe of possible learning goals that a fellow might choose to work on during the workshop. However, the curricular goal does not define the target area of need for an individual fellow. Finding out where that particular fellow struggles with giving bad news will help identify a scope of work for that teaching session that will move the fellow on her personal learning trajectory towards the program's curricular goal.

Concretely, assessing learner needs and goal setting are activities that can happen at the beginning and end of a teaching encounter. By invoking goal-setting at the beginning and end of the encounter, you will activate mental activity that constitutes learning: self-observation, self-assessment, and reflection-in-action. These activities can happen in a hallway, in a conference room, in a patient's room, or a small group workshop.

Key Skill: What do I say to start setting goals?

Helpful questions include: What do you want to work on in this next encounter? Where have you felt stuck in the past? Is there something particular you would like to try?

Key Skill: Engaging the fellow. Depending on your teaching context, there may be multiple layers of goals to identify and address. Your objective is to engage the learner in the learning that is about to occur (whether a rotation or a patient encounter) and to prompt self-reflection and self-assessment for the fellow. If the general goals are defined, engaging the learner allows them to focus the areas where they feel they need the most work. As importantly, it forces them to self-assess their own strengths and weaknesses--a critical skill for life-long learners.

For example, in a longitudinal learning context (e.g. one day to one year), you can ask participants to set goals for the entire session. "What brought you here?" "What do you hope to leave with?" "What would you like to accomplish during this time together?" "What areas would you like to work on during this course/rotation/clinic block?" Questions such as these frame the big picture for teachers and learners alike.

For shorter sessions, or within one practice block in the longer session, a more focused, specific goal will set the stage for an interaction with a patient. "What would you like to work on today?" "Given where you are now in your course/in your training, what would be most useful for you to work on during today's session?" Drilling down further, during the specific skill practice encounter, the learner in the 'hot seat' can now identify a specific goal to work on with the presenting patient, ideally tied back to one of the bigger picture goals. "Thinking about this patient presentation, given your goals for the day, what would you like to focus on during this encounter?"

Key Skill: Formulating and refining goals. Practically speaking, it helps to write down goals where they can be reviewed and revisited during the teaching session. During a clinical encounter, this might take the form of notebooks or index cards; within a workshop flip charts that can be posted around a workshop room can be used. The act of writing down a goal confirms the learner's intention and commitment to that goal. In long-term settings, such as clinic block, or even over the course of one-day, goals may evolve and change in response to experiences and

interactions with patients and other learners. While a commitment has been made, these should be viewed as dynamic documents.

Faculty can play an active role in shaping and refining learning goals, and it takes practice. Faculty can give fellows feedback on their goals in a number of ways. Simply restating the learning goal can clarify the focus. For example:

Faculty: Anything you want me to particularly look for, or observe for you?

Fellow: Well, I always feel anxious in these situations, when I give bad news. I tend to run on and jump in to reassuring them too quickly and might not give them time...

Faculty: Good. So, a concrete goal for you that I hear is that you want to work on giving the patient time to absorb the news, and also avoiding quick reassurance.

After posing the question about goals at the outset, faculty may move on to shaping the learner's unformed goals into something that can be accomplished in that session. This might include feedback to the learner about the goal being too broad and asking them to identify a particular piece within it that would be workable in the practice session. For example,

Fellow: I think I want to work on denial.

Faculty: Denial, good. Can you tell me what is it about denial that you want to work on during this encounter if it comes up? What would be most useful to you?

Faculty can also connect previously voiced goals or learner interests to the current patient encounter. For example:

Faculty: What are your goals? What kinds of things do you want to try to be sure to do?

Fellow: Well it's a difficult situation, and I think it is hard to be direct and I tend to beat around bush.

Faculty: Ok, I can watch for directness. Anything else?

Fellow: The usual things, fumbling, staccato speech.

Faculty: And the other thing you brought up earlier was whether you were able to figure out where the patient was coming from, what his goals were. So maybe I can watch for that?

When a fellow cannot formulate a goal, the faculty can help by naming common issues other learners face. If the fellow says "I just want to get better at giving bad news," the faculty can respond with "Some people trouble giving the news without jargon. Others have trouble dealing with the patient's emotions. Are either of those something you'd like to work on?"

Key Skill: Operationalizing Goals. After getting clear on the goal, the next step is to help the learner identify how they will achieve the goal during the patient encounter. This will set you up for effective feedback later. For example:

Faculty: What do you want to work on?

Fellow: I want to try and follow the patient's needs rather than my agenda.

Faculty: How do you think you will try to do that?

Fellow: By listening. Trying to just respond to what they are telling me.

Faculty: It sounds like feedback on how you are doing with active listening would be useful.

Doing the work of goal setting helps the learner get more out of a teaching session, even though it does take time. Think of goal setting as an efficiency tool for teaching. You want to target your teaching intervention to just where the learner needs it. Good self-assessment and goal setting can help you.

Key skill: Tracking fellow emotions during goal setting. Just as an experienced clinician would track a patient's emotional responses in addition to their cognitive responses, a faculty teaching communication can learn a lot from tracking the fellow's emotions. Not that we think fellows will display a lot of emotion—at this point in their career, most of them have learned to keep their emotions to themselves (and some can be quite distanced from even their own emotions). What we especially look for is evidence of fellow hesitation in talking about goals. Underlying a fellow's hesitation, we most often find 2 issues: concern that they won't be able to do the communication that is being proposed (either because they don't know how or don't have confidence in their skills), or they are concerned that the topic at hand will make them feel emotions that they would rather not deal with—for example, that giving a patient bad news about cancer recurrence will generate feelings of sadness in themselves.

Responding to fellow's emotions in the same way that you would respond to a patient's emotions can be surprisingly helpful as a learning tool. As with patients, you do not have to fix the fellow's emotion or make it disappear—simply bringing it to light can enable the fellow to develop an awareness that will facilitate practice and learning. Most clinical settings where teaching occurs are not places where a clinician's own emotions can be talked about in much depth—we think these require special learning environments. But noting the importance of one's emotions can be a source of tremendous personal growth for fellows (and clinicians at every level, really—it's a lifetime's work). Empathy for clinicians who do the difficult work of oncology is, in most training situations where we have worked, in very short supply.

Key Skill: Using the learning goals as reference points for the rest of the encounter. The faculty payoff for doing the work of goal setting is the goals provide direction for the middle and the closing of the teaching encounter. A single patient encounter generates so much observational data that without a clear goal-directed focus, the teaching can lose direction, and worse, learner engagement. True, other issues will undoubtedly arise, tempting a knowledgeable faculty to take a detour—but the downside of a teaching detour is that you will lose the learner engagement.

Pearls: How do you know your goal setting has been successful?

- You know you have a good working goal when the learner has identified a specific issue or behavior that is observable and can be practiced/tested in the next practice/clinical encounter.
- The goal should accomplish something that is important to the learner and to your goals for good communication.
- It should also feel like the right level of challenge for the learner – that is, not so discrete that it does not push the learner or critically impact the encounter. The learner should be working in the ‘optimal learning zone’, which reflects a balance of anxiety and confidence, innovation and comfort.

References

Fryer-Edwards K, Back AL, Arnold RM, Baile W, Tulsy JA. Tough Talk, <http://depts.washington.edu/toolbox>

Kurtz M, Silverman J, Draper J. Teaching and Learning Communication Skills in Medicine. Radcliffe Publishing, Second Edition, 2005.

Balancing your commitments to patient & fellow

how much can a fellow practice with a real patient?

Learning Objectives

To identify important considerations for attending physicians who are teaching communication in real patient encounters, including:

- Balancing obligations to the patient as well as to the learner;
- Sharing power with the learner;
- Being transparent about your role and actions during the visit;
- Learning when to intervene.

The challenge of teaching in real-time

Oncology faculty teach in a variety of different clinical settings, and these settings all have different institutional expectations that define your role and influence your decisions about how to participate in a real patient encounter with a learner. These contexts will shape how you intervene. For example, in a fellows' clinic where you are a rotating faculty preceptor and the fellow is the patient's primary oncologist, you would act and teach differently than when you are seeing your own patients in your clinic, and a fellow is spending an afternoon with you.

Many of our teaching modules address activities that occur before or after a patient encounter. In this module we address some common questions that arise while attendings are in clinical encounters with trainees.

How do I introduce myself?

Setting up your role within the visit gets things off on the right foot and avoids confusion later on. You need to make clear in your introduction what your role is going to be and what the fellow's role is going to be. You will have worked this out with the fellow ahead of time. If you are a clinic preceptor, and the patient is the fellow's patient, you might say "I'm the supervising physician today. I just came in to see how things were going." If you are seeing one of your patients, you might say, "I'm working with a fellow today, and she will be talking about your lab tests, and then I'll talk more with you about what they mean."

Key point: Since settings vary so much, and attending preference varies, be explicit about your role to the fellow and to the patient. Don't assume the fellow will know what you want.

If the conversation isn't going well, when should I take over?

Since in Oncotalk Teach we are emphasizing teaching in which learners do some talking, a major decision point for teachers is when to intervene. Specifically, if you think a patient needs something in the encounter that the fellow is not doing, when should an attending step in and take over the conversation?

There is not a single answer to this question. In some cases, you will have the opportunity to shift from a “learner talks” to a “teacher talks” learning opportunity. There are other instances where your obligations to the patient will override your obligations to the fellow. For example, if a patient is becoming distressed and a trainee is not addressing the distress in some way (eg being empathic, acknowledging, etc), then most attendings would eventually step in to address the issue directly.

Key point: If you have decided to step in, the important teaching point occurs later, after you and the trainee are both out of the room: you as the teacher need to acknowledge that you stepped in, identify and explain your reasons, and empathize with the learner, who is likely feeling a bit stepped on, and even a bit shamed. It is also good practice to find ways to step back out, returning the direct line of interview to the fellow if you are the preceptor. This both allows him/her a chance to recover with the patient directly and also returns you to your teaching obligations.

In addition to addressing the learner’s emotion, you should view your decision to step in as a teaching opportunity. First, did the learner understand why you stepped in? Can you make your concern explicit? If the learner saw why you stepped in, can the two of you brain storm about what could s/he could do differently next time. Second, what happened after you stepped in? Did you exhibit any behaviors that moved the interview forward? Can the two of you talk about these behaviors and the fellow’s ability to use them the next time? If things did not go well, it is still important to debrief this and come up with ideas regarding what the two of you could have done differently next time.

Is it ok for me to take notes?

We take notes while we are watching trainees for a couple of different reasons. First, it helps us stay awake and pay attention. Second, good notes about the process help us remember the learner’s goals, anchor our observations to concrete details (when you said x”), and thus give better feedback. Third, sometimes it is a good use of time to take notes that we can give to the patient as a record of what we discussed, which is particularly helpful when discussing treatment options.

Key point: If you want to take notes, explain to everyone at the beginning, so they won’t be wondering for the entire visit what you are doing.

What if my pager goes off during the visit?

This is inevitable, so the issue is: how do you explain what you are going to do to the patient and to the fellow? Again, be explicit with them both.

Key point: This depends on your role and what you are doing when it goes off. If you are precepting a fellow’s patient and it goes off while the fellow is talking, it might be reasonable for you to step out of the room to answer the page with a brief acknowledgment (“I’ll return in a minute”). If you are in the middle of talking yourself, you might need to excuse yourself when the first opportunity arises (“Would you mind if I answer this now? I’ll be right back”). You may want to acknowledge the interruption for the patient in an empathic way (“I know it is disruptive to your thinking so I apologize”). Or it might be ok to ask the fellow to answer the page for you and get you if it’s urgent. Recall however, that in this case you are directing the fellow in a way that they

will miss part of an encounter. Whatever decision you make is a teaching opportunity with the learner once the interview is over.

Conclusion

Being a teacher in a real patient encounter challenges your commitment to the patient and your commitment to the learner. In any instance you may prioritize one or the other. Once you have decided, though, you can acknowledge what is happening and explain what you are doing. A faculty intervention might have felt good to you, but it might have felt bad for the fellow. Your awareness of how fellows feel and your ability to create shame should guide your debriefing. Remember that the way you treat learners should parallel the way you treat patients—let them lead the way, and treat them with respect.

Using yourself as a role model

tapping the power of modeling

Learning objectives

- understand when role modeling should precede practice
- describe a “teacher talks” approach for modeling skills that are new to a learner

Introduction

Role modeling is critical in teaching communication skills. Learners need to see that the teacher ‘walks the walk’ that they recommend to others. Without this level of authenticity, your recommendations about best communication practice are likely to be ignored.

The role modeling you do works on at least 5 different levels: demonstrating a specific skill (“demonstrating expert practice”); observing things as an expert that a novice doesn’t pick up (“observing from an expert’s perspective”); demonstrating how everyday reflection is an essential practice of being a great communicator (“demonstrating metacognition”); explaining to a learner how they can go about learning or refining a particular skill (“using scaffolding in the learning process”); and finally by encouraging a learner’s personal development (“stimulating personal development”). In this module we will discuss each of these levels briefly.

Demonstrating expert practice (“teacher talks”)

As a faculty member, your behavior in itself tells learners important implicit messages about how they should communicate. In addition, as an expert, you can demonstrate a level of practice that a learner may not have realized is possible. For example, many students have never seen an effective empathic response. Thus, teaching by demonstrating expert practice helps them see the kinds of behaviors you want them to learn, and it sets a standard for the level of skill to which they should aspire. Effective demonstrations can help learners move from a novice perception that communication skills are magical to a more advanced perspective that communication is composed of specific skills they can practice. Also, you can use demonstration almost anytime you are seeing a patient with a learner.

1. Goal setting. Although the teacher may be doing the talking, you should still negotiate learning goals because novice learners don’t know what to watch for during the interaction. The topic that you choose should be negotiated with the learner based on the situation (e.g. what is likely to come up), their question (I am not sure how to build rapport with someone I do not know) and your view regarding what would be most educational for the learner (e.g. you think the learner has trouble being empathic so you might ask them to notice your empathic statements). In general, one should have the learner watch for only 1-2 tasks initially as it is often hard for them to observe and track specific details.

2. After coming out of the room, ask the student what she observed, related to the learning goal. It is likely that the student will be positive (both because you are skilled and because you are the more powerful person in the interaction). If you have time after discussing the learning goal, you ask about observations more generally, such as “what skills that worked”.
3. If the conversation did not go as you expected, you might discuss what you thought did not go well or how you felt you could have been better. It is more likely that you can do this than a learner who would be feeling like they are criticizing an attending.
4. At the end it may be helpful to summarize one important teaching point to take away from the encounter. In addition, see if you can get a commitment from the learner to try the skill in their next encounter and discuss any barriers that may interfere with its performance.

Observing from an expert perspective

Role models also point out what they are observing to learners at times that are not linked to learner goals. For example, an attending might say after an encounter, “Did you notice how the patient was shifting back and forth in her seat? I think that was evidence of being nervous, even though she said she was doing fine.” As a role model, you can volunteer these observations to your learners when: (a) you have observed a good example of something, (b) when you’re not sure the learners understood the example, and (c) you have the time. The observation can be tied to your behavior: “The reason that I continued to make empathic statements is that I noticed her calming down every time I acknowledged how hard this is.”

Metacognition as an everyday skill

A skill that advanced practitioners use is metacognition, which is a term from learning sciences referring to reflection about the process of learning and practicing. For example an attending might comment in response to a learner question that “I had this hunch that he might have a difficult time talking about his own goals, so even though I decided to ask him, I was ready with some things to suggest as possibilities when he came up short.” The importance of showing how you use metacognition is twofold: first, it demonstrates to novice learners how metacognition works as a skilled practitioner makes a complicated judgment, and second, it shows that metacognition is an integral part of expert practice. Novice learners often assume that when they know more content that decisions will be simpler. In actuality, skilled learners use complicated patterns of thinking that enable them to examine more possibilities in less time, and metacognition is the way they build those patterns.

Using scaffolding in the learning process

Role models can also facilitate learning by describing how they went about learning a new skill. For example, an attending might describe how he trained himself to be more aware of patient emotion by assigning himself to notice one emotion every visit, and writing briefly about what he observed in a journal once a week. These activities could be called ‘scaffolding’. Like the scaffolds that support buildings while they are being constructed, an observation and journaling assignment can support development of a new skill. Once the skill is developed, the journaling is not necessary in the same way, just as when the building is complete, the scaffolding can be taken away.

Stimulating personal development

Finally, role models can engage learners in discussions that facilitate personal development. If the learner is to use himself as an instrument, a certain degree of calibration is important, and this calibration comes through personal development. We commonly observe learners making strides in areas such as commitment to a kind of work or topic, understandings about how their own life story influences and enriches their work, and aspirations about what kind of physician they want to be. While these conversations often take place outside of formal learning situations, learners tell us that they are incredibly valuable and can be turning points in a career.

Feedback that engages fellows

beyond the feedback sandwich

Learning Objectives

- Provide feedback based on learner goals
- Respond to emotional reactions of learners receiving feedback
- Calibrate a learner's self-assessment by focusing feedback on the issues that are closest to their learning edge

Building new standards for what fellows consider 'good'

Feedback may be the single most important part of the teaching encounter. Through feedback, learners become aware of which of their behaviors facilitate or inhibit successful communication. Feedback also helps them think about how to improve their communication either by engaging in more desired behavior or decreasing ineffective ones. Feedback is most useful to the learner when the recipient does not become defensive, and when the feedback promotes open discussion, increases the testing of new skills, encourages alternative approaches and, ultimately, facilitates behavior change in the learner.

Unfortunately, feedback often results in exactly the opposite outcomes. Learners feel judged, are unwilling to experiment and end up resenting the entire communication skills training process. When they hear the word "role-play" or "standardized patient," many physicians remember their experiences in medical school with a PTSD-like aversion. To avoid such responses, feedback must be delivered in a way that does not feel critical or personal, and that is perceived to be of value to the learner.

Addressing the fellow's learning goals

We have found that using the fellow's learning goals makes the feedback process more straightforward. (This approach was developed by the Calgary group, who use the term "Agenda-led outcome-based analysis"). In this approach, feedback focuses on the needs of the learner and is structured to be descriptive, but non-judgmental. An important principle of the approach is that feedback should be solicited rather than imposed. As we described earlier, the learning process starts by engaging the learner in goal setting, along with an expectation that feedback will address those learning goals. After the patient encounter, the faculty need to start with those goals in talking about feedback. The analysis of the communication is outcome-based in that observations are made with regard to how the learner's behaviors affect desired outcomes for

both the learner and the patient. This approach is useful because it minimizes judgments about persons (“you just seem to have an inability to do that”) in favor of specific behaviors (“when you said x, I observed that the patient did y”)

This process can be further augmented when the facilitator calibrates the learner’s self-assessment. Calibration refers to a process of focusing the discussion and feedback on those issues that are closest to the learning edge for each learner. Through the use of probes, such as “What is it about this case that makes you uncomfortable?” the facilitator can ask learners to think about their own internal cognitive or emotional processes affecting the interaction.

The Feedback Process – Structuring a Feedback Session

1. Start with the fellow’s previously identified goals. Remind the learner what they were. If the fellow had identified a skill, try to make an explicit connection between the skill and the communication outcome--for example, rather than only focusing on the process of “more open ended statements,” identify outcomes such as “patient feels supported after hearing bad news.”
2. Ask the fellow for self-assessment and problem solving first, prior to giving your feedback. What did the learner think went well; and what remained challenging?
3. Don’t make suggestions until the learner has identified the problems. Consider offering your observations to help the learner self-reflect.
4. Involve the fellow (and others if working with a group) in problem solving – if done well, the task then becomes one of jointly solving a problem rather than judging the learner

Nuts And Bolts Of Delivering Feedback

1. Feedback should be **descriptive** rather than judgmental or evaluative (I saw rather than That was good)
2. Make feedback **specific** rather than general (When you said X the patient did Y rather than You were empathic)
3. Provide **balanced** feedback and be supportive (Stress both the positive things that the learner did to achieve her goal as well as behaviors which the learner is trying to modify)
4. Focus on **behaviors** rather than personality
5. Share observations (I saw, I observed, I realized) more than give advice (You should, you must, you overlooked)
6. Make offers and suggestions, generate alternatives (I wonder if)
7. **Check the learner’s interpretation** of feedback (What do you think? We have come up with a lot of ideas. Do any seem like they would work for you?)

An example

Faculty: What’s your sense of what’s going on with this patient?

Fellow: I think she’s denying what’s going on.

Fellow: One of your goals was listening. How do you think you did there?

Fellow: I feel like I was talking a lot.

Faculty: What made you feel that?

Fellow: There is just so much information I was trying to get out about treatment options and our next steps. I just didn't want her to think there was nothing more we could do.

Faculty: Do you think what you were saying accomplished that goal?

Fellow: Well, I think I never really gave her a chance to tell me how she felt about the situation.

Faculty: Let's think about what might help you remain more quiet...

Pearls

1. **Propose and test hypotheses.** There are three types of barriers that impede communication skills. First, the learner may not know what to do. For example, the learner may not know that "wish" statements are useful to building a connection when the patient hopes for something that is unlikely to occur. Second, the learner may know what to do but not be sure how to do it. For example, I may know that I should be empathic but not be sure what how to act that way. Finally, there may be emotional or attitudinal barriers to my operationalizing the skills. For example, my sadness over the patient crying may lead me to not explore her feelings. A good question that would test this hypothesis would be "When the patient began sobbing uncontrollably, I was wondering how you were feeling at that moment." Other examples of hypothesis generating questions are in Appendix A.
2. **Make observations in the form of suggestions** "one of the things I'd invite you to try is slowing down a bit. Because you are talking very fast, did you notice that?"
3. **Empathy for the fellow can make feedback more effective.** Most fellows are highly aware of the extent to which attending physicians and other faculty evaluate them. Empathy for the challenge of learning, as well as the awkwardness of being observed, can help create a climate in which the power differences are at least acknowledged.
4. **Phrase feedback that is unrelated to the original goal as an additional goal:** "Your goal was to try to talk less because that showed you were really trying to listen to the patient's concern. You might also consider as a related goal that when you do talk after listening, to reflect back to the patient what they just said to make sure you heard it correctly."

Pitfalls

1. The feedback sandwich: "These are the things you did well, this is what you did poorly, but you really did do some good things." The positive comments are perceived as insincere, and the "meat" on the inside is felt to be judgmental. More importantly, the sandwich is not tied to the learner's goals and thus are more difficult to internalize.
2. Evaluative and non-descriptive phrasing of feedback: "That was really good – I could tell you really cared about her" (without saying what about the behavior conveyed that). Or, "That's really the wrong way to respond to a statement like that."

3. Giving feedback about too many things. Like changing too many medications at once, this overwhelms the learner. In addition, when you give feedback on many things, the learner is more likely not remember the key things you wanted them to focus on.

References

Kurtz S, Silverman J, Draper J. Analyzing interviews and giving feedback in experiential teaching sessions, in *Teaching and Learning Communication Skills in Medicine* 2nd edition, Radcliffe, Oxford, 2005.

Fryer-Edwards K, Arnold RM, Baile W, Tulsy JA, Petracca F, Back A. Reflective teaching practices: An approach to teaching communication skills in a small group setting. *Acad Med* 2006;81:638-44.

Closing: Take-home messages that resonate

what did the learner really get?

Learning Objectives:

- Describe how to use the closing to reinforce learning
- Understand how to use closing to build agendas for future learning
- To acknowledge learner work and effort

An opportunity to reinforce learning

The closing usually represents only a small proportion of teaching. Yet the “take home message” can represent an opportunity for the fellow to reflect on skills or insights gained. When learners articulate personal take-home messages, they engage again in the learning process, and provides a step of repetition that studies show is important for retention of new learning. Finally, asking for an explicit take-home message allows the faculty to assess how the learner is incorporating new information.

When faculty explicitly value fellows’ expertise (as it accumulates), faculty support fellows in taking responsibility for their own educational needs. This adds to the process of empowerment recognized as important for lifelong learning and builds fellows’ commitments to use what they have just learned.

When do I use this skill?

This skill is used at the end of the session of skill practice sessions, whether after seeing an individual patient or working on communication skills in a group. When teaching one on one, this is likely only to take 2-3 minutes; when working with small groups try and leave 5-7 minutes for a reflective summary.

To do this skill well requires that you keeping careful notes about exactly each learner is doing and its relationship to their learning goals.

Key Skill: What do I say?

1. After finishing feedback, use an open-ended question to ask the fellow what they are taking away from session.
 - “What’s the most important thing you’ve learned from this?”
 - “ Let’s take a second to reflect on what we’ve just seen. What one thing would you like to take away from today?”
 - “ What did you do differently today that you want to keep doing?”

2. Reinforce learning or work that has occurred and connect this to the previous teaching you have done or their learning goals.
 - “ I think we saw how difficult it is not to respond to patient emotion with some sort of reassurance.
 - “ We saw in this session when emotions are really intense you need to stay with empathic responses until the patient recovers’
 - “ We saw how in the past while it was sufficient to make an empathic response, this time you had to make an effort to really understand what was going on with the patient”
3. Use your own thoughts and feelings to empathize with difficult challenges.
 - “I could tell you were really working on this”
 - “This reminds me of a difficult experience that I had...”
 - “What you did that made this a valuable learning experience was...”

What does teaching success look like?

The beauty of asking for a closing take home lesson is that you get a direct read on the efficacy of the teaching you just did. After a successful session, you can expect a variety of responses: Learners will comment on both their strengths and weaknesses. They will eventually become more accurate in their observations and self-assessments of their behavior and emotions, and less likely to assume that what happened in the interview is the result of the patient’s personality. Learners will build on communication principles you have used in previous sessions, summarize the learning points that you were trying to make, commit to using a specific skill in the future, formulate goals for their next session that build on their behavior, and even expand on observations made by the facilitator.

We find this kind of teaching success to be exhilarating and rewarding—far more than when we teach in the usual I’m-the-expert-you’re-the-student model so widespread in medical education.

Pitfalls

1. Adding more take-home points to what the fellow volunteered—if they didn’t get your teaching point, you probably won’t be able to salvage the session now. Pay attention to what they did take away and think through how that happened.
2. Being too general or vague (just saying “good job”) and not focused on examples of specific behavior
3. Bringing up new topics in closing--especially issues related to fellow emotional reaction that you don’t have time to develop.

References

Newman P and Peile E. Valuing learners experience and supporting further growth; educational models to help experienced adult learners in medicine. *Brit Med J* 2002;325:200-202.

Hesketh EA, Laidlaw JM. Developing the Teacher Instinct 3: Facilitating Learning. *Medical Teacher*. 2002;24(5): 479-482.

Facilitating group learning when you are dealing with multiple learners

Learning Objectives:

- Describe advantages of using a group to teach communication skills
- Describe a stepped approach to teaching communication skills in a group

Taking advantage of opportunities to involve a group

Teaching communication in clinical settings is often done on one-on-one but opportunities to teach a group are common. For example, on work rounds, a group may go in to see a patient together and, later, outside the room, give the learner feedback. Alternatively, during attending rounds, a brief role play with the entire team to illustrate an important communication point.

Using the group to teach communication skills has advantages over one-on-one teaching. First, it is efficient: the entire group learns—and teaches—at the same time. Second, teaching in groups can simultaneously serve individuals with widely differing learner styles – some people learn by doing, while others by watching, for example. Third, feedback from a peer may be even more influential than feedback from a teacher. Thus, it is important to know how co-ordinate teaching within a group when teaching communication skills.

When do I use this skill?

- Work rounds
- Attending rounds that are conducted in part in a conference room
- Teaching conferences that involve:
 - reviewing videotapes of visits
 - interviews of real patients in front of a group
 - simulated patients who have been prepared with character scripts.

Existing teaching references often talk about 'group dynamics' but little of the source literature (mostly written by psychiatrists) has been translated in a way that can be used in clinical teaching in medical settings. In this section we will summarize some principles of teaching groups. Our previous web publication, Tough Talk, and our qualitative study in Academic Medicine both gives more detail about how to teach using simulated patients in small groups (the format we used in the original oncotalk conferences). In addition, the book XX provides a great deal of basic information about how to teach in groups with standardized patients, particularly for a medical student audience.

Principles of teaching groups

Set goals for the group

When teaching a group, you will need the learner doing the talking to have a goal (see Module 3), and you will also need each group member to have a goal (most commonly, observing for the talking learner's goal and contributing feedback later). Thus the setup will take a bit longer than when you are working one on one. You will also want to set a goal for how the group will work together (for example, everyone should expect to contribute feedback), and you may need to set guidelines for that work (for example, agree on how to give good feedback). So the teacher will want to ask herself, have I laid out the goals and expectations clearly?

Consider the group as a whole

Try to get a sense of the group's mood: are they engaged? Distracted? Tired? We often think of "taking the group's temperature" as a way of helping ourselves decide how big of a challenge to take on in the teaching encounter. A critical aspect of the group as a whole is how they interact with each other: do they talk and respond directly to each other, or only to you? The question the teacher can ask herself is: Are they working effectively together? If they only talk to you, ask the next person to respond directly to the person who prompted the comment ("Could you ask Carl that question?") or redirect ("Carl what do you think about Susan's question?") An easy way to encourage interactions is to make sure they give feedback to the person on the "hot seat" rather than through you.

Watch individual contributions

Besides the group as a whole, of course, watch for the contribution of each individual member? Has Bonnie not said anything? Does Paul seem engaged? Is that sadness or worry on Linda's face? Many times, individual group member issues are framed as "problem people". We think that it is more useful for teachers to ask themselves: are the individual group members contributing to their capacity? A related question is whether the group has pigeon holed group members into specific roles. For example, one group member may be viewed as talking too much. The other group members, however, encourage this behavior by not talking as much and looking to him/her every time a new question is raised. Thinking about how the group encourages specific behavior may help you come up with interventions (calling on people before the dominant speaker talks; asking him/her to let others go first, etc).

Actively structure your relationship as group leader with the group members

Working with a small group triggers many preconceptions and assumptions about expertise, power, and authority. Does Paul try to counter everything I say? Does Linda shrink in fear from any feedback? Does Bob want to be the expert? These issues run deep, and every group member behaves based on past experience in groups. So while you can't control their past experience, you can be intentional about how you use your power and expertise. The teacher can ask herself: am I giving guidance and feedback to the group about how they are doing and how they are meeting my expectations and hopes for them as learners?

Celebrate success for the learner doing the interview

The learner doing the interview often feels exposed, and so the teacher needs to make sure that good work is identified and recognized explicitly. In this way the teacher will be modeling feedback about positive behavior, which many medical trainees are unfamiliar with giving or receiving. The teacher should be asking herself: how can I provide support to the learner so that he experiences some success? If the learner doesn't experience any success, the rest of the group will know it—and nobody will volunteer next time around.

What do I say?

Let's walk through an example—say, setting up and running a role play during attending rounds.

1. Remember prior to going into the room (or starting the role play) to develop a learning agenda with person doing the interview. If the student says she wants feedback about “whether she is empathic” you can assign this task to members of the group. This keeps them involved in the process and focuses them on specific skills.
2. After the patient interaction, start by checking in with the student who did the interview. Try to find out if there is one area on which the student wants to focus feedback from you and the group. (This may be the learning goal identified before the interview). Questions that you can ask are: what happened in the interview? What was working? What and where did you get stuck? What did you notice in the patient's reaction? What did you notice in your own reaction? What were your goals? What did you do to help to achieve these goals? What do you wish you would have done differently? What skills might help you achieve your goals?
3. Prior to trying to work through with the student's specific agenda, it is best to ask the student what they did well – either in this domain or the one they mentioned at the beginning. Often, particularly in a group, the learner will have trouble coming up with anything specific that they did well. Then ask permission if you can get feedback from the group. One way to phrase this is to say “Before we address the student's concern, can you tell the student what he/she did that was successful. Ask for specific skills that worked well (i.e. start with positives). If the student had concerns in Step 1, you should make sure you refer back to these areas.
4. Now, after hearing the positives, turn back to the student. First, ask for their view on the feedback (did you see that you did those positive things?). The goal is to have them see what they did well so they use them again in the future
5. Now ask them if you can problem solve with them regarding the area in which they wanted feedback. Before turning to the class, see if you can let the learner make suggestions or problem solve. Then involve the whole group in the problem solving (When asking the students to do this, try to focus on what they would have done rather than asking them to tell the student what he/she should do. What might you do if you are in a similar situation?)
6. Go back to the student and ask if how they will be able to use the feedback in their next encounter.
7. It is often helpful in the end to ask the student what the “take home message” was from the session. One can also ask the other members in the group.

Commonly encountered problems

What if one person talks all the time? Consider the possibility that the learner is very engaged and wants to share her experience. If this interpretation is correct, one merely needs to thank the learner for all her contributions and ask to hear from others. (“I appreciate your comments. You have contributed a lot to the discussion. Let's see what others think.) In future sessions, you may want to start with an expectation that everyone should have ‘equal air time.’

What if one person is very critical of others? First ask yourself if you have made the rules clear. Because so much of medical education is critical, this learner may think s/he is just doing what is expected of her. Second, even if you have gone of the rules for feedback, the culture of medicine is so strong that the person may have just forgotten. Gently interrupting the comment and reminding the learner may help, eg “Joe, we are focusing on what Jim did well. Can you name something?”

Learning group facilitation

A lot happens simultaneously in a group, and the reality is that nobody can track everything. In the beginning, focus on one skill at a time, and find a co-facilitator to watch for the other domains—then debrief in order to improve your tracking. A key group skill to begin with is to decide when and how to intervene to improve the ways that group members talk to each other—in general the more they respond to each other, the better your group is doing. (Notice if they all talk only to you, the faculty). This is obviously a huge issue, which runs beyond the scope of this brief manual. To learn more about what to track and how to intervene, see Tough Talk (<http://depts.washington.edu/toolbox>)

Pitfalls

Going to the group before going to the student

Unstructured debriefing – asking the group “how it went”?

Allowing the group to “beat up” the learner.

Losing sight of the learners goals when the group goes in a different direction.

References

Fryer-Edwards K, Back AL, Arnold RM, Baile W, Tulskey JA. Tough Talk,
<http://depts.washington.edu/toolbox>

Kurtz M, Silverman J, Draper J. Teaching and Learning Communication Skills in Medicine.
Radcliffe Publishing, Second Edition, 2005.

How learners progress

is there a developmental sequence of skill acquisition?

Conceptual model for learner development re: communication skills

In our own teaching of communication skills, we have found that encouraging learner development requires some idea about how learners progress. What are the stages of skill development? We haven't found anything in the literature that really addresses this, so we have laid out a conceptual model based on our own experience. We offer it here as a tool for teachers, and to stimulate further discussion and research on the topic.

These domains reflect elements of a communication event between physician and patient (or family). They function in a dynamic and integrated way during real-time patient interviews. However, for the purposes of teaching, we have isolated the domains and described a developmental trajectory within each. Teachers can use the concepts in the trajectory to help identify where a learner is currently working and where they might go next in their learning and skill development.

A teacher can also use the domains to make choices about where to focus during a teaching encounter or feedback session (or may guide learner goal setting within the domains). When making these choices, a teacher may use one domain to move toward another (e.g. start with a cognitive skill with the end goal of facilitating reflection on emotion if going for the emotion directly would potentially be non-productive for that learner/group at that time).

A. Cognitive skills related to communication

1. recognizing what communication task you face
2. identifying/knowing a cognitive map/approach to use
3. customizing the map for the particular situation

B. Ability to recognize and respond to patient emotions (empathy)

1. recognizing emotion
2. naming and acknowledging emotion
3. using emotion data to guide discussion in the encounter

C. Ability to recognize and respond to emotions in self (self-awareness and self-regulation)

1. recognizing emotion
2. naming and acknowledging emotion
3. handling our emotions so they facilitate rather than interfere with task at hand

D. Social and group skills

1. recognizes membership in group (turn taking, following ground rules)

2. offers feedback and suggestions that facilitate learning
3. actively moves group toward cooperation/teamwork (either through participation or leadership)

E. Motivation

1. Does not yet prioritize skills (communication/emotion) ('why should I bother')
2. Willing to experiment or try new skills ('don't know if this is worthwhile but I'm willing to give it a shot')
3. Embraces skills as a critical part of doctoring ("this is the kind of doctor I want to be")

This is our current working model, and we've found it very useful in thinking about our own teaching. We provide it here with some major caveats. It hasn't been formally validated, and we don't know whether all these milestones are recognizable to other investigators. But we provide it here to make our own approach to teaching communication more transparent--for the science of teaching to progress, we need more conceptual work, and we need to know more about what learners think.