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Acknowledgements

Acknowledgements

This project was made possible in part through a grant from The Greenwall Foundation. The observations and experience with teaching comes most recently through our work with Oncotalk, a training program for Oncology Fellows funded by the National Cancer Institute (<http://depts.washington.edu/oncotalk/>).

I am indebted to the faculty of Oncotalk for teaching me the subtle, yet powerful skills that are necessary to teach well. These faculty, Bob Arnold, Tony Back, Walter Baile, and James Tulsky, have tremendous capacities as people as well as teachers, which makes them such a pleasure to work with. Their insights are infused throughout these teaching materials, but the limitations are my own.

I would also like to thank the other consultants, program managers, and research assistants that made this work possible, especially Frances Petracca, Rose Callahan, and Carla Calogero. Tom Gallagher, a Greenwall Faculty Scholar and clinician-teacher, graciously contributed the module on Error Disclosure. The manual and website designs are by UW Publication Services designers Karin Mellskog and Nigel Hensius.

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Prelude

Prelude

RATIONALE FOR ANOTHER TEACHING SKILLS MANUAL

Many excellent teaching manuals exist that focus on skills for small group facilitation, skills for teaching interviewing, and skills for working with adult learners. We have read and learned from many of these volumes; you will see them referenced throughout the Modules here and in the Resources for Teaching Annotated Bibliography. Despite the significant contributions of these works, we were still left with a sense that something was missing. This teaching toolbox aims to fill that gap.

We focus on teaching complex communication skills beyond basic interviewing techniques. Because these communication skills take the doctor and patient into territory of ethics, the conversations can be difficult and often emotionally charged. Teachers need different skills to help guide learners through this tough terrain. The conversations are tough, not just for the doctors, but for the teachers as well. The tools we provide here should help give teachers a foundation for entering and engaging in this difficult terrain.

Many argue that ethics and communication cannot be taught. Since these skills lie in the realm of the interpersonal, they do build on skills and practices we begin developing from our earliest interactions. However, evidence shows that practice and experience can lead to development and enhancement of these skills. This human element is where the moral work of medicine happens. We have a responsibility to attend to these skills and work to develop them, even as we strive to perfect our other core clinical skills. Quality patient care depends on it.

Teaching future medical professionals is a gift. When we interact with students, residents, fellows, or colleagues, we have many opportunities to learn and grow ourselves, in addition to promoting growth in others. We have approached this work of teaching by thinking about it as a service. We are not there to impart knowledge or impress others. We are there, working with learners, because we are genuinely interested in helping them become better doctors. Ultimately, attending to the interests of physicians-in-training will promote better patient care.

STRUCTURE OF THE TOOLBOX

The Toolbox includes two kinds of Modules: Core Skills Modules and Special Topics Modules. The Core Skills Modules address teaching skills that are critical to the process of teaching. These skills will be applicable in many different teaching settings, with many different content areas. The basic core skills will sound familiar to those well-versed in the teaching literature. We work to review fundamental principles of each core skill, while applying them to the specific demands that work with ethics and communication skills teaching will place on the teacher.

Because the work of teaching is nuanced, tools for teaching cannot be simple checklists of procedures to follow and words to say. Tools for teaching must enact a particular approach. Any teaching manual will be limited by the fact that we must make these complex and subtle practices somehow operational so that others may take them up. Our materials are informed by theoretical perspectives, practical experience, and a continuous feedback loop between faculty, students, and outside observers. In the Core Skills Modules, we offer a rationale for teaching practices along with suggested phrasings that are derived from teaching practices. This combination should allow experienced teachers to deepen their practice as they reflect on their own work and consider ways these suggested strategies might be incorporated into an already robust practice. These teaching tools will also help a novice teacher get started and build a creative teaching approach.

A WORD ABOUT METHODS

The teaching examples that are included throughout this manual were extracted from two years of observations of small group teaching situations primarily with oncology fellows. Small group sessions were video or audio taped and then transcribed. Three separate coders with education backgrounds reviewed the tapes and the transcripts, identifying elements of effective teaching strategies. Coders also identified challenges for facilitators. Portions of transcripts were reviewed with the original facilitator for further reflection and insight on the issue illustrated in the teaching exchange. Excerpts from these teaching encounters appear throughout these materials.

All four of the faculty observed have different strengths and teaching styles. What joins them together is their common interest in fostering growth and insight in the learner. The teaching excerpts included here are intended to be illustrative rather than prescriptive. Once the spirit of the practices described is clear, you will be able to adopt your own language or strategies for communicating it with your learners.

A BRIEF REVIEW OF EDUCATIONAL THEORY

Behavior change is challenging. Changing physician behavior is particularly difficult. In designing an educational intervention for oncology fellows, we drew from the medical literature and educational theory. At the foundation of our program are three educational theories. As background to these teaching materials, we describe each theory briefly. The modules that follow are all informed by these theories.

Adult Learning Theory. There has been some debate over whether or not adult learning theory is a meaningful concept, or even a theory at all. The basic premise of adult learning theory is that activation is necessary for skill development and behavior change. It makes sense that all learners need to be activated, not just adults. Without engaging in this debate, we borrowed some key tenets from this model. An effective teaching session will:

- Create need
- Tailor teaching to learner goals
- Apply to practice

Social Learning Theory. Adopting new skills and behaviors requires that one step into a new role. Doing engrains a behavior more effectively than reading or hearing about it. For these reasons, we tend to emphasize role modeling and skill practice in our sessions. While most learners initially resist role plays, having a chance to practice new skills in a safe environment can be very useful [see the Challenges for suggestions for overcoming learner resistance to role playing].

Positive Psychology/Solution-Oriented Therapy. We borrowed an assumption from psychology that if you ask a person to do more of something they are already doing well, you are more likely to see behavior change and success than if you only point out the deficits. We like doing more of what we do well – it feels good and we can build confidence. By leveraging our strengths, we can actually do less of the behaviors that might be less positive. Focusing on strengths can also generate enthusiasm in the learners – an important element if you want them to continue working in these areas.

TEACHING ETHICS IN A CLINICAL SETTING: FINDING TEACHABLE MOMENTS

Teaching ethics in clinical settings or medical schools can be difficult. Medical students and trainees are focused on patient care issues, passing the boards, and getting good evaluations. Ethics can be seen as peripheral to the biomedical core content and skills that young physicians-in-training prioritize.

Because ethical issues arise daily in the practice of medicine, faculty can meet the students where they are with their interest in patient care matters. Faculty can capitalize on teachable moments for ethics in patient care and clinical practice by focusing on communication events that arise frequently for trainees. Certain communication events are challenging for everyone, even the most experienced clinicians. Consider the importance of several of these common, but complex, communication events:

- Acknowledging Uncertainty
- Informed Decision Making/Consent
- Breaking Bad News
- Discussing Medical Errors
- Transitions to Palliative Care
- Managing Family Conferences
- Do Not Resuscitate Orders

Teachable moments can arise during any observed patient encounter, or even during a case presentation or debriefing during a team meeting. You might find yourself at the bedside, in the hallway, in the team meeting room, or in a seminar or lecture hall to discuss these issues. You might set aside a block of time to practice certain skills that are particularly important for the service or residency. These teaching materials are intended to give you a framework for thinking about your teaching in a variety of settings.

PREVIEW OF TOOLBOX FEATURES YET TO COME

These first few Core Skills and Special Topics Modules will get you started. Many more tools will be added to the Toolbox as we move forward. In Core Skills, we will address skills beyond the basics that will help you refine your teaching as you move forward in your own development. The Special Topics Modules will grow overtime as we, and colleagues, capture the specific teaching approaches that are helpful and unique to new ethics and communication content. Future Special Topics include: Informed Decision Making, Transitions to Palliative Care, Family Conferences. We welcome your suggestions as we move into these new areas.

We are all life long learners and the practice of teaching is one that evolves over time. Our hope is that these materials promote reflection and inspire practice changes that you will find useful in your own work.

REFERENCES:

Kaufman DM. Applying educational theory in practice. *BMJ*. 2003 Jan 25; 326:213-6.

Short review article describing three educational theories and applying them to clinical teaching.

Phy MP, Offord KP, Manning DM, Bundrick JB, Huddleston JM. Increased faculty presence on inpatient teaching services. *Mayo Clin Proc*. 2004 Mar;79(3):332-6.

To increase the opportunities for teachable moments for ethics, faculty – including nonclinical ethics faculty – can spend more time on inpatient services with the team. Contrary to some concerns expressed, increased faculty presence is associated with higher resident satisfaction and a more favorable learning experience.

Rosenbaum JR, Bradley EH, Holmboe ES, Farrell MH, Krumholz HM. Sources of ethical conflict in medical housestaff training: a qualitative study. *Am J Med*. 2004;116(6):402-7.

This study identified five categories of ethical conflict, most having important communication aspects: concern over telling the truth, respecting patients' wishes, preventing harm, managing the limits of one's competence, and addressing performance of others that is perceived to be inappropriate. Conflicts occurred between residents and attending physicians, patients or families, and other residents.

Overview

Teaching Module: **Overview of a Skill Practice Session**

We teach skills in many settings, including at the bedside, on teaching rounds, in noon conferences, and in small group settings. We have developed a model for small group teaching of communication skills that has been employed in multi-day retreats and also in one-hour workshops. Many principles and practices from this teaching approach are applicable to other teaching settings. The brief overview here provides a roadmap for specific teaching skills, some of which will be developed further in the modules that follow.

Before you get started, you will have an idea of what you want to teach: your teaching objectives, core content to cover, perhaps even the teaching strategy you want to use. The content of your teaching will need to fit within the process of a teaching session, regardless of the teaching strategy you decide to employ. This module provides an overview of the process considerations you should make. Examples of core content for teaching sessions follow in the Specific Topic modules.

Any teaching session will have an Opening, a Middle, and a Closing. For an overview of the skills relevant for a skill practice teaching encounter, see the [Resources for Teaching](#). These teaching skills should be considered as tools that you can use when you need them. Not all teaching encounters will require every tool from your toolbox. The tools described below are considered the most useful for a successful teaching session. In this module, we highlight key activities that should be accomplished in each segment with examples to illustrate the concept described.

THE OPENING

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 as a group many times or whether it is a new group. 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? a half day? a week?) and how well the participants know each other.

A teaching session often comes in the middle of a busy day, or is set among competing demands. Your job as facilitator is to prepare the participants for the work that is to come. This requires engaging them, identifying goals for the session, setting clear expectations for how the group will work together, and also setting a tone. Each of these tasks is described further below.

TABLE 1. KEY TEACHING TASKS DURING OPENING: THE BASICS

Teaching Task	Specific Behavior	Example
Engage the group	<ul style="list-style-type: none"> • Focus attention • Address barriers • Highlight relevance 	<i>“The task today is to give bad news. I imagine this is something you have done many times, and that it may not always be comfortable for you, is that right?”</i>
Set Expectations	<ul style="list-style-type: none"> • Review session goals • Describe structure/ agenda • Discuss ground rules 	<i>“Today’s session is all about practicing DNR discussions. Each of you will get a chance to practice today.”</i>
Set Tone	<ul style="list-style-type: none"> • Attend to room set up • Model interaction at start • Elicit questions 	<i>“I want you to think about how to push yourself a little bit. I want to spend a minute asking you to think about what’s the area that would be most useful for you to work on today?”</i>

Engaging the Group: Focusing the attention of the learners is an important first task regardless of teaching setting. This can often be accomplished very quickly, or with a simple comment (e.g. *“I want to spend some time this week working on responding to patient emotion”*). With more time, it can help to first elicit pre-existing beliefs the learners may have about the skill of interest. If learners can voice their concerns or skepticism up front, this can go a long way toward diffusing any resistance or anxiety. You can foster discussion about the concerns (e.g. *“do others share this concern?”*) or, if time is short, you can simply ask them to humor you and try something different today and see how it goes. Asking permission to go forward aligns you with the learner and creates a more collaborative atmosphere.

Setting Expectations: Being explicit about what you want from your learners can go a long way toward making that behavior happen. Learners have participated in many learning experiences up until this point and will bring a number of assumptions to the teaching session. You need to help them understand what kind of session this will be (e.g. *“This session is about skill practice, so I am not going to stand up here and lecture at you.”*) If there are certain behaviors you would like from the group, be explicit about those (e.g. *“We all are going to be giving feedback to the person in the hot seat, so it can help if you take out your notebook and jot down some phrases or behaviors that you notice that worked especially well for the learner.”*) By being clear, you are giving learners an opportunity to meet you for the encounter.

Setting the Tone: Setting expectations will only go so far if you do not also follow up by modeling some of what you expect. For example, if you have emphasized group participation, go out of your way to invite group members into the discussion very early on. Respond to contributions positively or invite other group members to respond to a comment, so the tone of collaboration and group work is fostered. If collaboration is a goal for you in teaching, you can invite your participants to help create ground rules that will work for them, or decide on the way the practice sessions will work.

THE MIDDLE

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. If you have done your work setting expectations and focusing attention in the Opening, the learners should be primed to work. Here, more specific goal setting is needed as each learner will need to set goals for the particular learning encounter. The learner will need feedback and guidance forming take-home lessons from their patient encounters. Each of these tasks is described below and also in greater depth in the [Core Skills Modules](#) that follow.

TABLE 2. KEY TEACHING TASKS DURING THE MIDDLE: THE BASICS

Teaching Task	Specific Behavior	Example
Set Up	<ul style="list-style-type: none"> • Set Stage • Assign roles to tasks 	<p><i>“Ok, our first patient is about to arrive. She is a returning patient here for her CT results. I need a volunteer to be the interviewer.”</i></p>
Focus	<ul style="list-style-type: none"> • Elicit specific goals for task • Focus group on feedback 	<p><i>“What do you want to work on during this encounter?”</i></p> <p><i>“We will all watch and be ready to give feedback.”</i></p>
Manage Group	<ul style="list-style-type: none"> • Elicit feedback • Manage input 	<p><i>“What did people notice?”</i></p> <p><i>“Brenda said she felt stuck there. What might other people try if you were in this situation?”</i></p>
Summarize	<ul style="list-style-type: none"> • Elicit self-assessment from learner re: goals • Elicit or help name take-home point 	<p><i>“So, what are you taking away from this?”</i></p> <p><i>“Is there anything that you would like to be sure to work on next time?”</i></p>

Set Up: The task of setting up a skill practice exchange can help all participants to be clear about what the expectations are. This step can focus primarily on setting up the patient encounter. Set up can also create safety by reinforcing the ground rules set earlier and by being clear about the parameters of the encounter (e.g. *“You have about 25 minutes in the hot seat. We can start and stop as many times as you like. If you haven’t called a timeout within about 5-7 minutes or so, I may do so just to check in with you and see how it is going.”*) During this stage, other tasks are assigned, including asking group members to observe and give feedback on specific aspects of the encounter.

Focus: Helping the learner identify a focus for the skill practice session can help them attend to a specific set of skills during the encounter. Without focus, there is the potential for too much to be happening during an encounter and the learner will have a hard time making any meaningful observations about it. Identifying a focus, primarily through goal setting with the learner, can also give you and the group a place to focus your observations for targeting feedback. In some cases, like open role-play sessions, where the learner wants to work will define the whole encounter.

Manage Group: Some of your teaching will occur in 1-1 sessions, but more often, you will have a team or other workshop participants to attend to in addition to the learner. Much of what you do in the Opening will help set the expectations and tone for how you want the group to be involved. During the skill practice session, you must continue to monitor them to assure your expectations are being met. Are they paying attention during the skill practice session, perhaps taking notes? Are they giving useful, specific feedback? Are all members of the group contributing, or just a few? Are the quieter members paying attention and do they have an opportunity to contribute if they wish?

Summarize: After working through a skill practice session with a learner, it is important to check back with her and ask what she is taking away from the session (e.g. *“Having gone through this, is there a take home point for you?”*). Asking this simple question prompts the learner to self-assess her own learning. 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.”*).

THE CLOSING

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. Closing can be the place for the faculty to give a summary of teaching points, to praise the group, and give appreciation for hard work done. It can also be a good place to ask learners to identify lessons they are taking away. Key tasks of closing can be conducted in the space of just a minute or two if necessary.

TABLE 3. KEY TEACHING TASKS DURING THE CLOSING: THE BASICS

Teaching Task	Specific Behavior	Example
Summarize specific learning points	<ul style="list-style-type: none">• Ask learners to identify skills or insights gained (or you summarize)• Reinforce progress observed	<p><i>“Other things people took away from this morning?”</i></p> <p><i>“We got a great start on giving useful feedback to each other today.”</i></p>
Help learners build personalized learning agendas	<ul style="list-style-type: none">• Ask learners to identify a specific new learning objective to work on.• Ask learners for a commitment to try something new from the session	<p><i>“I invite you to think about your goals and – now that you have some basic comfort with the skills – what it is you’d like to work on, what areas you find to be most challenging in the interviews over the next couple of days.”</i></p>
Acknowledge learner work and effort	<ul style="list-style-type: none">• Voice appreciation for the work learners have done	<p><i>“I can really see how hard you were each working today.”</i></p>

This Overview of the process of a teaching session should provide you with the basic tools you need to get started. The Core Skills modules that follow build on each of these basic tools and the Specific Topics will get you started thinking about your teaching content as well as process.

Goal Setting

Teaching Module: **Goal Setting**

Faculty and learners both need to think about goal setting. 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. In this way, goal setting is both the starting point for all teaching encounters and also the map that points the way for future work.

RATIONALE:

Communication skills are multi-faceted and patient encounters bring up many issues. Effective goal setting helps focus attention on particular areas where you want to work.

- In small group settings, asking learners to set goals can cue observers for areas to watch and focus on for feedback.
- Having clear goals, as a teacher or a learner, helps you recognize when you might be heading off track and need to either re-examine your goals or re-direct your course so that you can achieve them.
- Goal setting helps us become more intentional about our work. In a busy area such as medicine, it is easy to get reactive and just deal with whatever comes up in a given week. Goal setting allows you to assure you are getting the professional development you need.

PITFALLS:

- Learners sometimes identify goals that are too big or too general to be useful. A learner might say, *“I just want to work on communicating better.”*
- The learner might identify goals that are important to them, but you as faculty have other observations about areas where they should be working.

SUGGESTED PROCEDURE:

Goal setting will often take place in a teaching context, such as a course or a clinical rotation, where there are existing curricular goals. 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 the curricular goal of the workshop is teaching residents skills for Breaking Bad News, that now defines the universe of possible learning goals that a resident might choose to work on during the workshop; it does not yet define the target area of need for each resident. Finding out where each resident struggles with breaking bad news will help identify each individual learning edge within this global communication skills area.

Prompt Self-Reflection and Assessment. Depending on your teaching context, there may be multiple layers of goals to identify and address. 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 separate, more focused goal setting should occur. *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?*

Formulating and Working with Goals. Practically speaking, it helps to write down goals where they can be reviewed and revisited during the teaching session. This might take the form of notebooks, index cards, or flip charts that can be posted around a workshop room. The act of writing down a goal confirms the learner's intention and commitment to that goal. Posting or sharing these goals with the rest of the group can help everyone support the learner in achieving the goal, and can also give learners other ideas for goals that might be useful for themselves. In long-term settings, even over the course of one-day, goals may evolve and change in response to experiences and interactions with other learners. While a commitment has been made, these should be viewed as dynamic documents.

Faculty often play an active role in helping shape learner goals. Learning to set specific goals takes time and practice. Faculty can give learners feedback on their goals in a number of ways. Often faculty can simply restate the learner's goal so that both are clear about the focus. For example:

FACULTY: *Anything you want us to particularly look for, or observe for you?*

LEARNER: *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.

Faculty involvement may range from merely posing the question about goals at the outset to shaping the learner's unformed goals into something that is do-able in the session. Mid-range involvement 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,

LEARNER: I think I want to work on denial.

FACULTY: Denial, good. Can you tell us what is it about denial that you want to work on during this session? What would be most useful to you?

Faculty can also serve as a connector between previously voiced goals or learner interests and 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?

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

FACULTY: Ok, we can watch for directness. Anything else?

LEARNER: The usual things, fumbling, staccato speech.

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

Operationalizing Goals. After getting clear on the goal, faculty can help the learner identify how they will achieve the goal during the patient encounter. For example:

FACULTY: What do you want to work on?

LEARNER: 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?

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

FACULTY: So, sounds like active listening will be useful. What kinds of feedback would be useful to you?

Doing the work of goal setting helps the learner get more out of a skill-practice 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.

Closing the Loop. An important element in goal setting is returning to the goals after the skill practice or patient encounter is completed. After spending time up front clarifying the area that the learner wants to focus on, ask at the mid-point or at the end of the encounter if the learner is meeting her goals. Following up with some questions for self-assessment can help facilitate this. For example, “*You really wanted to work on silence during this encounter. I saw you use this technique at several points. How did it feel for you? (learner response) Was it challenging for you? (learner response) How do you think it felt for the patient?*” These reflective questions will help reinforce the learning that has occurred in the skill practice session.

New skills and insights will undoubtedly arise during the course of the skill practice which can also be discussed. Returning to the original goals will help the learner reflect on the growth that occurred during the practice session, or perhaps will help to reinforce what learning steps should happen next. In addition to reinforcing the learning, closing the loop will help imprint the usefulness of goal setting on the learner. That is, if you set your intentions toward something, you can often achieve it!

PEARLS

- Learning how to set effective goals taps into a higher order skill of self-assessment. One must have an awareness of limitations before being able to identify specific skills to develop next.
- Goal setting will be most effective if faculty can return to the learner’s goals at various points in the teaching session, but particularly at the end. Reflecting on how one is doing relative to the goals is part of skill development and refinement of one’s ability to set goals. It will be reinforcing to the practice when the learner experiences the pay-off and the success of achieving her goals.
- Coupling a return to the goals with reflection and goal setting for future sessions can keep the cycle of reflective practice going.

Feedback

Teaching Module: **Feedback**

Few opportunities exist in medical training, and particularly in medical practice, for physicians to get feedback on interactions with patients. Even when working in teams, the interaction with the patient is rarely observed by peers or mentors. Feedback becomes a critical part of skill practice sessions, as these sessions provide an opportunity to hear from peers, faculty, and sometimes the patients themselves, how the patient interaction went.

RATIONALE:

While one goal of skill practice teaching is to help the learner develop self-assessment skills, giving feedback based on external observations can help the learner calibrate her own sense of her strengths and limitations.

- Learners often focus on their limitations, not aware of their strengths or what it is that they already do that is effective. Giving specific positive feedback reinforces things the learner is doing well.
- Without being videotaped or observed, it is difficult to know how one's body language, affect, or tone comes across to others. Providing feedback in these areas can help a learner move forward, as they can say the 'right' things but if mismatched with body language, the effectiveness of the communication skills will be limited.

PITFALLS

- It takes effort to give specific, constructive feedback. Targeting concrete behaviors takes careful observation. Often feedback is too general ("good job").
- Many of us have not had good role models for giving constructive feedback. It is more comfortable for us to stay in the realm of positive feedback without addressing areas that might need work.
- Alternatively, many of us assume that the positive behaviors do not need to be discussed. We miss an opportunity to reinforce what someone has done well.

- Learners can only absorb a certain amount of feedback. Giving some specific feedback while not overwhelming them is a difficult balance to strike.

SUGGESTED PROCEDURE:

Be specific. The most effective feedback is specific. Faculty can take notes during the patient encounter to capture specific phrases that the learner used that were particularly effective. Often learners will not remember what they said, or be conscious of the skills they are employing instinctively. Reinforcing the skills helps to bring them into conscious practice. In the exchange below, the faculty used the group to help the learner identify specific behaviors she was using that helped the conversation go smoothly. He starts by checking in with the learner and closes by offering his own observations and feedback.

***FACULTY:** So, let's stop for a minute and talk about how's it going before now. How's it going?*

***LEARNER:** I think it's going well. The patient's comfortable, he's makes me feel comfortable, we're on the same page, he doesn't want any more chemotherapy.*

***FACULTY:** So what are the things that you are doing that get you all that information that make it easier. What is she doing? [Turns to the group participants]*

[4 Participants respond with feedback]

***FACULTY:** I liked how you initiated the interview. You said, "I gave you a lot of information last time. Before we start I want to see what your questions and concerns are." so you started off very clear, you were organized, you said ... 'let's check in' at the very beginning. And then all the follow up questions were based on what he said. So he said something, you summarized and went further. It was like a dance and you were right in step.*

Tie Feedback to Learner Goals. If you have done the work of goal-setting at the outset, you have asked the learner for particular areas where he would like feedback. It is important to close the loop and given him feedback about how he did with those goals.

***FACULTY:** You've done some great things. You asked specifically about talking too much? You didn't. You did a really nice job. All the information you are giving has been in really tiny chunks; just little pieces and then getting his reaction. So, the thing that you were concerned about you are doing really well.*

In another exchange, faculty helps to problem-solve with the learner and extends the learner's goal to address the challenge that has come up in the encounter. Not all feedback needs to come at the end by way of summary statements. Giving feedback in the middle of a skill practice session can be very useful for helping the learner continue to work at his learning edge.

FACULTY: *Timeout. How do you feel about the way things are going?*

LEARNER: *I think I am sort of wandering. I don't think I am staying on track.*

FACULTY: *Give me an example of where you feel you were wandering.*

LEARNER: *Well, when he was going on and on about family and all of that stuff I wasn't quite sure whether to go in that direction or where to go. So I'm not sure that I was really focused... [Learner continues and group discussion occurs]*

FACULTY: *I know you said before that you wanted to follow his lead. And he was sort of bringing up all sorts of things –*

LEARNER: *– I wasn't sure where to go first. I was overwhelmed.*

FACULTY: *What I am hearing is that you wanted to follow him, but there was all this different stuff, and you couldn't prioritize – there was so much. So maybe what you could have done is ask him to prioritize it for you: “It sounds like this news is bringing up all sorts of things. What do you feel – if you can prioritize now – are your greatest concerns?” Do you want to try that?*

LEARNER: *Okay, sure.*

Tie Feedback to Behaviors. Feedback should also be tied to specific learner behaviors. What did he do, and what might he do differently? Sometimes a group member can give feedback that is not tied to a behavior, such as, “*I think the patient was really confused by what you were saying.*” Faculty can work to reframe the feedback into something that the participant observed or heard, and what was said or done by the learner, e.g. “*When you said ‘Phase I trial’ the patient seemed to sit back and her eyes kind of glazed over for a second. What do you think Phase I trial meant to her? What would you like to be conveying to her right now?*” Faculty can also frame their request for feedback in very specific ways to encourage more specific feedback, e.g. “*Well, let's get some feedback, Okay? I'm curious what do people think about what has gone on so far? What did you observe?.*”

The Feedback Sandwich. Much has been made about the “feedback sandwich” in medical education. The expectation is that you should frame your negative comments with two positive comments to be more palatable for the learner. There are strengths and weaknesses to this approach. Taking the best of what is intended might be the workable strategy for you.

We agree that learners should get feedback on both things that they are doing well and things that they might do differently. Starting with positive feedback can enhance a learner's sense of safety. A limitation of positive feedback in the sandwich is that if the learner has been socialized to the approach, they often say they cannot hear any of the positive feedback because they are waiting for the other shoe to drop. You can get around this by emphasizing with the learner that there

were specific things that she was doing that were really effective. You want to point them out to assure that she will do them again in the future.

The issue with negative, or “constructive”, feedback is that we do not have many role models for doing this well. Negative feedback can come across as tough criticism, or more often, can just get skipped because it is uncomfortable for both faculty and learner. Modeling giving and receiving feedback about areas to work on can help set the tone and expectation that there will be an open exchange of feedback with you. Making it part of the routine of what you give learners and what you ask for from them means that no one is singled out. Everyone has areas that they would like to continue working on. Playing to learner strengths is one of our strategies that we emphasize. You can frame feedback in terms of skills they could use more often (e.g. “*You did a great job with your first empathic comment to the patient. I think if you kept doing more of that throughout the interview, she would have felt even more connected with you.*”)

This strategy also works with a whole small group (e.g. “*One thing you guys are doing well is exploring. Maybe what you want to focus on is simply making empathic statements – acknowledging, legitimizing emotions first, before trying to take it to the next step to learn more about it*”).

PEARLS

- Feedback is the primary way to reinforce learning.
- Feedback can come from faculty, other group members, or the patients themselves.
- Emphasize specific behaviors learners are doing well.
- Work at the learning edge with learners by helping them to problem solve the places where they get stuck in the interview. By giving feedback about what you observed about the difficulty, the learner can often generate ideas about what to do differently.

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Using the Group

Teaching Module: **Using the Group**

Using the group effectively is a skill that is employed most frequently during the Middle of a teaching session, but it is also relevant in the Opening and Closing. This module will highlight strategies to use throughout a teaching session, but will focus primarily on the Middle.

RATIONALE:

Skill-development teaching sessions rely heavily on individualized teaching, in which the faculty works 1-1 with the learner. In a small group, or on teaching rounds, this individual focus can leave the rest of the group or team members unengaged. Using the group becomes important for a number of reasons, including:

- If an expectation has been set that group members will be turned to during the teaching encounter, group members are more likely to stay alert and attentive.
- As a teacher, you can take advantage of having multiple observers watching the communication encounter. They will notice and articulate skills or behaviors that you might not have included in your observations.
- It can help the learner to hear from peers. Not all the teaching points need to come from you.
- Many of us learn by observing others, so you can set expectations that the observers will learn during the encounter as well, if they attend to specific things the learner is doing well, or considering things they might do differently if they were interacting with the patient.

PITFALLS

- Using the group requires trusting the group. There are always uncertainties about how the group will respond or what kind of feedback they will give. You will need to be ready to do some recasting, reframing, or redirecting, if comments are off-base.
- Using the group takes time. Once assignments or expectations have been set, the participatory behavior must be reinforced by including time for observer comments.

SUGGESTED PROCEDURE:

Group members can be enlisted to participate in most aspects of the teaching session: agenda setting, observations, problem-solving, giving feedback, and summarizing.

Agenda Setting: When Opening a skill practice session, it is important to assess learners assumptions and fears, all the while creating buy-in for the process. During this discussion, you are engaging the group and reinforcing expectations that you may have set at the outset regarding group participation. These are general, open-ended questions that get the group reflecting on the task at hand. Some questions you might use include: *“What is challenging about doing role plays to learn communication skills?”* *“Given the range of skills and strategies we have discussed so far, what stands out to you as important or useful to your practice?”* or *“What do you think makes breaking bad news so hard?”*

You can facilitate the discussion, which need only take a few minutes, and use a flip chart to capture their ideas. Using a flip chart creates the expectation that you will get responses from the group (you have to record something, you are poised), allows the group to review what has been said so far so they can add or extend comments, and also gives you some control over how the comment gets framed in summary. Restating the comment on the flip chart, with permission of the participant, can frame the suggestion in either a more generalizable or cogent way that ties to your own teaching goals while still having a foundation in the participant’s suggestion.

Observations: When working with role plays or at the bedside, generally one learner is in the ‘hot seat’. If you have begun by goal setting with the learner, eliciting skills that they particularly want to work on during this session, you can ask the rest of the group to help you watch for those skills.

Assigning Tasks: Some faculty prefer to make assignments, breaking up the skills of interest into very specific, discrete skills, so that each group member can stay focused. It is difficult to track the range of things that are going on in an encounter, between nonverbals, patient reactions, and specific, varied communication skills. Having only one thing to watch for can help a novice observer give focused feedback. However, making specific assignments takes time and can seem forced. Read your group and consider using the assignment strategy if some group members are not participating, or give non-specific feedback. Important for either method of using the group for observations is reinforcing their behavior by asking for their observations, even if only in the last few minutes of an encounter.

Problem-solving: If a learner gets stuck at a certain place in the patient encounter and a timeout has been called, by either the faculty or the learner, after the initial debriefing with the learner, the faculty can ask the group for suggestions. Tone is important here as there is a risk of ‘de-skilling’ the learner if other group members try to fix the encounter. However, many learners find it helpful to hear a range of ways others might respond in a patient encounter, allowing them to choose one of the suggestions to try when moving forward. The message here is that there is more than one ‘right’ way to respond in the encounter. For example:

FACULTY: *Okay, How could Jules make an empathic response? What could he say?*

LEARNER: *'I can see how difficult this treatment is for you.'*

GROUP MEMBER 1: *'I'm sorry you feel this way.'*

GROUP MEMBER 2: *I would have probably said to my patient, 'man this sucks,' and the patient would have said, 'you're darn right'.*

FACULTY: *So maybe you could pick one of those suggestions and we can kind of roll back the interview. So why don't you ask her again how she's doing, and see what happens.*

In another encounter, the faculty member stopped the standardized patient interview right when a difficult question was asked.

FACULTY: *I stopped there because she just said the most difficult thing. So now we're going to have to respond to that. What I think we should do is come up with some possible responses to that, okay? So, let's hear some ideas, how he should respond to that when she says, "We're going to beat this thing."*

This strategy can be used as a way to offer support to the learner. In this case, the faculty had advance knowledge that the question that was asked would be a hard one for him.

Feedback: An important way to close the loop after asking group members to be observing the encounter is to ask them for feedback. The work for the faculty here is priming the group members to be specific with their feedback, so that the learner has some data to work with next time. For example:

FACULTY: *Other things people noticed?*

GROUP MEMBER: *I thought she did a great job.*

FACULTY: *I thought she did great too. What did you notice that she was doing that helped to make this encounter go so well?*

If expectations have been set and the group is working well together, often short-hand can elicit the feedback from the observers:

FACULTY: *Timeout. You did 2 things so well, I'm timing out even though it's short. What are the 2 things? Can people..?*

Another challenge for faculty here is helping the group members give balanced feedback, and not just focus on the positive or just the negative aspects of the encounter. Framing your elicitation of

feedback specifically can help. For example, “What are other things that people noticed that she did well?” or “What are some things that you might have done differently?”

The group can be used to provide another perspective for learners who may struggle with a perception of themselves. For example, if the learner is worried that she is talking too much in an encounter, or is being too controlling of the interview, you can just ask the group to give feedback on that particular concern. Since physicians and medical trainees rarely have peers observe them in patient encounters, just having outside observers can be very useful to calibrate the learner’s own self-assessment.

Strategies to Engage the Group: Several strategies can be used to engage the group. For example, the faculty can set expectations early on, being explicit about the role he or she expects group members to take during the communication skill practice session. For example, when the faculty is describing how the practice session will go she can say:

FACULTY: *“What will happen is that the learner will talk with the patient for about 5 minutes or so, and we’ll all watch, being ready to give feedback.”*

If a group member remains disengaged, a number of further strategies could be used to explore with the member what might be going on. At this stage, thinking about parallel skills that are employed in patient interviews can help you. If you are talking with a patient and notice affect change, you might try exploring with the patient or inviting her to talk about what is going on. Another strategy might be to test a hypothesis with the patient, for example, “You seem a little sad to me, is there something going on that you would like to talk about?” or “As we’ve been talking I noticed that you seem to be getting tense, is that right?” Just as you use these skills with patients, you can use them with your group members:

- **Setting Expectations:** *“It can help to take a few notes while you are watch the encounter, so when you give feedback at the end, it is really specific and tied to particular words or phrases that you observed.”*
- **Naming and Exploring:** *“We haven’t heard from you yet John, what are you thinking about?”*
- **Inviting:** *“John, we haven’t heard from you yet, what did you notice that Sue did during this encounter that helped the patient open up to her?”*
- **Hypothesis testing:** *“It seems like this part might be hard for you, I was wondering, and tell me if I’m right or not, if this particular scenario is striking a chord of some kind.”*

Group Process Expectations. An educator several years ago noted that groups go through predictable stages when working together. He described them as: *forming, storming, norming, performing*. You should expect that a group will take some time to form and develop a style of working together. Even a group that is working well will reach a point where something shifts and the group will need some attention (the storming phase). It can be useful to return to some of the strategies used during the Opening of a session to refocus and explore what issues have emerged for the learners as important now that they are part way through an experience.

PEARLS

- If learners are participating with you in the group, they will feel some responsibility for what is happening in the group which will heighten their involvement and engagement.
- The small group environment can become quite dynamic and energizing for everyone, when all members are engaged and participating.

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Emotion

Teaching Module: **Addressing Emotion**

Teacher-learner encounters can bring up emotions, much as encounters between physicians and patients can. As with physician-patient relationships, addressing the emotion when it is felt or observed can help.

RATIONALE:

Patient care is emotional work, but physicians are rarely given the training or opportunity to express emotions that accompany this work. Often people are even unaware of their underlying emotional state. Unaddressed emotions often appear elsewhere, either in anger, resistance, or a desire to end the encounter (teaching or patient) early. If emotions are unacknowledged, they can serve as a barrier to further learning. It is important to acknowledge emotions when they come up, so the work of learning and doctoring can continue.

PITFALLS:

- Faculty may worry that exploring emotions of their learners could be seen as an invasion of privacy, so it is safer to keep the discussion at the level of content.
- Talking about emotions can be seen as “touchy feely”, when the work of doctoring and communication skills needs to be very concrete and pragmatic.
- Often faculty do not explore learner emotion as they feel they do not have the training to deal with personal emotions once they are out on the table.

SUGGESTED PROCEDURE:

Name the Emotion. When making an observation about a learner’s emotional state, often the teacher will have a hypothesis about what is going on. You can test your hypothesis by naming the emotion with the learner, and see what happens (e.g. “*You seem sad today.*”) The learner can have a chance to clarify the emotion (e.g. “*No, I’m not really sad, just feeling a bit run down.*”) or open up if they wish (e.g. “*Actually, that last patient interaction really got to me.*”).

Explore. Often teachers will get a sense from a learner that something is going on. If your sense is that your observation might lead to some worthwhile reflections, you can explore the emotion with the learner.

FACULTY: *How is it doing this all day long?*

LEARNER: *I don't have this experience all day long, you have consults. But I worry sometimes that I will have trouble, because this is what I love, I get a high off of it, everyone has the thing...best time to be a physician.*

FACULTY: *So, what I'm hearing you say, is that even if it makes you sad there is a certain degree in which the connection through the sadness makes up for the sadness and is what you like about being a doctor.*

LEARNER: *It's huge, it's huge.*

GROUP MEMBER: *It is an intimate relationship.*

LEARNER: *And people let you in and it's amazing.*

FACULTY: *But it is different for everybody and everybody does it differently. I think it is a real blessing to be able to say, to be clear for yourself about what makes you get up in the morning and say I really like to do this.*

Give Feedback. Sometimes the learner will identify the emotion directly. Depending on the circumstances, faculty can help offer a perspective to the learner by sharing observations and feedback.

FACULTY: *I know you were very anxious...*

LEARNER: *I'm still anxious! Whenever I give bad news.*

FACULTY: *If you are still anxious, where does that come from?*

LEARNER: *...the seriousness of the work we are dealing with ...*

FACULTY: *Do you think this is typical of your encounter for you? What you just did here, do you that was different than what you normally do?*

LEARNER: *Well, my reactions with him I do with my own patients, but it is not typical with all of you here! But I often feel anxious when I respond to patients like this.*

FACULTY: *Well, for what it's worth – I understand that you have that perception – and that certainly you have that anxiety feeling inside. Earlier you said that you worry about yourself talking too much, which could be one way*

your anxiety comes out. This time, you appeared quite calm. You spoke slowly and left lots of room in the dialogue for the patient.

In another exchange with a different learner:

FACULTY: *Okay, so you had a little trouble with the start-up and we just discussed that. But the point at which you actually called “Time” what were you stuck with there?*

LEARNER: *She seems emotionally upset, right, and I try to give, try to name that emotion: “I can see you’re upset.” And I don’t see any response.*

FACULTY: *Okay...what kind of response do you want to see?*

LEARNER: *Well, I want to engage her in the conversation, so I can know how to help her better. Maybe it’s just some time that I have to wait –give the emotion some time to digest, and let it out.*

FACULTY: *How long do you think she was crying before you said anything?*

LEARNER: *I don’t think it was long. It was just getting to the point where I felt nervous.*

FACULTY: *Exactly, good, good. It was maybe ten seconds.*

LEARNER: *That short?*

FACULTY: *I understand that you feel anxious, that you feel nervous in front of this kind of emotion – she feels horrible. And she is sitting there with it and she has blanked you out of the room. So you can just be there with her, and let it go as long as it needs to go. And just touch base – not necessarily inquire anymore – but just support. Just with an empathic statement, something like: “This is obviously a bombshell for you.” Okay, do you have a sense of how you might do that?*

LEARNER: *Well, again, I think I realize I set up too much goals for myself. I really just have to see how the patient responds.*

FACULTY: *Yes, try to touch in with her emotion right from the beginning, and then go on with the rest of the story.*

Turn Insights into Practice. Connecting emotions, and our responses to them, to practice can help reinforce the importance of this awareness for clinical care. By connecting with a practical implication, the teacher can avoid the pitfall of feeling like they are inappropriately exploring learner emotions.

LEARNER: *I think I have been, in my routine practice, I have a little bit of avoidance behavior, in terms of eliciting emotions. One way I use to avoid it is by focusing on the medical aspects, like what I did last time... [runs through various medical descriptions & analyses], trying to hide my emotions and trying to avoid what she is feeling right now. So I think that is most useful for me – that we do not need to avoid emotions.*

FACULTY: *That's great. You have a wonderful insight into what is making you have the behavior that you have. So now, let's try to translate this into the skills. Now that you understand what's going on, let's turn it into practice.*

Flag for Further Thought. Not all emotions and responses will be able to be addressed or explored in the moment. However, faculty can still identify what might be happening and flag it as something to discuss at a later time. Flagging it makes faculty thinking transparent (e.g. “we don't have time for this now, but I want to get back to it later”) rather than just moving away from the topic or emotion without acknowledging it explicitly. Learners might assume that they shouldn't go there if the faculty just moves on quickly. Faculty can also ask the learner to think more about what the issues are. Reflection can often be more productive given more time. For example:

FACULTY: *How are you doing?*

LEARNER: *I am learning.*

FACULTY: *Good. What did you learn?*

LEARNER: *Acknowledging emotions before going ahead with other exploration.*

FACULTY: *Great things to learn, great things to learn. I think you really did a nice job, and worked with that. Maybe at another time we can talk about why it was so hard – maybe think about that a little bit – why it was so hard to get out those statements, about acknowledging emotion. Because once you did clearly it felt very good to [the patient].*

PEARLS:

- Addressing learner emotion by either naming it, acknowledging it, or exploring it, can help raise self-awareness within the learner about places where they have difficulty.
- Identifying how emotions can impact patient interactions can help learners find positive coping strategies for their emotions, such as simply acknowledging they are part of a normal response to working with patients in difficult and sad situations.

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Challenges

Teaching Module: **Common Teaching Challenges** (& Tips for Recovering from Them)

Just as with patient care, not all your teaching encounters will go smoothly. The goal in both situations is not to be perfect, but rather to be aware of potential challenges and to develop strategies for addressing them when they (inevitably) come up. We have identified a few of the most common challenges that we have faced when doing skill practice work with medical trainees.

Resisting the Role Play. There are very few learners who embrace role play work right from the beginning. More often, learners will challenge the relevance of doing role play work. Some comments you might hear include:

- *“This just seems unreal. I can’t act like I normally do with my patients.”*
- *“If I had a relationship with this patient, it would be different, but this is an artificial situation.”*
- *“This is ok, but in reality I have to also deal with writing orders, following up on medications, and a waiting room full of other patients!”*

One way to respond to this challenge is by anticipating it and addressing it upfront. Before you begin a skill practice session, ask the learners what they don’t like about role playing. Once those concerns are out on the table, ask them to imagine why it is that we still ask them to do it. You can be upfront by acknowledging the limitations of the context – it is artificial and the learners will not have developed a relationship with the patients yet. You can also reinforce the safety of the situation and characterize the skill practice as an opportunity to practice new skills, take risks, and make mistakes. Once the learners have had some practice with the skills, they will be able to try them in real patient care contexts.

You can also ask how they learned other clinical skills. *“Think about the last new clinical skill you learned. How did you learn to do it?”* Most likely, they will say things like, “By observing someone do it,” “by practicing,” “by walking through the steps in a ‘dry run’ before I did it with a patient for the first time,” and so forth. Often learners assume that communication skills should just come naturally and that they are somehow different from other technical skills they have learned over

the years. Reinforcing the connections can help the learner appreciate the need for a dry run with the communication skills also.

Finally, you can simply ask the learners to humor you. Often no amount of negotiating or arguing will help the learner feel good about heading into a role play. Just asking the learner to try it and see how it works, can be your most effective route.

Questioning the Content. When teaching communication skills, often faculty will bump up against pre-existing beliefs in the learners that run counter to the approach being taught. This learner resistance is not to the process (as above), but rather to the content itself. This also is to be expected, as many of our communication strategies ask the learner to turn a usual practice on its head. Some ways this challenge might appear as follows:

- “How do we know this works. Have they been tested in an evidence-based way, or do we have surveys to show that patients like statements of understanding?”
- “I think most patients would just get annoyed if you tried to ask them anything before giving them the test results.”
- “How can you say that so it doesn’t sound fake? It just sounds so contrived, or psychobabbly to say that.”
- “But I won’t be there throughout her treatment. Isn’t it misleading to promise her that I won’t abandon her?”

Many of these challenges from the learners reflect misconceptions about what the skill is asking them to do. In those cases, identifying the misunderstanding and clarifying the expectation can be helpful. For example, in response to a discussion about how exploring with a patient before you give bad news is likely to be harmful or just annoying, the faculty member clarified:

FACULTY: The other thing I want to mention is social chitchat. ‘how you doing’ ‘how’s the weather’ ‘how was the game last night’ Those statements have nothing to do with anything. That you usually don’t want to spend a lot of time on, but it has its role. So the other thing is ‘how have you been doing since the last time I saw you,’ and that’s not chitchat that is exploring the patient’s expectations and finding out where they are right now.

Faculty can also encourage learners to find the words to say that will feel natural and not forced. By returning to the goal of the communication skill (e.g. to show support, to encourage, to explore, to diagnose, to align with the patient, etc.), the learner can identify a way to accomplish the goal but through her own words. Acknowledge that the statements can feel awkward at first. Encourage the learner to try them out. It is possible that feedback (explicit or implicit) from patients will help reinforce the skills once they are employed.

Limited Self-Assessment Abilities. Since one of the teaching strategies we emphasize is checking in with the learner and asking for an assessment of his own abilities, this works best with learners who have good insight into their strengths and limitations. However, not all learners are good

observers of their own behaviors. Others will have different assessments of the patient encounter than you have. Finding middle ground with these learners is a teaching challenge.

Some challenging learner behaviors include:

- Saying an encounter is “going pretty well” when you think it is not going so well.
- Having difficulty naming an emotion the patient is experiencing, or that the learner is clearly experiencing, in the encounter.
- Missing the teaching point

These are challenging teaching situations because they risk setting up a conflict between the teacher and the learner. You have a different assessment and you want to communicate it. You have a few options. You can use the group (e.g. “*What observations did you all have from this exchange?*”). Often group members will identify some of the teaching points of interest, which keeps you from having to set yourself up as disagreeing with the learner. You can ask the learner to explore her own observations (e.g. “*How did the patient seem during the discussion?*”). By asking the learner to consider a few more data points, sometimes you can elicit some new insights into the encounter. In other circumstances, or after those two options have been tried, you need to be direct if it is a point you want to get across. Keeping your observations and feedback tied to specific behaviors can really help your feedback not seem personal (e.g. “*I noticed that you seemed to be pulled back into your chair for much of that discussion. Did you notice that?*”).

You also want to promote the underlying issue here which is developing the learner’s ability to self-assess more accurately. By giving direct feedback and asking probing questions, you can help the learner’s self-assessment ability to develop. Your teaching will be most effective if you can meet the learner where she is, even while engaging her in the next steps to move forward in her own development.

Group Dynamics. A common challenge for teachers is managing group dynamics. It is rare to have a group that works well together right from the beginning, all contributing equally, respectfully, and fairly. More often, you will have a few silent group members, or a few dominators that set the tone for the whole group. Addressing these issues early and often can be the best strategy toward redirecting the tone and setting expectations within your group. You can try invitations and direct questions to the group to draw others into the discussion (e.g. “*That is an interesting idea Steve, what do the rest of you think?*”).

A group member might pose all his questions to you, in deference to your expertise. To answer him directly will go counter to your goal of engaging the group, so you can always turn a question back out to the group for their thoughts before you answer (e.g. “*What can you do when the patient starts to get hostile and you are trying to be empathic?*”). Your response to his question will re-engage the group in the discussion and it will also model for the group that you value their contributions, and demonstrate for them that you will be in the role of facilitator rather than expert-lecturer for the day.

If a dominant member does not take any of your cues, you might talk with her separately outside the group. Emphasize that you appreciate her insights but that your main concern is in giving everyone an opportunity to share their ideas.

One of the primary challenges of teaching is that you are often asked to attend on multiple levels. You will be paying attention to course goals, content areas, skill practice, as well as learner responses, group dynamics, your own responses, and time management. Doing all of this well takes time and practice. There are several strategies you can employ to help you get there:

- **Sharpen your observation skills.** It takes practice to attend on multiple levels. When you begin, it is likely that you will focus on the content of the teaching lesson. As you move forward, consider consciously choosing one additional thing to pay attention to during the session (e.g. “*Are all group members participating?*”). Over time you will add more and more elements.
- **Develop and test hypotheses.** Get curious about your learners. Once you have begun making observations, start developing ideas about what might be going on (e.g. “*Tom seems really withdrawn today. I wonder if he had a tough call night last night.*”). The next step is testing your hypothesis by asking about it (e.g. “*Tom, how was your night last night?*”).
- **Be transparent.** You can let learners know what is going on in your head as a way to enlist them in the process (e.g. “*I’m just conscious of the time and I am wondering how we can fit these next two pieces in before the break.*”).

These, and many other, challenges will come up during your teaching sessions. When you encounter them, it is not a sign that your skills have failed. It is simply the nature of teaching something as complex as communication skills and ethics to a group of learners as diverse as physicians-in-training. Developing the abilities to recover from these challenges when they occur is the goal for you to be successful in your teaching.

DNR Orders

Teaching Module: **Discussions about DNR Orders**

Teaching learners about DNR discussions is one of the more difficult tasks in teaching communication skills at the end of life. As with other communication areas, habits are likely to have developed around DNR discussions that are difficult to break. Furthermore, a model of communication has developed which may not achieve the true goals for these discussions and may only serve to create greater misunderstanding. These barriers to learning must be addressed before new skills and approaches can be adopted.

RATIONALE:

Conceptual and skill barriers exist for DNR discussions. Addressing the conceptual barriers will help create space to develop necessary skills.

The DNR discussion has come to have an important legal role in patient care. The legal features of the document are partly to blame for the focus of DNR discussions being on reading lists of treatments to be withheld or provided and on obtaining the patient's signature. Having a signed DNR Order in a patient's chart helps reassure the team that they need not go through the motions of a resuscitation effort that they believe is futile.

However, there are also important ethical considerations for a DNR discussion. With ready access to life-prolonging technology, it can be difficult for the family, the patient, or the health care team to acknowledge when important transitions in the goals of care may have changed. A DNR discussion can help the patient clarify his or her own goals, and allows the family and patient to talk openly about hopes and fears at the time of death.

PITFALLS

- Old habits are hard to break. It can take multiple discussions and attempts before the learner is able to let go of current beliefs and practices. Experiencing success will be the best reinforcement in this case.

- Old models are pervasive. A learner is likely to be surrounded by others who also hold beliefs regarding DNR discussions as legally necessary. Developing the learners' confidence with the new approach will be the best way to have them become effective role models within their programs.

SUGGESTED PROCEDURE:

Assess Pre-Existing Beliefs. All learners will bring assumptions about DNR orders and discussions. Before you begin with a new paradigm, it is important to elicit and address the assumptions that learners currently hold about DNR orders and discussions. A variety of strategies can be used:

- Ask. *“How do you normally approach your DNR discussions?”*
- Use a pre-test quiz. List common beliefs about DNR orders and discuss whether or not they true.
- Role-play a DNR discussion and debrief observations.
- List common phrases that appear in DNR discussions (e.g. *“do you want us to do everything possible to bring you back if your heart stops?”*). Discuss the risks and benefits of the phrases.

Often if any of these strategies are used in a small group setting, at least some participants will take the position that the existing approaches to DNR discussions are not effective or comfortable for either the patient or the physician. There are several important teaching points to make during this opening segment:

- Do we ask hospital patients, *“if you get an infection, would you like me to treat it with antibiotics?”* Why are DNR discussions treated differently than other clinical decisions?
- Do patients really want CPR? Discuss what it is that patients want and what choices it is reasonable for them to make (see discussion below re: the new approach). Are there misconceptions (e.g. CPR success rates on TV) that lead patients to request CPR?
- When is it appropriate for physicians to give recommendations to patients?

Introduce a New Approach. Because of the legal and ethical traditions that emphasize patient's rights to choose and direct their health care, DNR discussions have become more about presenting choices and obtaining patient signatures. Having meaningful choices is an important aspect of respecting patient autonomy; however, in many cases, resuscitative efforts do not represent a reasonable care option for patients. Particularly when a DNR discussion is approached as a menu of treatment options, decisions about individual treatments become even more meaningless (e.g. *“I would like chest compressions but no shocks please.”*) More often than not, what patients want is not the treatment itself, but the outcome of the treatment (e.g. *“I would like to be on a breathing tube, but only if it gets me over a temporary bump and I can be restored to my former level of function.”*) No one really wants CPR, but they might be willing to tolerate it if it achieves their goal of extending life.

With these distinctions in mind, it becomes more productive to focus on the outcomes wished for by the patient. The clinician can then determine if there are any available medical interventions that can help the patient achieve those outcomes. In some cases, the answer might be: “*I wish I could promise you a full recovery, but I am afraid I cannot.*” If the clinician can elicit the patient’s goals, hopes, and fears for the end-of-life, the clinician can make an informed recommendation to the patient based on what will be beneficial, from the patient’s perspective. The steps of our recommended protocol is presented below in Box 1 and also in the Oncotalk Module: “Talking about Advance Care Plans and Do Not Resuscitate Orders.”

BOX 1. 6-STEP PROTOCOL TO NEGOTIATE GOALS OF CARE¹

1. Create the right setting
2. Determine what the patient and family knows
3. Ask how much they want to know and discuss with you
4. Discuss goals of therapy
5. Recommend medical care that contribute to patient goals
6. Explicitly address care (like CPR) that does not contribute to goals and recommend against it

¹From the Oncotalk Teaching Module on Advance Care Plans and DNR Orders, available upon request.

Practice or Observe. Address Barriers Again. Even after a discussion, once the learner gets back in the hot seat with the patient, old habits are likely to re-appear. For example:

***LEARNER:** I wanted to talk with you about decisions that may need to be made around the time of death. It sounds like, and please correct me if I am wrong, but that overall your goals are to stay as comfortable as possible and continue to visit with friends and family as long as you can, is that fair to say? Ok. A lot of times we like to talk to people about what happens if something should come up, if your heart would stop beating and that you would stop breathing, you know, pretty much at the time of death. And there’s a couple ways you could go. One of those is to do a full resuscitative effort, which would involve things like chest compressions, potentially even shocks to the heart, being put on a breathing tube, that sort of thing. And that’s awfully, that’s a lot to go through at the end. Especially when the chance of having a major success is quite low, probably a zero percent chance of bringing you back and that you would be able to live through all that basically. And so, I think in keeping with your goals, at that time if your heart were to stop beating, or you were to stop breathing, maybe letting nature take its course. Would that be a more reasonable approach to take?*

In a role-play setting, this is a good place for the faculty person to time-out and check in with the learner to see how it is going. It could be that the learner realizes they are right back into old habits again with the discussion. This learner went back to listing the procedures that could be done in a resuscitative effort and posed the question to the patient as a choice, even as she characterized the choice of full resuscitation as being highly unlikely to succeed. It could be that the learner needs help identifying the sticking point. By diagnosing where the learner is first and eliciting self-reflection, your feedback will be more effective. An example of a faculty intervention could be:

Faculty Behavior	Faculty-Learner Exchange
Checking In with Learner	<p><i>FACULTY (F): Time out. How's it going?</i></p> <p><i>LEARNER (L): Oh, it's going pretty good. Pretty typical kind of conversation.</i></p>
Explores	<p><i>F: Typical in what way?</i></p> <p><i>L: Just that she's asking appropriate questions, she's not being combative or anything. Normally in the past I would have already, right off the bat, after a minute and said, you know, do you want us to resuscitate.</i></p>
Affirms observation	<p><i>And I was trying to avoid that.</i></p> <p><i>F: So you took more time getting there.</i></p> <p><i>L: Mmhm.</i></p>
Asks learner to describe the exchange (what does the learner think happened?)	<p><i>F: Ok. Earlier on, you asked her about her goals and sorts of things she wanted to accomplish. So, then when you got into the part about the CPR and all that, how did you present it?</i></p> <p><i>L: Well basically I tried to just give two options. I tried to avoid saying 'do nothing', that's why I tried to say 'let nature take its course'.</i></p>
Names the behavior	<p><i>F: But you presented her with a choice.</i></p> <p><i>L: Right. [pause] And I guess your saying that that's, uh...</i></p>
Makes explicit the mismatch between the behavior and the goals	<p><i>F: Well, you know, you don't really think in your heart of hearts that it is a choice. You really want to make strong recommendation. You don't really think that one side of that choice is going to make any sense given where things stand. So, it is really not a choice in your mind. You presented it as there are two ways we can go. You certainly gave a recommendation, you said...</i></p>
Affirms behavior	<p><i>L: I didn't really present, I gave a soft opinion rather than a strong opinion.</i></p>
Gives clear feedback	<p><i>F: But it still came out as a choice. So I think that's the part that gets confusing. How do you think if you might be able to do it differently?</i></p>
Asks learner to problem-solve	<p><i>To not make it such a choice like that.</i></p> <p><i>L: Just frankly state, 'I don't think that doing aggressive measures with your overall goals and wishes.' Do you state it that strongly?</i></p>
Role models some language	<p><i>F: Well, I think what you can do is first of all, find out more about what she is thinking... Without going into all that CPR stuff. And see what comes out of that. You may be able to just say, 'we can make sure that happens.' Positive, positive, positive. And then, 'I need you to know, there's also some stuff that we're not going to do, because it just doesn't make sense for the situation.' Do you think you could try to pick it up?</i></p>
Invites learner to try again	<p><i>L: Mmhm. Yeah. So, it takes the explicit choice out. But yet, you are getting her wishes.</i></p>

Experience Success. If the learner can experience having a DNR discussion that is led by the patient, rather than by the physician, the teaching points will become much more clear to the learner and to others observing. For example, the second role play might go something like this:

LEARNER: *I was just wondering what you have thought about that, or what you've imagined for the time of your death.*

STANDARDIZED PATIENT: *I'd certainly like to be at home. I hope that it's not painful. And it'd be great to have my boyfriend here. Can you arrange that?*

LEARNER: *I think that sounds peaceful and very appropriate, and I'd certainly like to help you make that happen. Certainly I would like to keep you comfortable, as you said, and it would be nice if your boyfriend was here. There are things we can do to facilitate that. One thing that comes up a lot of times, and it's really not compatible with what you are describing to me, is that sometimes when someone stops breathing we rush in and do aggressive resuscitation, put people on breathing tubes, do chest compressions, shocks to the heart, things like that. Really I don't think that is a good idea, with what you are telling me here, and just having more of a loving, peaceful, nurturing environment at the time of death sounds more like what you are telling me, rather than doing tubes and machines, and things like that.*

STANDARDIZED PATIENT: *I'd agree.*

And the faculty can help reinforce the positive experience:

Faculty Behavior

Faculty-Learner Exchange

Checks in	<p>FACULTY (F): <i>Time. How did that go for you?</i></p> <p>LEARNER (L): <i>It went better. Just that whole 'what have you envisioned or imagined for the end.' I think that's pretty useful. It let's you find out what they're hoping is going to happen. Then you can bring in the DNR thing, and you can make a very strong statement that you think it's a bad idea in light of their goals. It felt a lot better than the usual DNR discussion.</i></p>
Affirms learner's self-assessment	<p>F: <i>I agree, I thought it went a lot better too.</i></p> <p>L: <i>And then you can just segue back into what we are doing for you, with the hospice and all that.</i></p>
Uses the group for more feedback	<p>F: <i>Exactly. What did other people think?</i></p> <p>PARTICIPANT: <i>I think it went very well. It was really smooth and not awkward at all. L seemed really relaxed.</i></p>
Reinforces positive feedback	<p>F: <i>Right, you seemed more relaxed. That's a good observation. You seemed more uncomfortable when you were doing it the other way.</i></p>
Checks in	<p>F: <i>You seemed more relaxed doing it this way. Did it feel that way to you?</i></p> <p>L: <i>Oh, it did. It did. Like you said, you're aligning yourself with the patient. You're not doing this antagonistic thing.</i></p>

Give Permission to Make Mistakes. When learning any new skill, it is easy for learners to get frustrated with early awkward attempts. Faculty can help encourage learners to work through this stage by affirming that everyone takes missteps during patient encounters. The important tool for learners is to know they have the ability to “repair” the conversation. For example:

***LEARNER:** Now, as you know, your death is pretty close. Have you had any thoughts about what you would want to do, or what your goals would be?*

***STANDARDIZED PATIENT:** It feels strange to talk about goals about dying.*

***LEARNER:** Let me put it this way, what are the things that are important for you right now?*

Address the Emotion. DNR discussions are difficult for physicians because they can bring up feels of loss or even failure. Physicians can also worry that by raising the topic of death, they will upset the patient. For the physician and the patient, it is natural to be sad during these discussions. Most patients are very aware that they are dying and welcome the chance to talk about their hopes and fears with their physicians. For example, during one discussion following a DNR discussion with a patient the participants identified the following emotions:

Faculty Behavior

Faculty-Participant Exchange

	<p><i>PARTICIPANT 1 (P1): It seems mean. Or not appropriate. It feels like you are taking away that one last chance.</i></p>
Reflects back	<p><i>FACULTY: So it feels like you are taking away something.</i></p> <p><i>P1: You don't feel like saying it actually. You know in the back of your mind that it's not going to work. But it's hard to say that.</i></p> <p><i>P2: For me, it is easier to depersonalize it by just going through the technical part. Going through the list. Especially now, after seeing the relationship build, it's harder.</i></p>
Reflects back	<p><i>F: So you are saying that doing it in sort of a technical way can keep you away from letting it touch you in a personal place.</i></p> <p><i>P1: It is sad.</i></p>
Explores	<p><i>F: So what do you do with that sadness?</i></p> <p><i>P1: I don't know. It's just hard. You think about it a lot.</i></p>
Offers perspective	<p><i>F: [pause] I think if you can be there with the sadness, that can go a long way toward giving the patient what she needs from you.</i></p>

VARIATIONS FOR DIFFERENT TEACHING SETTINGS

Each of the above steps can occur with real-time patient care. Take a few minutes in a quiet meeting room before you see the patient. Ask the learner to describe her usual approach to DNR discussions. Are they comfortable for her? Invite the learner to approach it differently this next time, by focusing on the patient's goals and affirming the treatment being provided to meet those goals. Observe the encounter and give feedback at the conclusion.

PEARLS

- Behavior change is going to take time.
- Embracing underlying assumptions about the purpose of the DNR discussion will help facilitate the transition to new communication skills
- Focusing on patient goals and how the care team can and cannot meet them can help the discussions go much more smoothly for both patient and physician. Respect for patient autonomy can be met more easily through a goal-centered discussion than by obtaining a signature.

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Errors

Teaching Module: **Talking About Harmful Medical Errors with Patients**

RATIONALE:

Since the 1999 Institute of Medicine report “To Err is Human,” a resurgence of interest has occurred in reducing medical errors and improving the quality of healthcare. Yet despite our best efforts, harmful medical errors will continue to occur. The issue of whether and how to disclose harmful medical errors to patients requires that physicians integrate their understanding of bioethics, doctor-patient communication, quality of care, and team-based care delivery. Despite a long-standing general consensus among ethicists that harmful errors should be disclosed to patients, evidence exists that at present such disclosure is uncommon. The issue of whether and how to disclose medical errors represents an ideal opportunity for educators to explore the interface between ethics and communication with their learners.

PITFALLS:

- Many physicians worry that disclosing errors to patients will precipitate lawsuits. Despite strong evidence that patients are more likely to sue physicians when communication breaks down, fear of malpractice suits will be a significant barrier for open discussion about errors with patients.
- Physicians can get mixed messages from risk managers and hospital administrators who explicitly say physicians should not apologize to patients as an apology is an admission of fault. How to handle apologies effectively is a key issue for error disclosure.

SUGGESTED PROCEDURE:

Patient Safety Basics. The emerging patient safety movement provides an important backdrop for discussions regarding error disclosure. Previously, it was assumed that most medical errors were due to providers who were either incompetent or lazy. Using this “bad apple” framework, one would improve the quality of healthcare by seeking out the bad apples and removing them from the barrel, a process often referred to as “quality by inspection.” A primary goal of the new patient safety movement is to educate providers about the substantial flaws in this bad apple framework.

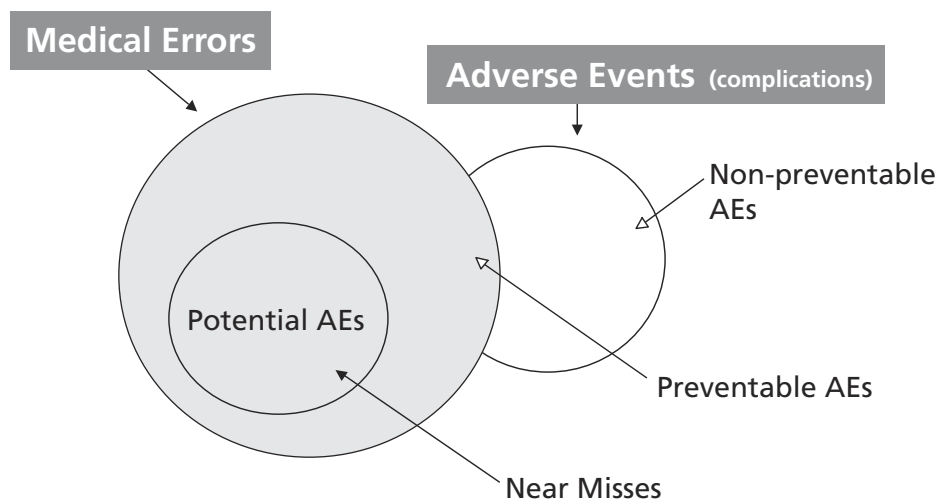
Drawing from lessons learned in other high risk industries such as nuclear power and aviation, patient safety experts assert that most medical errors are due not to incompetent providers but rather due to flaws in the systems of care. These flaws, often referred to as “latent errors,” represent the breakdowns in the healthcare system that made the error itself more likely to happen. These patient safety principles have important implications for preventing medical errors. If one understands the system contribution to most medical errors, there should be a diminished tendency to blame the involved healthcare providers.

Furthermore, the patient safety movement argues that not only is the bad apple approach to medical errors inaccurate, this framework promotes secrecy about errors. When one seeks to improve quality by identifying and removing bad apple providers, it is natural that healthcare workers who make errors would want to keep these errors to themselves. Such secrecy surrounding errors prevents proper analysis of errors and inhibits efforts to prevent recurrences of the error. More open communication among healthcare workers about errors, as well as decreasing the “culture of blame” in healthcare around errors, are both seen as prerequisites to understanding why errors really happen and how they can be prevented.

Another important component of the patient safety movement has been to promote greater clarity about patient safety terms. It is critical that one be able to differentiate an adverse event from a medical error (see Figure 1).

- Adverse Event: harm resulting from the process of medical care rather than from the patients’ underlying disease.
- Medical Error: failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.

FIGURE 1. RELATIONSHIP BETWEEN ERRORS AND ADVERSE EVENTS



From Figure 1 it should be noted that the vast majority of medical errors are not associated with an adverse event (i.e. do not cause harm). Similarly, most adverse events are not associated with a medical error and therefore are not preventable. For the remainder of this module we will focus primarily on the overlap between medical errors and adverse events, namely medical errors that cause harm.

Ethical Rationale for Error Disclosure. A variety of ethical rationale have been offered for disclosing harmful medical errors to patients.

- **Informed Consent:** In some respects, error disclosure is a form of informed consent, conveying important information to patients that they need to make informed decisions about their subsequent medical care. To that extent, it is important to recognize that informed consent is a positive obligation, i.e., an obligation physicians have to come forward with relevant information that patient should know, rather than waiting for the patient to extract the information from the physician with probing questions.
- **Truth-Telling:** Other ethicists justify the need to disclose errors as a form of truth telling, which suggests such errors should be disclosed even if the information is not essential to informed decision-making.
- **Justice and Fairness:** Theories of justice also support error disclosure, as such information is often a prerequisite to a patient accessing appropriate compensation for their injuries.

Current Practices. Despite these compelling ethical rationale, there at present exists a disclosure gap; our current clinical practices do not come close to meeting the practices recommended. A variety of studies have documented error disclosure rates of approximately 30 percent. Multiple barriers inhibit disclosure, ranging from fear of malpractice to shame and embarrassment from admitting to a patient that one has made an error. Furthermore, few physicians have had formal training in error disclosure, and therefore may feel quite uncomfortable conducting such conversations.

More recent work suggests that this disclosure gap primarily relates to differences between doctors and patients about the content of disclosure. Physicians generally agree with the basic principal that harmful errors should be disclosed to patients, but in practice choose their words carefully when talking with patients about errors. This careful word choice typically involves acknowledging that an adverse event took place but not explicitly admitting that the adverse event was due to an error. Such partial disclosure conversations can actually be counterproductive, as patients' belief that important information about an error is being hidden from them is a common precipitant of malpractice suites.

This disclosure gap also reveals unexplored ethical complexities in error disclosure. For example, no consensus currently exists regarding basic standards for the content of disclosure. In addition, oftentimes it is unclear whether an error happened and whether the error was associated with an adverse event. Furthermore, little consensus exists regarding the disclosure of errors that caused minor or no harm, whether fatal errors should be disclosed (since the patient can no longer derive any benefit from any disclosure), or whether to disclose harmful errors that have happened to

patients who are likely to die soon regardless of whether the error took place. Such complexities represent ideal opportunities for teachers to probe how learners are balancing the ethical complexities involved in error disclosure.

KEY ELEMENTS IN THE DISCLOSURE PROCESS.

1. Understanding Patient Preferences for Error Disclosure. Recent studies have found that patients desire a consistent set of information about harmful errors (outlined in Box 1).

BOX 1. ELEMENTS PATIENTS PREFER IN ERROR DISCLOSURE

1. An explicit statement that an error occurred
2. What the error was and the error's clinical implications
3. Why the error happened
4. How recurrences will be prevented
5. An apology

Patients generally report wanting this information provided to them without having to ask their physicians a litany of questions about the error. Patients desire such information even about relatively minor errors. However, important gaps exist in our knowledge of patients' preferences about error disclosure. Most of these prior studies have solicited patients' preferences when they are not acutely ill. Patients who have just experienced a medical error may have different preferences than patients considering a hypothetical situation when they are feeling well. In addition, it is not known in any prospective sense whether providing patients with this information improves outcomes such as patient trust, satisfaction, and the intent to file a lawsuit.

2. Understanding the disclosure process and possible pitfalls. Physicians should approach disclosure conversations with considerable caution, foresight, and planning. Thorough analysis of an event is usually necessary before it can be definitively determined that a harmful error took place. In addition, many physicians experience great emotional distress following an error, distress that can distort the physician's judgment about whether an error took place and if so whether the error caused harm. While patients should be provided timely information about harmful errors in their care, physicians should resist the urge to tell patients about errors until the facts of the case are clearly known. In many institutions, formal disclosure policies exist to ensure proper analysis and planning takes place before the disclosure occurs. Trainees should consult their attending physician or other senior supervisor before discussing an error with a patient.

3. Disclosure Communication Skills. Many of the basic communication skills that apply to delivering bad news are equally applicable to disclosure conversations. Physicians should choose an appropriate physical setting for such conversations. Careful consideration should be given to which team members should be present. For example, having a nurse manager and/or pharmacist

present, if the error in question involved these services, can provide patients with useful information about why an error occurred. However, having too large a team present for a disclosure conversation can intimidate the patient and should be avoided.

Error disclosure involves both communicating information as well as addressing the patient's emotions. Over emphasis of either dimension, such as responding primarily to the patient's disappointment and anger but sharing little information about the event in question, can lead to poor disclosure conversations. In addition, clinicians should recognize that error disclosure is more than just giving bad news to patients. Error disclosure involves possible culpability on the part of the clinician and therefore may feel risky to physicians in ways that simply sharing bad news does not. This fact makes it especially important that physicians consciously reflect on their own emotions during the disclosure conversation and consider how these emotions are effecting their communication with their patients. Comments perceived by the patient as rationalizations or defensive on the part of the physician, though a natural reaction in response to angry comments made by the patient, can fuel patient anger and are to be avoided.

PLANNING THE CONTENT OF THE DISCLOSURE CONVERSATION.

Planning a disclosure conversation requires careful consideration on the part of the physician about what specific words to choose when describing the event to the patient. As above, patients want physicians to explicitly state that an error occurred, describe what the error was and why the error happened, how error recurrences will be prevented, and to apologize. In particular, physicians may underestimate patients' desire to know why an error happened and how recurrences will be prevented, information which shows patients that the physician and institution have learned from the event and have plans for preventing recurrences. Physicians must balance their interest in meeting patients' preferences with other concerns and recommendations, such as the advice many physicians receive from risk managers that the errors not be disclosed in a way that admits liability or that places blame.

Many physicians worry that in disclosing an error they could actually precipitate a lawsuit. The relationship between disclosure and malpractice is complex. It is fair to say that overall disclosure does not appear to stimulate lawsuits, and may in fact make lawsuits less likely. In individual cases, however, it is possible that even optimal disclosure could precipitate (or fail to prevent) a lawsuit. This uncertainty regarding the relationship between disclosure and malpractice makes consultation with colleagues and with risk managers of paramount importance before disclosing an error.

The deliberations physicians go through while deciding what words to use in disclosing an error to patients provide important teachable moments about balancing conflicting values and priorities and then operationalizing these decisions through effective communication skills. The following cases can be used to elicit discussion and foster skill practice.

Vignette A

You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive “10 U” of insulin. The “U” in your order looks like a zero. The following morning the patient is given 100 units of insulin, ten times the patient’s normal dose, and is later found unresponsive with a blood sugar level of 35. The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.

Questions for Discussion

- What were the errors in this case? Why did they happen?
- Imagine you are this patient’s attending physician and are meeting with them after the error to describe what happened. All learners will want to tell patients “the truth” about what happened. What is the truth? How should it be communicated to the patient?
- Truth telling exists along a spectrum ranging from frank lies to statements that are literally true but deceptive or misleading. What are the pros and cons of using the following language to disclose this error? “You received more insulin than you needed.” “You had a bad reaction to the insulin.” “There was a miscommunication about your insulin order.”
- Should the physician explicitly say the words “error” or “mistake”?
- Should the physician accept responsibility for this error? If so, what specific language would communicate such acceptance of responsibility?
- Should the physician apologize and if so what words should they say?
- Consider variations on this vignette, such as increasing harm (patient suffers permanent neurologic damage such as a stroke with hemiparesis), patient dies from hypoglycemia (or little or no harm) patient becomes slightly dizzy but the insulin overdose is quickly recognized and corrected with no ICU admission necessary)

Vignette B--Hyperkalemia

You start an outpatient with hypertension on a new medicine with a common side effect of increasing the potassium level. The patient’s baseline potassium level is normal (4.0). You order a repeat potassium blood test to be drawn the next week, but forget to check the lab results. Two weeks after the patient begins this new medicine they start feeling palpitations and go to the emergency room. In the ER the patient experiences an episode of ventricular tachycardia requiring cardioversion. The patient’s potassium level at the time of this event is 7.5. The patient is hospitalized for four days, and makes a full recovery. The patient returns to your office for a follow-up visit. On reviewing the patient’s chart you see the overlooked labs, which showed the patient’s potassium had risen substantially from 4.0 to 5.6. Had you seen this elevated potassium earlier, you would have stopped the new medicine and treated the hyperkalemia, likely avoiding the life-threatening arrhythmia.

Questions for Discussion

- What were the errors in this case? Why did they happen?
- Imagine you are this patient's attending physician and are meeting with them after the error to describe what happened. All learners will want to tell patients "the truth" about what happened. What is the truth? How should it be communicated to the patient?
- Truth telling exists along a spectrum ranging from frank lies to statements that are literally true but deceptive or misleading. What are the pros and cons of using the following language to disclose this error?
- Should the physician explicitly say the words "error" or "mistake"?
- Should the physician accept responsibility for this error? If so, what specific language would communicate such acceptance of responsibility?
- Should the physician apologize and if so what words should they say?

PEARLS

- Patients want physicians to explicitly state that an error occurred, describe what the error was and why the error happened, how error recurrences will be prevented, and to apologize.
- In most cases, disclosure does not appear to stimulate lawsuits, and may in fact make lawsuits less likely.

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Bibliography

Teaching Resources: **Annotated Bibliography**

Brookfield SD *Becoming a Critically Reflective Teacher*. Jossey-Bass, 1995.

Building on the insights of his highly acclaimed earlier work, *The Skillful Teacher*, Stephen D. Brookfield offers a very personal and accessible guide to how faculty at any level and across all disciplines can improve their teaching abilities. Applying the principles of adult learning, Brookfield thoughtfully guides teachers through the processes of becoming critically reflective about teaching, confronting the contradictions involved in creating democratic classrooms and using critical reflection as a tool for ongoing personal and professional development. Using numerous examples, Brookfield describes what critical reflection is and why it is so important

Cranton P. *Understanding and Promoting Transformative Learning : A Guide for Educators of Adults*. Jossey-Bass, 1994.

Drawing on numerous examples from nearly twenty years of experience as an adult educator and researcher, Cranton relates transformative learning to current adult education perspectives. She describes how learners undergo transformative learning. She examines individual differences among learners, and she presents practical strategies for fostering and supporting transformative learning—including questioning techniques, journal writing, consciousness-raising exercises, and experiential activities. Jack Mezirow's theory of transformative learning has developed over nearly two decades into a comprehensive and complex description of how learners construe, validate, and reformulate the meaning of their experiences. But what exactly is transformative learning? How does it differ from other concepts of adult learning? How can educators actively foster transformative learning with adult learners? In this book, Patricia Cranton describes the theory and process of transformative learning in terms of experiences with which we are all familiar: from the learner who is struck by a new concept or a different way of thinking about something to the learner who changes her personal life based on new insights. Cranton also describes approaches the educator can use—such as fostering group interaction and encouraging learner networks—to provide support for the transformative learning process and help learners to support each other.

Jaques D. ABC of learning and teaching in medicine: Teaching small groups. *BMJ* 2003;326:492-494.

Kurtz S, Silverman J, Draper J. *Teaching and Learning Communication Skills in Medicine*. Radcliffe Medical Press, 1998.

Combined with its companion, this book provides a comprehensive approach to improving communication between doctors and patients throughout all three levels of medical education (undergraduate, residency, and continuing medical education) and in both specialist and family medicine. Examines how to construct a communication skills curriculum, the individual skills that form the core content of communication skills teaching programs, and specific teaching and learning methods.

Mezirow J. *Fostering Critical Reflection in Adulthood : A Guide to Transformative and Emancipatory Learning*. Jossey-Bass, 1990.

This book presents successful programs, techniques, and strategies for helping adult learners tap into their rich and diverse life experiences as a basis for growth and lifelong learning.

Pinsky LE, Monson D, Irby DM. How Excellent Teachers Are Made: Reflecting on Success to Improve Teaching. *Adv Health Sci Educ Theory Pract*. 1998;3(3):207-215.

The authors surveyed forty-eight distinguished teachers from clinical departments regarding the role of instructional successes in learning to teach. Using qualitative content analysis of comments, the authors identified nine common successes in clinical teaching associated with planning, teaching, and reflection. In anticipatory reflection used for planning, common successes occurred by involving learners, continuously innovating, creating a positive atmosphere for learning, considering the learners, engaging the learners, preparing adequately, and limiting content. When reflecting-in-action, the success experience most commonly mentioned was maintaining flexibility in action. Reflecting-on-action after a successful teaching event, they commented on the importance of thoughtful analysis and choosing an appropriate strategy. These teachers incorporated reflective practice into their teaching as an essential component of professional development and incrementally improved their teaching based upon successful instructional experiences.

Pinsky LE, Irby DM. "If at first you don't succeed": using failure to improve teaching. *Acad Med*. 1997 Nov;72(11):973-6.

The authors surveyed a group of distinguished clinical teachers regarding episodes of failure that had subsequently led to improvements in their teaching. Specifically, they examined how these teachers had used reflection on failed approaches as a tool for experiential learning. The respondents believed that failures were as important as successes in learning to be a good teacher. Using qualitative content analysis of the respondents' comments, the authors identified eight common types of failure associated with each of the three phases of teaching: planning, teaching, and reflection. Common failures associated with the planning stage were misjudging learners, lack of preparation, presenting too much content, lack of purpose, and difficulties with audiovisuals. The primary failure associated with actual teaching was inflex-

ibly using a single teaching method. In the reflection phase, respondents said they most often realized that they had made one of two common errors: selecting the wrong teaching strategy or incorrectly implementing a sound strategy. For each identified failure, the respondents made recommendations for improvement. The deliberative process that had guided planning, teaching, and reflecting had helped all of them transform past failures into successes.

Westberg J, Jason H. *Fostering Learning in Small Groups: A Practical Guide*. Springer Publishing Company, 1996.

Text on teaching health care in small group settings, for medical educators, particularly problem-based learning instructors. Discusses strategies for planning and facilitating small group sessions.

Domains

Teaching Resources: **Domains of Good Communication Teaching**

This table represents an initial walk-through of a teaching session with Tony Back and Kelly Fryer-Edwards making observations about effective teaching behaviors and objectives. We make certain assumptions about the teaching session: it is skill-based, involving role-play, with a small group of students.

Facilitator Goal or Task	Behavior or Observation
OPENING A SESSION	
Engage learners	<ul style="list-style-type: none">• Introduce self & others• Focus attention (change the channel)• Frame the session in learner-centered terms• Throughout session, are learners:<ul style="list-style-type: none">– Making eye contact– Asking questions (showing curiosity)– Taking responsibility for learning or new skills (being a self-directed learner)
Model desired attitudes and behavior	<ul style="list-style-type: none">• Start with open-ended questions• Elicit learner response• Allow silence (thinking time)• Be polite (avoid sarcasm or harsh humor)• Leave space for learners to talk
Assess learner expectations and goals	<ul style="list-style-type: none">• Ask learners directly for their goals or expectations of the session (e.g. what do they need to know or hope to learn?)• Assess learner assumptions about skill or clinical practice issue being taught• Assess learner fears and beliefs about learning method

Facilitator Goal or Task	Behavior or Observation
OPENING A SESSION (continued)	
Help learners formulate reasonable goals for the session	<ul style="list-style-type: none"> • Help make learning goals explicit • Match goals to learner knowledge and interest • Identify goals that can be accomplished in the session (vs. long-term goals)
Establish relevance of session topic	<ul style="list-style-type: none"> • Identify reasons why learners might care about the new skill or knowledge
THE MIDDLE	
Overcome barriers to learning, especially regarding affective issues	<ul style="list-style-type: none"> • Allow learners to state why role-playing might be valuable • Name assumptions and barriers • Ask for discussion about why certain barriers exist (e.g. be explicit about role-plays feeling risky and explore why) • Seek learner buy-in to try method • Reiterate that the experience is valuable
Set up activity	<ul style="list-style-type: none"> • Be clear about what can learners expect and how will the process work (encourages buy-in and learner safety if they know what is going on) • Give learners not involved in the role-play specific tasks (e.g. to listen for specific cues that will help with feedback)
Involve learners in practice of specific skills	<ul style="list-style-type: none"> • Identify and address specific tasks • Have learners actually try out skills (rather than just talk about trying them)
Provide feedback	<ul style="list-style-type: none"> • Model how feedback should be given (e.g. ask learner to evaluate first, then give specifics about skills done well and those that need work) • Encourage group to give feedback • Feedback should be descriptive, non-judgmental, behavioral, focused on sharing information rather than giving advice, and limited to what the recipient can take in • Emphasize balanced and positive feedback, especially for the “doctor” player

Facilitator Goal or Task**Behavior or Observation**

THE MIDDLE (continued)	
Monitor group process and involvement	<ul style="list-style-type: none">• Provide safety for learner activity in the group• Use learner names• Use fairness when calling on learners• Attend to group nonverbals (e.g. is there anxiety? Is anyone shut down?)• Assure a balance of talking and listening activities among all learners• Encourage signs of engagement (e.g. Are the learners really working? Are they making comments that seem risky (perhaps personal)? Are they thinking on their feet? Are there “ah-ha!” moments?)
Manage group process	<ul style="list-style-type: none">• Encourage noncontributing learners• Manage dominators• Use nonjudgmental vocabulary• Be authentic in your responses and reactions• Show appreciation for insights made
Calibrate the challenge for learners	<ul style="list-style-type: none">• Be sensitive to a variety of learner needs (e.g. how can you keep folks from being bored or overwhelmed?)• Allow learners to experience some success• Learners should come to identify their own “sticking points”
Identify opportunities to explore affective issues for learners	<ul style="list-style-type: none">• Acknowledge and name affective issues that arise during clinical encounters• Gently probe learners to reflect on their own particular emotional reactions• Invite comment on what it feels like to have these conversations• Ask learners if they want to discuss emotions or barriers further
Link learning activities to pertinent literature, especially empirical research	<ul style="list-style-type: none">• Point learners to references in the course reader and other references• Strive for balance between information giving and interactive learning

Facilitator Goal or Task**Behavior or Observation**

CLOSING THE SESSION	
Summarize specific learning points	<ul style="list-style-type: none">• Ask learners to identify skills or insights gained (or you summarize)• Ask learners to identify where future learning could happen (or you suggest)
Help learners build personalized learning agendas	<ul style="list-style-type: none">• Ask learners to identify a specific new learning objective to work on.• Ask learners for a commitment to try something new from the session
Acknowledge learner work and effort	<ul style="list-style-type: none">• Voice appreciation for the work learners have done.