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What makes education in communication transformative?

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In our years of teaching communication skills, we have had our share of duds. But we have also had successes that went far beyond our expectations, interventions that had a catalytic effect on learners—leaving them changed and renewed. The medical literature has little to say about these kinds of peak learning experiences. Yet when we talk to other accomplished educators about the work that really matters to them, these are the moments they talk about.^{1,2} In our experience, these catalytic events are the kind of learning that creates physicians who plumb the humanistic aspects of their work, physicians who have a curiosity about people and a capacity to build relationships that foster healing. In fact, such learning experiences can be transformational. What can a teacher do to encourage transformational learning? In this essay we describe four essential design principles that will help create an environment in which such growth can occur.

What we mean by transformational is that learners take away more than another factoid, or even collection of skills; they leave with a new way of thinking about their work. They take on a mission, a sense of what their work should accomplish that is much larger than a shift in attitude. After one of our communication workshops, one fellow went home and tried out, in clinic, her new skills in responding to emotion. The very first patient said to her, surprised, “no doctor has ever talked to me like this”—and the experience changed how she thought of her work as an oncologist. In the workshop we had focused primarily on skills, not wanting to seem too “touchy-feely.” What we did not anticipate was that through practicing the skills, she changed her way of being a physician. As Aristotle might say, moral practice shapes our character. By walking the walk, one becomes a different person. We would say the same for communication skills: practicing empathy creates a new way of thinking about doctoring.

Our collective experience in understanding what engenders transformative education is based on two linked projects, both funded by the National Cancer Institute, Oncotalk and Oncotalk Teach. Oncotalk was a 4 day national intensive communication skills retreat for Medical Oncology fellows that ran from 2002 to 2007.³ In Oncotalk we developed a residential workshop for teaching communication skills, with a core of skills practice with simulated patients in small groups surrounded by a series of reflective experiences, both formal and informal. The outcomes we collected indicated that the Oncotalk intervention resulted in measurable changes in communication behaviors.⁴ What we did not expect is that the project changed how many of these fellows viewed their relationships with patients. They have written articles, taught other learners, and created a new social network of oncologists committed to communication as a fundamental part of their work.⁵ Oncotalk Teach is an ongoing faculty development project intended to translate the teaching practices

we identified in Oncotalk for a different teaching situation. While the teaching in Oncotalk was done in specialized workshops, most communication teaching occurs during outpatient clinic and inpatient rotations. Oncotalk Teach focuses on equipping faculty to teach communication more effectively in these real-time encounters.⁶

The fundamental distinction in Oncotalk and Oncotalk Teach is that communication involves two kinds of data: cognitive data about what the patient or trainee understands; and emotion data about what the patient or trainee is feeling.^{7,8} This distinction between cognitive and emotion data enables physicians to respond with a larger repertoire of gestures and words, and importantly, enables them to see exactly where empathy is needed and how it changes an encounter. How does this all lead to transformation? Unfortunately, we have little empirical evidence to guide us. The undeveloped state of the science in this area is what prompts us to suggest the following hypotheses.

We find that a small set of design features and teaching skills contribute to transformational learning experiences. We do not know if these features are necessary or sufficient, but we would swallow hard if we had to leave one of them out of our next teaching experience.

First, we design a learning workspace that puts the learner's practice at the center. What does this mean? Rather than focusing on teachers as knowledge ATMs from which learners make passive withdrawals, we make the learner's effort, discovery, and feedback the primary educational experience. The teacher functions mostly as a coach, or guide, watching and providing feedback on what the learner is trying to improve rather than be an encyclopedic expert with all the answers. For example, the teacher asks the trainee to set learning goals in a way that requires the learner to discover and define her own learning edge. The teacher then provides feedback to reinforce what she has accomplished (as opposed to everything that the teacher thinks she could have done better), and points her toward the next goals towards mastery.

Second, the skills practice is structured as a reflective process. What we mean by this is that reflection is not 'added on' at the end; reflective prompts are built into every step. For example, a learner's turn in the 'hot seat' is preceded by a facilitator's prompt at goal setting (eg "What makes this task difficult for you? Let's focus on that") which requires the learner to draw on past experience.(ref) During the course of a workshop, the facilitator might build subsequent goals upon the initial goals (eg "Let's take this a step beyond what you did yesterday"), adding yesterday's experience to the learner's (and the group's) bank of direct experience.

Third, the teacher engages the group as a learning community. This is a different function than coach; the teacher is acting as a facilitator. We do this by establishing a group norm about how to give feedback, and expecting the group to participate in the feedback. We judge the group to be working at a high level when group members are speaking to each other (rather than the facilitator), when they are willing to disagree respectfully, and when they take on learning as a collaborative project. While the subject of running groups is much larger than we can treat here, we want to point out that little research exists in what makes learning groups effective—yet in our experience the group work has been critical to the quality of learning that occurs. The widely taught therapeutic group process model of 'forming, storming, norming, performing' does not really fit our educational groups. Our facilitation work is more focused on engaging the learners as group members who learn, in addition to empathic skills for patients, how to treat each other with empathy.

Fourth, we consider the learner's motivation and willingness to try something new as variables that we must optimize. This factor could be called "readiness to learn," and while it sometimes involves teaching those who are ready to learn, it also involves fostering

personal change. Oncotalk recruited nationally to identify fellows willing to spend 4 days learning communication. But even before these fellows arrived at the conference, we consciously tried to heighten their motivation. A week before the conference started, the fellows received an email asking them to describe a case they would to be better at handling next time. We used those cases to give our practice sessions the flavor of the challenges they face—not to confront them with the ‘patient from hell’ but a version of that challenge in a learning situation where they could experience at least a measure of success. To be sure, even asking oncology fellows to think twice about using the term ‘patient from hell’ asks them to change in a very significant way. Their readiness to learn is critical to transformational learning.

These four design features—placing practice at the center, structuring practice as a reflective process, engaging a learning community, and optimizing readiness to learn—warrant further testing, outcome design and measurement, and refinement. What is clear is that the ways we learned about communication in medical school, from watching experts at a distance to hearing nostrums like ‘see one, do one, teach one’, don’t work. In fact, they result in a negative transformation where students believe that there is nothing they can do to promote caring encounters. The work of acquiring communication expertise is so daunting that, unsupported, students conclude that they ought to be pretty good already, and that it takes too much time.

We had to relearn how to communicate after completing our medical training. We look back on those lecturers telling us to be nicer as ineffective, maybe even counterproductive. We already knew how to be nice. What we didn’t know was how to integrate an enormous amount of biomedical expertise with the lived experiences of individual patients. For us, the transformation occurred haphazardly. We believe, however, that as educators we can do better than our predecessors. We can be more intentional, tactical, and visionary as change agents in the culture of medicine.

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