Compassionate Communication in Medicine

Facilitator Guides & Educational Materials

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UC San Diego Health

SANFORD COMPASSIONATE COMMUNICATION ACADEMY FELLOWSHIP

UC San Diego

SANFORD INSTITUTE FOR EMPATHY AND COMPASSION

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"For most of us, the path to becoming a physician is one that normalizes suffering and separates the human body from the human experience. These are coping mechanisms that allow us to go towards pain to help our patients without falling into despair. However, many of us forget where we started. We lose the ability to reengage and connect—even to speak in a way that taps into the humanity that we share with our patients. The rich experience of this fellowship is defined by the contributions of the artists who take us by the hand and lead us back, who remind us of why we chose medicine, and who show us how we can show up for our patients as humans."

— Isabel Newton MD, UC San Diego Health

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How to Use this Book

Navigating within this document

Exercises and materials are categorized by the primary principle they teach, although many exercises address more than one. For example, "Time Traveler" is a Speak Plainly exercise that also touches on active listening and perspective-taking. Click on a specific exercise (or category) on the Contents page to jump directly to that exercise within the document.

You will notice the structure of exercises includes the **title, the time recommended to facilitate, the learning objective, the exercise Set Up, Debrief and Talking Points**. This structure allows time and space to explore, and experiential learning that puts the focus on the student and the offerings they experience shared through discussion and reflection.

Each of the following should be considered part of the time needed to facilitate:

- Set up and facilitation of the exercise.
- Debrief, allowing group discussion and optional written reflection. Use the debrief suggestions as a guide but do not feel obligated to ask every question.
- Use the talking points as a method of closing the loop on the debrief discussion. Ideally, the participants will close the loop through the debrief discussion. The talking points we have included are reflective of discussions we frequently hear from our participants, so use what your participants have said to conclude that exercise before moving on to the next. If the exercise is particularly emotional, you might consider including a short 2 – 4 minutes written reflection prior to final talking points/discussion/closing the exercise.

Supplemental materials and **Role Play** characters to support some exercises are located in Appendix A.

Look for the television icon for links to demonstration videos of our most popular exercises.

Why the arts and humanities in medicine

Operating from within the T. Denny Sanford Institute for Empathy and Compassion at UC San Diego Health, the Center for Compassionate Communication utilizes techniques from the arts and humanities to improve healthcare providers' communication skills through a robust survey of empathic and compassionate principles directly related to interpersonal communication.

The arts offer a mechanism for us to step away from our daily pressures and into the realm of story, imagination, metaphor, and creativity. Through these humanistic practices, defenses are lowered, and broad lessons can be discovered. After studying these principles, providers

demonstrate increased personal awareness and professional satisfaction. These types of improvements lead to better health and wellbeing outcomes for providers and patients alike.

The exercises drawn from theater, journalism and visual arts that are described in this book have been collected from the works of well-known master teachers like Viola Spolin, Konstantin Stanislavski, etc. What makes this curriculum novel is the facilitation and application methods taught in interdisciplinary cohorts that include professionals in healthcare and the arts. Through years of trial-and-error we have learned ways of translating principles from one discipline to the next and the importance of making the lessons relevant through discussion and reflection. We continue to learn from our students and Affiliate Faculty, and welcome contributions to this living "textbook" from educators and innovators who are working in the field.

We offer this Guide as a comprehensive reference for the exercises and materials our expert facilitators use when teaching live and/or Zoom sessions.

Our story

A harrowing flight over the Rockies ended with a glass of wine, a martini and a collaborative partnership that has lasted 15 years and influenced the launch and trajectory of three institutions dedicated to innovations in communication curriculum. Authors Evonne Kaplan-Liss and Val Lantz-Gefroh, who were both impacted at a young age by healthcare crises, describe their unifying goal as sharing ways to facilitate more compassionate communications for patients and families in their most vulnerable moments.

Their story began in 2009, when they met as founding directors of the Alan Alda Center for Communicating Science at Stony Brook University. They were challenged to disrupt the status quo and create innovative tools to help physicians and scientists communicate to different audiences with empathy and clarity. They carried the mission forward and created curriculum based in the arts and humanities for the inaugural classes in the Burnett School of Medicine before coming to UC San Diego's Sanford Institute for Empathy and Compassion to train trainers and evaluate the impact of these methods.

Evonne's background as a physician, journalist, and chronic patient informed her understanding of language, message structure and the perspectives of the patient and doctor. Val's career as an actor, director and teacher influenced her ability to internalize and shape experiences that respond to the emotional needs of an audience. Together they champion the values of empathy, listening and story to change the conversation in health and science. They have traveled the world leading conferences and facilitating workshops that have been shared with thousands of scientists, business leaders, physicians, and students in hundreds of institutions.

Much of this work begins with a simple rule: "Yes, and."

"Yes, and..."

A foundational concept and philosophy drawn from improvisational theater is the rule of "Yes, and." The improviser must accept the "offer" of their scene partner and build on it so the scene moves forward for the audience. In improvisation, the rule leads to attentive listening, engagement, and connection with the scene partner(s). In medicine, the same principles apply. At times though, the rule might seem difficult if the perspective of the patient is contrary to scientific truth.

"Yes, and" doesn't mean compromising your knowledge, but rather accepting that this is the "scene" you are in. "Yes, and" can be hard to manage, and sometimes the only legitimate response is no. In many cases, just applying the rule first can shift your perspective from reaction/response and on to more active listening.

A Word on Using Role Play in Communication Training

We all use role play as a simulation training method in the medical communication field to increase learners' proficiency with communication and interpersonal skills. Role play is also used to develop authenticity, sensitivity to patient needs, self-awareness, and a reflective capacity.

Despite the multiple benefits of experiential learning, participating in a role play can cause anxiety. It can feel artificial and "fake" to some. Learners may feel exposed by the simulation and debriefing in a way that threatens their professional identity; they may feel defensive discussing their personal performance in front of others.

Because of possible resistance it is important to spend a few minutes in your session(s) upfront to address these issues, to establish buy-in, and provide learner safety. To read more about role play processes, click here.

A Word on Narrative Humility

Sayatani DasGupta states that, "narrative humility acknowledges that patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story." It asks that we examine the nature of the self, paying particular attention to two core properties of personal identity—individuality and continuity.

For a deeper dive in this topic, see Background on Narrative Humility in Appendix C.

We Welcome Your Additions

We have put this guide together as a starting point for your facilitation needs. As medical educators, we welcome your discipline-specific contributions! If you have developed a workshop that includes these or other exercises that you think would benefit the group, please reach out to Director of Communication Education Val Lantz-Gefroh, so that we can incorporate your work into this living manual. Vlantzgefroh@health.ucsd.edu.

Warm-Up Exercises

"You know, the experience of being in it is really disorienting… and you don't quite know what you're going to do. You don't know what exercises are about. You don't know where anything is going but it's not disorienting in a scary way, it's disorienting in this kind of adventurous kind of way that stimulates even greater openness of heart and mind."

—UC San Diego Physician

"Yes, and"

[Small or large group 10 – 15 min.]

"Yes, and" is a philosophy to accept the "offer" of your scene partner and build on it. In medicine, that principle might seem difficult if the perspective of the other person is contrary to scientific truth. "Yes, and" doesn't mean compromising your knowledge, but rather accepting that this is the "scene" you are in. For example, mom might be concerned about vaccinating her children with the HPV vaccine. Following the rule of "yes, and" might lead you to inquiry to better understand her concerns so you can address them from a place of compassion. "Yes, and" can be hard to manage, and sometimes the only legitimate response is no. In many cases, just applying the rule first can shift your perspective off of reaction/response and on to more active listening and inquiry.

Learning objective:

Recognize the philosophy and impact of "Yes, and" in conversation.

Set-up:

Ask participants to pair up with another person. Invite the group to define an initial topic of conversation together (Example: dogs, chocolate, summer vacation, etc.) Partners will have one minute per round to discuss the topic, and there will be three rounds. At the beginning of Round 2 and Round 3, instruct the participants to change their topic. Provide guidance as follows:

Round 1: No

Person A begins the conversation with a declarative statement about the topic. For example: "Dogs are the best pets!" Person B responds, beginning with the word "No…" For example: "No, dogs are nothing compared to cats." Person A then responds back to Person B beginning with the word "No…" and the conversation will continue for one minute with each subsequent line beginning with "No."

Round 2: Yes, but

Tell participants to change the topic. Person A begins the conversation with a declarative statement about the topic. Example: "Chocolate is the best ice cream flavor!" Person B responds, beginning with the words "Yes, *but*…" For example: "Yes, but vanilla helps cleanse the palette." Person A then responds back to Person B beginning with the words "Yes, but…" and the conversation will continue for one minute with each subsequent line beginning with "Yes, but."

Round 3: Yes, and

Tell participants to change the topic. Person A begins the conversation with a declarative statement about the topic. Example: "Summer is the best season because it is when I can spend time with my family!" Person B responds, beginning with the words "Yes, *and*..." For example: "Yes, and I also find ways to give myself permission to relax." Person A then responds back to Person B beginning with the words "Yes, and..." and the conversation will continue for one minute with each subsequent line beginning with "Yes, and."

Debrief:

- What was the most engaging of the three conversations you just had? Why?
- What was the difference between "No" and "Yes, but?" "No" and "Yes, and?"
- When you are engaged in conversation with someone you like, which philosophical approach do you typically take?
- When you are in a difficult conversation, which is your default approach?

Talking Points:

Often our default in difficult conversations is either "No," or "Yes, but." Sometimes the only answer is no – and you probably can feel when that is true. Often though, our default of "yes, but" might seem like listening, but often that "yes" before the "but" is just for appearance, or to not seem overtly like you are saying "no." The improvisation rule and philosophy of "yes, and" is intended to *move the scene forward*. It requires you to listen deeply and expand, even in moments that you might not necessarily agree.

Imagine a vaccine resistant parent saying, "I'm not sure the COVID vaccine is right for my child." Your impulse might be, "No, you are wrong." Or "Yes, but the science says the vaccines are safe." Both are true and essentially say the same thing but negate the feelings behind that hesitancy. Another option is: "Yes, I know you want what's best for your child. As a parent I chose to vaccinate my kids based on the evidence and I see the benefits first hand. What questions can I answer for you to help you with this decision." "Yes, and" invites openness, narrative humility, and connection. It isn't always the answer – but often, it can lead you to a more connected path of listening and communication.

Watch the facilitation demo: https://youtu.be/eAkITYmmoBI

Clown Bow ("Ta DA!")

[10 min.]

Learning Objective:

Establish playfulness within the group to break down barriers and tensions. Recognize and practice the value of letting go of mistakes.

Setup:

Participants work in pairs (person A and B), facing one another.

Part 1:

The goal of the exercise is to alternate counting to three as quickly as possible, over and over without stopping. (For example, Person A says "one," Person B says "two," person A says "three," person B says "one," etc.). If at any point, someone makes a mistake (speaking at the same time, saying the wrong number, stumbling over your word, etc.), both partners must throw their arms above their heads and shout an enthusiastic *"Ta DA!"* Once Ta DA is shouted, partners immediately return to the goal of counting again. Let this happen for about 20 seconds until most groups have experienced "Ta DA" at least once.

Part 2:

Stop the group and introduce a new rule. This time the number "two" has been replaced with a clap. One, clap, three, one, clap, three, etc. If partners are slowing down to be perfect, call out to the group to speed up – push each other. "Side-coach" away from excuses or apologies over mistakes and reinforce Ta DA as the tool to begin again. When participants have had at least two or three "Ta DAs," set up Part 3.

To see side-coaching in action, click the Mirror video for an example.

Part 3:

The rules are still the same, except this time the number "three" has been replaced by a stomp: "one, clap, stomp, one, clap, stomp, etc.). Remind participants not to slow down, and watch out for the excuses/apologies. Let this go for a while until you feel like even the perfectionists in the group have given over to the silliness.

Questions for Debrief:

1. What did you need to do to be successful in this exercise?
2. How did it feel to make a mistake?
3. What is the purpose of "Ta DA"?
4. What happened to your energy level because of "Ta DA"?

Talking Points:

Making mistakes is unavoidable, but we can control how we react to them. In this exercise, you were asked to celebrate your communication mistakes, which allowed you and your partner to move on to accomplish the real goal. Shouting “Ta DA” after making a mistake is not something you can do in life, but accepting that the mistake has happened and moving forward *is* something you can do! In essence, you are saying “yes, and” to your mistakes, and thereby creating space to move forward. This can be helpful to learn to take yourself less seriously and forgive simple blunders.

 Watch the facilitation demo: https://youtu.be/dA5RkSCq7bk

18 Seconds

[15 min.]

Learning Objective:

Recognize the time it takes to tell and listen to an important event.

Setup:

- Participants work in pairs (person A and B), facing one another.
- Instruct both participants to identify a recent event that they feel comfortable sharing with their partner that was upsetting or frustrating in some way. Person A speaks first and Person B only listens (no clarifying questions or statements of empathy).
- (Facilitator will privately time this interaction for about 60-90 seconds, and gently announce to the group that we will switch roles).
- Person B speaks now and Person A only listens (again - no clarifying questions, etc.)
- Facilitator privately times interaction and cuts group off at 18 seconds. Group will likely protest this quick cut-off, which will lead you to debriefing why they are upset.

Questions for Debrief:

- What happened? Why are you upset?
- The second group felt cheated of time - how did the first group feel?
- First group - did you feel like you got a relatively full understanding of the problem your partner was communicating?
- Second group - did you feel like you got a relatively full understanding of the problem your partner was communicating?
- Generally speaking, the second group was not able to express themselves and their listeners didn't feel informed. How long do you think the first group was given to speak vs. the second group?
- Depending on the energy in the room, you might consider allowing the second group to complete their story before moving on to Talking Points.

Talking Points:

Research shows that the average time it takes for a physician to interrupt their patient is 11- 18 seconds, but if you allow your patient to continue telling their story, on average that story will begin to resolve in 60 - 90 seconds. One of the reasons physicians give for a lack of compassion is "I don't have time."* What did you gain in the extra seconds listening to the first story that was lost in the second story? Beyond the time to hear the fuller story, what else is established?

**Source: Compassionomics*

Watch the facilitation demo: https://youtu.be/pJOxjpM4oWA

Switch

[10 - 15 min.]

Learning Objective:

Recognize common ground that is spoken and unspoken to build connection.

Setup:

- This is a group activity—participants are seated in a circle with one person in the center. There should be one chair less than the number of participants.
- Center participant will ask a question of the group using an example of something visual that the group might have in common. For example: If you are wearing jeans, switch.
- Following the question, anyone wearing jeans will switch to another chair. In the act of switching chairs, the center person will (hopefully!) grab an empty seat leaving a new participant in the center. Repeat for several rounds of common ground that is visually evident.
- As the group begins to warm up, ask that the questions become about something not visually evident. Examples: If you come from a large family, switch. If you are afraid of heights, switch. If you love coffee, switch. Etc.
- Facilitator can encourage the questions to become more substantive. Can you ask a question that addresses fear? Can you ask a question that addresses hope? Can you ask a question that addresses values? Etc.
- Depending on how the group is responding, consider adding a couple final rounds by taking another chair away and leaving 2 people in the center. These 2 players will create the question one word at a time, so neither player will know what question will emerge. Example: (A) If... (B) You... (A) Have... (B) Any... (A) Plans... (B) To... (A) Eat... (B) Pizza... (A) Tonight... (B) Switch!
- The act of asking these final questions will add both heightened listening from the center players and the group, and if the more substantive questions have led the game down a vulnerable path, these final rounds will likely add levity.

Questions for Debrief:

- What surprised you in this exercise?
- What did you notice about common ground in this group?
- If you chose to share your vulnerability in this exercise, what enabled that choice?

Talking Points:

Our views and perspectives are the result of experience and allowing those common intersections to be recognized can help us move the conversation forward. Listen for common ground, which might be vulnerable and not immediately visible. This is a metaphoric "yes, and" to a respectful relationship.

Variations:

Depending on the expressiveness of the group, you can use pre-planned questions on sheets of paper set in the center of the circle that are relevant to the group. These sheets should be a combination of statements that are funny and personal. For a women's conference, for example, sheets might say "if you have ever come to a meeting with baby vomit on your shirt, switch" or "if you have ever worn two different socks, switch" all the way to "if you have ever been sexually harassed, switch" or "if you have been overlooked for promotion, switch." The idea with this round is to create a space where participants can admit to more vulnerability without having to verbalize it personally.

Observation & Listening Exercises

"…and what art does, it is a shortcut, you know it just…it allows me to be like, 'Alright, you think this way. Take your brain and twist it around. Let's look in this direction.' And soon we're all on the same page."

—UC San Diego Physician

Mirror

[20 min.]

Learning Objectives:

Understand the value of listening and the role of collaborative leadership. Practice skills in heightened awareness.

Setup & Facilitation:

- Participants work in pairs (person A and B). Person A will move and Person B will mirror these movements. Suggest that participants do not have to do typical "mirror" activities, they may simply move around. The goal is to stay together and do all of this silently.
- Allow Person A to lead for a few seconds and then announce that Person B will lead.
- Stop the exercise and ask one group to demonstrate for the full class with Person B leading. (Make sure the full group doesn't know who Person B is.)
- After they demonstrate for a few seconds, see if the class can identify the leader. Ask participants how they could tell who was leading. (Typical answers are a delay in timing, the movement was only logical to the leader, the follower was glued to the leader, but the leader wasn't as focused on the follower.)
- Ask Person B to make some adjustments in pace, logic and focus so observers can't tell they are leading. Slow down. Be logical. Most importantly put your attention on the follower. "If they are behind, it's not their fault; it's your responsibility." The demo this time will be significantly more focused. Feel free to side-coach if needed: "slow down," "pay attention," "is she with you?" etc.
- Ask the full group to repeat the exercise, but this time to make sure the focus is on their partner, slowing down and being logical in their movements. Side-coach them by encouraging them to be responsible-it's not about being complicated or clever; it's just about being clear, specific and responsible enough for your partner to stay with you.
- Announce a change in who leads several times. Following the demonstration, the partners usually get together with a great deal more focus and ease. Side-coach for them to work out any jitters and really work to be responsible for each other.
- Once focus is firmly established in the room, instruct that both partners are to lead and both to follow. This part of the exercise will often begin with a great deal of discomfort (laughter, goofiness, etc.). Side-coach to dare to let go-to allow whatever happens between them to happen.
- As the exercise goes on, and the initial awkwardness is acknowledged, a calm will usually fall over the group, as they become physically invested in their partnership. After the exercise, participants often feel very connected and want to talk to each other. See if you can take this impulse into a full group discussion.

Questions for Debrief:

- What is the value of this exercise?
- What did you learn about leading?
- When you were asked to both lead and both follow, what happened?
- How long did it take you to establish a connection with your partner?

Talking Points:

The truth of good communication exists in connection. When you were the leader of this exercise, your main goal was to move slowly, logically and specifically enough so that your partner could stay with you. If your partner couldn't keep up, your job was to make an adjustment so he or she could follow. When you're in a communication and place your focus on the listener(s) as you did in the mirror exercise, you will learn what they need to hear, recognize when you've lost them and be more likely to be able to guide them back to a place of understanding. It is equally important in this exercise to know when to follow—and how to come to a point of connection where leading and following ceases to matter.

Watch the facilitation demo: https://youtu.be/zbfzYF4IDo4

Dr. Know It All

[15 - 20 min.]

Learning Objectives:

Improve skill in listening, focus, collaboration, verbal agility, spontaneous thinking.

Setup:

- Line up participants in groups of three to six players.
- Players link arms. Each linked group will become a "Dr. Know-it-All." (People come from far and wide to hear Dr. Know-It-All speak because s/he is famously never wrong.)
- Ask each group to think of two questions (one from every day and one from science/medicine).
- To answer, each Doctor group will speak one word at a time, creating sentences as one entity. The group will bow together to indicate when they collectively feel they are finished speaking. (No discussion, such as "are we done?")
- The goal is for the speaking to become seamless as if it's coming from one mind. As improvisation guru Viola Spolin says, "Aim for one story, one voice."
- Side coach that the speaking "Doctor" connect with the group that has asked the question. Keep it fluid, like one person - not a robot answering!

Questions for Debrief:

- When was the answering or telling smooth?
- When was it disjointed? Why?

Talking Points:

- You had to work together to develop a reasonable, true answer or "yes, and" and adjust on the fly.
- Honing your listening skills is key, and it's important in any communication to be flexible enough to change your direction if something comes out of left field.

Watch the facilitation demo: https://youtu.be/sWLJKFtKbWs

Proverbs

[5 min.]

Learning Objectives:

Practice listening and the rule of "yes, and."

Setup:

- Participants stand in a circle.
- With only one person speaking at a time, build a "proverb," word by word.
- You can have people speak their word going one direction around the circle, or have people randomly offer a word as the inspiration grabs them. In that case, there's no signal for when it's your turn to talk, you just must sense when there's an opening. Your word should fit with what's come before.
- When the group senses that the proverb has been concluded, everyone should touch fingertips together five times and say wisely, "yes, yes, yes, yes, yes." It is helpful to practice the ending "yes, yes, yes, yes, yes" before the first proverb begins.
- Facilitator might begin the first proverb with the word, "Sometimes..."
- Create several proverbs.

Questions for Debrief:

Allow the proverb to be its own debrief. It is a closing activity.

Watch the facilitation demo: https://youtu.be/asQkx0qL1yI

Castle

[20 - 30 min.]

Learning Objectives:

Practice describing complex information with clear and vivid language. Appreciate the perspective of the listener.

Setup:

- Participants divide into groups of three or four.
- Each group will have one speaker and two (or three) who draw, with drawers facing the speaker.
- Give those who draw a blank sheet of paper and a pencil. Give the speaker a picture of a castle hidden in a folder so others can't see what the speaker sees.
- Within the group, nobody should be able to see anyone else's drawing or the picture.
- The speaker should describe the castle as vividly as possible while those drawing attempt to replicate the picture being described.
- After the initial minute of description, those drawing can ask questions and engage in conversation. Allow 3 - 4 minutes to describe and draw.
- After drawing time, let the speaker reveal the castle picture to the drawers and let the drawers see each other's pictures.

Debrief:

- Are the drawings at all like the picture of the castle?
- What's missing from the drawings and why?
- Are the drawings similar to each other?
- What was helpful to you in your speaker's description? What was confusing?

Talking Points:

Even in hearing you were going to draw a castle, an image immediately sprang to mind that the speaker was working against. We walk into every communication with our own preconceived notions—and curse of knowledge—and for that reason, no two people are going to hear things the same way. Think about what helped those drawing "see" the castle more clearly—was it a certain word? An analogy? Visual language? Starting out with the big picture and getting to the details later? This exercise can support our Speaking Plainly principles by practicing getting your main point to the top with clear, vivid language so your listener can quickly appreciate your message. While this is complicated with a castle, it becomes even more complex when emotional words are being explained—like cancer, or vaccines, or climate change.

Relationship Snapshot

[20 min.]

Learning Objectives:

Appreciate the impact of body language and hierarchy in the relationship.

Setup:

- Participants divide into groups of three.
- Instruct that participants will silently come up with a pose that describes the relationship suggested by the facilitator.
- Once the group has silently agreed on the pose, they should freeze. (this should take only seconds to determine).
- When all groups are frozen, facilitator will clap, signaling a "snapshot" has been taken.
- If participants are confused initially by these directions, run one round as an example.
- After several relationships have been "photographed" invite participants to physically describe a new relationship, and when they hear the clap to unfreeze and begin speaking in the scene. Suggested two rounds of scenes that unfreeze/speak.

Suggested Relationships:

A reunion of old friends; a disgruntled boss and overworked employee; wife reveals that she is having a baby; the loss of a parent; little brother has a secret; betrayal of siblings; colleagues win the lottery.

Debrief:

- How did you know who you were in the relationship when you weren't able to talk?
- How did you know what to say once language was introduced?
- How did you decide who was who without talking?
- When there was a high/low status in the relationship, which status initiated the pose?

Talking Points:

Your body in relation to another person tells an enormous story. Never discount the importance of the physical relationship when you are talking. Your body tells a story that everyone can feel. You and your partner become that relationship even without language. It's often the one thing we take for granted, but it can be the most important consideration, particularly when going into a difficult or hierarchical relationship. Remember Albert Mehrabian's research that determines how we establish trust in the first 2 minutes of an encounter - 55% body language, 38% tone of voice, 7% content.

Watch the facilitation demo: https://youtu.be/R8FeAB3haZE

Visual Thinking Strategies

[20 - 40 min.]

Background:

Developed by cognitive psychologist Abigail Housen and museum educator Philip Yenawine. Visual Thinking Strategies (VTS) is much more than an art curriculum; as a facilitation method and professional development program that fosters collaborative, inclusive, community-building dialogue, VTS has the power to change the way we relate to one another as teachers, students, and colleagues. For over 30 years, VTS has fostered reflective communities of practice in educational environments including classrooms, museums, and hospitals around the world. VTS is uniquely suited to support educators as they rise to meet the challenges and opportunities of a 21st century education. There are many resources online – we've included a couple below:

https://vtshome.org/

https://www.gvsu.edu/artgallery/visual-thinking-strategies-152.htm

This exercise is an opportunity to practice observation, inference, listening, perspective-taking and communication. We will utilize the reflective work of VTS to listen deeply to our internal voice and reactions, as well as to listen deeply to our colleagues. For this workshop you can use pieces from any artist. Some of our favorites are by Dana Schutz including "Gravity Fanatic" and "Presentation." You can also use "The Doctor" by Luke Fildes. You might choose to start with a piece of artwork, and then carry the same series of questions into a role play – or a more realistic photograph of a medical scenario.

Gravity Fanatic

Presentation

The Doctor

Learning Objective:

Practice skills in heightened awareness by applying the principles of Visual Thinking Strategies (VST) to observe a work of art.

Setup & Facilitation:

- Project your chosen work of art and invite participants to silently observe that work for up to 2 minutes.
- Once observation time is complete, invite one person to describe their observation by asking three simple questions:
  - What is going on in this picture?
  - What do you see that makes you say that?
  - What more do you see?
- Ask several participants the same three questions and recognize how the story changes/emerges.
- You may choose to discuss how this process impacted initial decisions about the image.
- You may choose to change the piece of artwork and share a realistic photo of a medical scene, using the same three questions.
- To further the application of these skills, consider adding time for the subsequent suggested role play activity.

Roleplay in Groups of 3 for Visual Thinking Strategies

[30+ min.]

VTS has the power to change the way we relate to one another as teachers, students, and colleagues. Let's use a Role Play in 3s to demonstrate this.

If you are new to facilitating role plays, refer to 'A Guide to using Role Play in Communication Training' at the front of this document.]

Learning Objective:

Practice skills in heightened awareness by applying the principles of Visual Thinking Strategies (VST) to a role play.

Setup & Facilitation:

- Participants work in groups of 3 (person A, B and C). See diagram for rotation:

Roleplay in 3's

Choose person A, B and C

Round 1
Person A – Character
Person B – Healthcare provider
Person C – Observer who will provide simple feedback

Round 2
Person B – Character
Person C – Healthcare provider
Person A – Observer who will provide simple feedback

Round 3
Person C – Character
Person A – Healthcare provider
Person B – Observer who will provide simple feedback

- Hand out one Who/What/Why character chart to each person in the group. With multiple groups, you can use the same 3 characters for easier debrief.
- Allow participants to read their character chart for a minute or so.

- Rotate through Rounds 1, 2 and 3 so all participants have an opportunity to play a character, a healthcare provider and an observer.
- Allow about 2-3 minutes per roleplay. Following each round, allow the observer to feedback for 5-10 minutes with the "actors" in the scene that has just played.
- Feedback should begin with a simple question to the healthcare provider character: What went well?
- Following feedback can include the same VTS questions turned into observation statements: This is what I saw happening. These are the things I observed that made me say that. These are other things I observed.
- Between each round, allow the next character to quickly review their character chart before announcing the beginning of the roleplay

Questions for Group Debrief:

- What did you gain as a player? An observer?
- What are some things you noticed from doing this exercise after VTS?
- How might you take this level of observation into your week?

The following three pages contain suggested Who, What, Why cases.

Cases for role play are written in a variety of formats. We like this format, as it is drawn from theater guru Konstantin Stanislavski's method and promotes a deep and quick understanding of the characters' circumstances that drive their behavior. In just looking at their own role, participants are forced to respond spontaneously, rather than pre-plan the feelings or reactions. This process is simple – and sometimes scary – but it leads the players to great discovery quickly because they have focused on justifying what their character needs and why. In other words, this process is a pathway to empathy.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Suzanne

Who: I'm Suzanne, a working mother with two young children and a widowed father who lives with us. I work two jobs—I cut hair most days at a salon in town and then on the weekends I have a small cleaning business that I run. I don't have insurance because I can't afford it.

What: Get answers about everything going on—my breast, my fear, my kid… I can't afford any of this right now.

Why: I found a lump on my breast, but I think it might just be a cyst and I can't afford a mammogram. My neighbor is a breast cancer survivor and insisted that I come in to get checked, but I can't really pay for anything beyond this visit right now. She's got me worried, which is annoying because I tend to get cysts and I think this is going to go away. I've had it for about a month, so it's more stubborn than most—but I think if you could just give me an antibiotic or something then maybe it will clear up. I've also got problems with my digestion; seem to be having a lot of diarrhea lately and then I take Imodium and then I get constipated. I'd love to get that sorted out too while I'm here. And one of my kids has this weird tic going on—can you let me know what to do about that? I want to get my neighbor's worry out of my head—I don't have time to worry.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Shaun

Who: I'm Shaun, I am a 62-year-old retired university administrator, just lost my wife to breast cancer; I have moved to San Diego to be with my daughter Alicia and care for my 9-year-old granddaughter as my daughter works full-time and really needs my help.

What: I need to decide what to do about my weight.

Why: I have always been heavy, and nothing I have ever done has helped me lose weight. I fact, it is getting worse, and my doctor tells me my "BMI" is too high, and I am a "ticking time bomb". In the last 2 years he has added medication for high blood pressure, high cholesterol and something for early diabetes. I'm always tired and he told me to talk to a new doctor right away about surgery to lose weight after my move to San Diego. I don't know how I am going to tell my daughter I need surgery when I am moving to help her because she needs me. I am also fearful of any surgery, as my mother died on the operation table for surgery for her uterus. I don't want to be pushed into making a decision, and I will have to check out this new doctor to see if I even want to listen to what he has to say.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Elise

Who: I'm Elise and my pronouns are she, her, hers. I'm a college graduate, but not really working in my field, which is art history. I've been making money in our family business, Harmony – we sell CBD products.

What: I've been really depressed and think I need help but I don't know where to turn.

Why: I'm so confused. I've been taking hormones for 6 months now to transition to a woman– but what I think I'm realizing is that I'm not a woman, but a gay man. I've fallen in love with my best friend, Tim, and he is encouraging me to get help before it's too late. I was really bullied as a kid – like in the worst ways – and my mom especially has always been very nurturing – but I've got PTSD about middle school for sure. My family has been supportive of all my treatments both emotionally and financially and I've enjoyed the prospect of my transition, but honestly, I'm having so many doubts - this week especially. I don't know if this is real, or if it's the hormones. I thought I was clear in my decision, but now I just don't know. It's making me really depressed. I don't want to go further down this path if it's the wrong choice. I'm scared.

Connecting Exercises

"I've just been in a much happier place seeing all these patients and, in such a short amount of time, and…just really trying to find joy in the interactions."

—UC San Diego Physician

The Many "Who's" I Am

[10 min.]

Learning Objective:

Identify the facets of yourself that can build common ground with your listener.

Setup:

- Work in partners (A and B)
- For one minute Person A will tell their partner as many facets of "who" they are with a very simple statement: I am _____, I am_____, I am_____, etc. This list can include "who" they are in relationships, personality, in the moment, etc.
- Model for participants: "I am Val. I am a teacher. I am an actor. I am a director. I am a mother. I am a wife. I am a sister of a cancer victim. I am the daughter of a cancer victim. I am a dog owner. I am stubborn. I am bossy. I am overly sensitive. I am a photographer. I am a student. I am hungry. I am 57!" Etc.
- Participants should not elaborate - just state the "who" simply with the statement I am ____. They need to fill one minute while their partner listens.
- Switch and have Person B speak while Person A listens.

Questions for Debrief:

- What did you learn about yourself in saying all of these "who's?"
- Did you find "who's" in common with your partner that you hadn't realized?
- What is the value of recognizing your "who's?"

Talking Points:

We define ourselves in multiple ways, but when we communicate we tend to only draw on one of our "who's" and forget that there are many aspects of our personhood available to connect with others. If you are talking about medicine with a group of colleagues, mentors or faculty, you probably should choose to speak as a physician—although at the same time, you've also been a patient and caregiver: other "who's" that can build bridges of connection, understanding and compassion. These other "who's" will expand your choices and authentically change the way you are talking, your body language, and your tone of voice.

Watch the facilitation demo: https://youtu.be/A3tbAQAIUcU

Story of Your Name

[Large Group | 40 - 75 min. based on group size]

While names are simply a fact about us, they often hold personal meaning. This exercise is intended to help participants reflect on that meaning and consider how their name relates to their identity. Secondarily, in listening deeply to others' stories we build fodder for connection and space for curiosity.

Learning Objective:

Reflect on personal identity to share with a group.

Setup:

- Ask participants to spend four to five minutes writing the story of their name. Be sure to let them know that these writings will be shared with the group. Encourage them to use pen and paper if they have it, otherwise typing on a device is fine.
- After the time is up everyone will share. Make explicit that preamble to their writing is not allowed; participants are to simply read exactly what they've written on the page.
- If conducting this exercise in person, hold comments until the end. If on zoom, you can encourage those listening participants to react via chat or Zoom reactions after each person has read.
- Move through the participants asking that each share their writing verbatim (again, NO PRE- or POST-AMBLE).
- After everyone has gone, use the debrief questions to facilitate discussion.

Questions for Debrief:

- What was this experience like to write and share?
- What did you discover as you listened?
- Did you feel as though the message you wrote and read was the message you wanted to convey to the group?
- Were you nervous while anticipating your turn? Did that make it more challenging to listen?
- Did you think of additional things you might say about your name or other ways you may have communicated the information as we heard others?
- When it comes to communication that helps build trusting relationships, how are stories, identities, and personalities important?

Talking Points:

- Names can be deeply personal, revealing our histories and aspects of our identity. It can be vulnerable to share personal things with a group of strangers—particularly if there are power dynamics at play.
- Listening can be difficult when our thoughts are racing; it takes intentional effort to quiet one's thoughts and lean deeply into listening.

Time Traveler

[20 min.]

Learning Objectives:

Recognize the perspective of someone from a different life experience to speak at an audience-appropriate level. Practice the uses of analogy and effective ordering of information.

Setup (Part 1):

Working in pairs – person A is a time traveler from 300 years ago and person B is from today. Person B is expecting an important call on their cell phone and needs to explain what a cellphone does so when it rings the time traveler doesn't think the speaker is a witch. With all groups working at the same time, let the partners talk for two minutes and then debrief.

Questions for Debrief (Part 1):

- Poll the time travelers: How many of you were talking to a witch?
- Poll a few of these people—what did they say that made you think they were supernatural?
- Talk to those who didn't think their partners were a witch. What did they do or say that made you understand? What analogies did they use? Body language?

Setup (Part 2):

Switch so the opposite person is now the time traveler. This time, the time traveler seems to have broken their finger and the person from today needs to convince them to put their finger into an X-ray machine. Remind them to think about what worked from round one – what are analogies you can use? How can you help this person understand by building on their knowledge? Again, with all groups working at the same time, let them talk for 2 minutes before you poll the time travelers.

Questions for Debrief (Part 2):

- How many of you were willing to put your finger into the X-ray machine?
- What did they say to help you?
- What analogies were used?
- What was different about the body language of the speaker describing the cell phone from the speaker describing the X-ray machine?

Talking Points:

Typically, the last question stumps them. They won't have considered body language here. Watch to make sure this happens, but almost always in the second round the speaker will lean in and use a much more compassionate tone of voice—so in round 2 there are fewer perceived "witches" and more willingness to comply—even when pain is involved. If you haven't already referenced Albert Mehrabian's research on body language/trust, do so here: body language accounts for 55%, tone of voice accounts for 38 % and content only accounts for 7% of what we believe and trust in the first 2 minutes of an encounter.

Watch the facilitation demo: https://youtu.be/DILBKZLlUfw

Addressing Emotion Exercises

"…the exercise really hit home for me–the importance of like, well, what is the root why they're upset or complaining? And if you can think about where it is they're coming from, the root or the positive piece, actually, that they care about, or that they love… that's where you can make really meaningful connections, and deepen the relationship in a way that shows compassion."

—UC San Diego Physician

Two-Minute Rant

[20 - 40 min. depending on group size]

This session builds discussion and provides practice around communicating in an emotionally charged situation. Our work in active listening helps inform the message we share and practice holding space in the face of others' suffering. Topics include managing clinician and patient emotion in medical encounters, recognizing emotional cues and application of emotional regulation. In addition, we discuss difficult conversations in clinical encounters, followed by roleplays based on individual learning goals. This exercise targets the importance of allowing and understanding our own emotions and behaviors, as well as those that play out among teams, patients, and families.

Learning Objectives:

Recognize the values that lie underneath an emotional outburst. Model deep listening skills to move forward in a conversation.

Setup:

- Participants work in pairs. Ask each to think of something that is upsetting or frustrating that they have been thinking about recently! The topic needs to be important—not a trivial issue like the taste of light beer or someone's lousy driving.
- Instruct person A to rant about this topic as their partner listens. Encourage the speaker to really let it loose as they would with a friend. Person B just listens—this is not a conversation, it is a rant.
- After Person A has spoken for 90 seconds to two minutes, switch with person B ranting and person A just listening.
- After both A and B have ranted, invite participants into a circle. Have each person think about the rant they heard from their partner.
- Instruct participants to introduce their partner based on what they learned from this rant, beginning with the line "I'd like you to meet my friend, _____." They must relay what they heard only in positive terms. Example: If I ranted for two minutes about how angry I am at my son's baseball coach for unfair playing time in the last tournament, my partner might introduce me by saying, "I'd like you to meet my friend, Val. What I learned about Val is how much she loves her son. She has watched him grow into a really capable young man and admires how much he is able to accomplish as an athlete…." etc.
- Side-coach them so the rant doesn't underscore the introduction. Example to side-coach away from in introduction to Val "… how much he is able to accomplish as an athlete by overcoming the prejudices of coaches that judge him based on his size and not his ability."
- If at any point you as the facilitator hear the rant, nudge them to dig deeper. Ask questions, like "What kind of a person feels that way?" or "What did you learn about this person that they didn't say?"

Questions for Debrief:

- How did you feel about the other person when you were introduced in positive terms?
- What happened to all the anger you felt while you ranted?
- Why introduce your partner with the line "I'd like you to meet my friend_____?"
- Was it hard to continue ranting for that long when your partner was really listening?

Talking Points:

Negative energy comes from the loss of something the person loves or cares about deeply. Peeking under an emotional outburst to recognize the good that's driving the person can get you closer to compassionate understanding. When the other feels heard, the rant can subside and the scene can move forward. When you are being challenged, listen deeply, address the value, and see what can move forward. This is very hard and takes tremendous practice.

Example: Think of someone with whom you feel you have no common ground, perhaps a parent who won't vaccinate his or her child. What is their driving force? They love their child and want to protect them. By acknowledging their value first, you can begin to build trust which is a game-changer in moving the conversation forward. It will also change you, by helping you learn not what you want to say, but what the other person is prepared to hear.

Suggested 5-Minute Reflective Writing

[5 min]

Learning Objective:

Using the two-minute rant, apply lessons of deep listening skills on a personal interaction.

Setup:

Suggest participants write in a notebook or on their computer. Lead them through a simple centering exercise. Example language: We've been working on deep listening and considering what lies underneath emotional expression. While we can't predict or control feelings, we can practice recognizing and naming values that underscore those feelings, leading to our own expanded perspective. Think of an interaction that didn't go well recently. Try to choose something that you can begin to look at objectively. Allow yourself to step into that moment, and the feelings that you had at that time. Some things were said that hurt; maybe some of those feelings are still unresolved. Take a breath and step away from the rant. Consider what was underneath that rant. In writing, practice introducing the values of the other person. Begin with the words, "I'd like you to meet my friend, _____."

Allow up to 5 minutes of writing. Discuss as a group what was discovered. Sometimes this is quite emotional.

Watch the facilitation demo: https://youtu.be/p3ULvuYFm94

Emotion in the Clinical Space

[This segment, devised by Gita Mehta MD, represents a two-hour workshop that includes activities I, II and III]

In this session we explore the role of emotion in the medical encounter. We address both how to approach patients' expressions of emotion, and how to manage our own emotion in a clinical encounter. Perceiving and responding to a person's emotional cues is considered an essential component of providing compassionate care.

I. Exercise: Recognize Non-verbal Expressions of Emotions

[30 min.]

Goal:

Improve skill in naming emotions, and recognizing non-verbal expressions of emotion, which may not be congruent with verbal statements.

Learning Objective:

Understand non-verbal sharing of expressions of emotion in clinical encounters you have experienced or witnessed. Open discussion on naming the emotion and difficulty in accurate reading—practice naming the emotion.

Set-up:

- This is a group activity—participants are seated in a circle.
- Each participant is invited to think about a patient interaction where that emotion was present (in either the patient or themselves).
- Participant will express this emotion through body language and non-verbal clues.
- Members of the audience will name the emotion, followed by a verbal description of the clinical scenario by the participant.
- Facilitator can begin with a demo.
- Debrief of exercise is a group discussion on naming emotion and difficulty in accurately reading non-verbal expression.

Debrief:

Group discussion on naming emotion and difficulty in accurately reading non-verbal expression.

Variations:

1. May use the Emotion Wheel to get more depth in recognizing the emotion.
2. Pair up participants to think of clinical interactions with high emotion, and then one of the pair will share a non-verbal expression of the scenario as above.

Concepts for Didactic Presentation

Most of our exercises lean on robust interactivity over didactics. However, depending on your students you might choose to provide some background prior to engaging in more interactive work. Here are some suggestions:

Emotion in the Medical Encounter

Cognition and emotion are inseparable. The two mix in every encounter with every patient.

Medical interactions can never be truly emotionless. Even if a doctor has a purely biomedical agenda or a patient only wants to know about the technical aspects of their diagnosis or treatment, they will still be feeling underlying emotion that leaks out in their verbal or nonverbal behavior.

And even if on the surface what is being said does not appear to be emotional in nature, patients and doctors bring with them past experiences in medical interactions and in their personal lives that may impact how they feel, what they say, and how they behave.

Emotions serve an evolutionary purpose – each primary emotion triggers us to act or behave in a way that furthers our survival.

Clinicians often fail to recognize the emotional driver underpinning patients' questions and, therefore, answer questions cognitively rather than considering how those questions have emotional resonance for the patient.

For patients, emotions have a powerful effect on well-being, health and disease progression; sharing emotions leads to therapeutic benefits to patients, reduces anxiety, depression, and confusion, and contributes to physical symptom improvement. Not responding appropriately to emotion cues is also associated with decreased patient recall of educational information in the visit.

Learning about emotions benefits not only patients and their ability to cope, connect, learn medical information and heal; but also aids physicians in terms of career longevity by potentially reducing the already high rates of burnout, depression, and suicide.

Usually, emotional issues are not explicitly expressed because of several factors—clinicians' attitudes, gender, patients' personality, culture, life experiences, severity and type of medical illness, etc. Patients may consider emotional aspects private. Emotion can be expressed in subtle ways by a patient, or may be only one-sided by the patient.

Emotional Cues

A cue is an action (also a few words) or event that is a signal for somebody to do something.

The term 'cue' points to communication process rather than content, in that a cue is a signal from the patient to the clinician, directing the clinician's attention to something.

Emotional cues are clinical opportunities for clinicians to provide compassionate care and build the patient's ability to cope and heal. Foundational skills of deep listening, empathic understanding of the person's perspective and suffering lead to therapeutic benefits for patients.

Emotion cues can differ in terms of their valence – i.e., the pleasantness or unpleasantness of an emotional stimulus:

Positive valence are cues with a subjective feeling of pleasantness or intention to convey positive information.

Negative valence are cues that carry a subjective feeling of unpleasantness, or intention to convey negative information.

The dimension of arousal refers to a subjective state of feeling "activated" or "deactivated." In this way, emotion cues can be positive high arousal, positive low arousal, negative high arousal, and negative low arousal. Though high arousal and negative cues are easily noticeable during a medical interaction, all emotion cues being expressed by the patient should be addressed to achieve optimal medical interaction outcomes such as accurate diagnoses, appropriate treatment plans, patient satisfaction, and a quality patient–provider relationship.

II. Exercise: Group Case Discussion

[30 min.]

Setup:

Breakout groups of three. Give participants a few minutes to read and reflect on the case before opening to discussion.

Case:

You are an oncologist seeing a patient with newly diagnosed metastatic (Stage IV) pancreatic cancer.

This is your first meeting, and the purpose is to establish care and discuss treatment options. You lay out the details of the currently recommended chemotherapy regimen, including details of the dosing regimen, likelihood of side effects, statistics regarding disease progression and control, citing clinical evidence for the most recent advances in care.

The patient quietly asks you "How much time do I have?" and looks like she is about to cry. You feel your hands getting sweaty, and your heart beating faster. You feel the overwhelming urge to reassure her, make her less sad and scared. You have survival statistics memorized for each stage (you just took the boards), but instead what pops out of your mouth is, "I don't have a crystal ball, everyone is different. I have a lot of patients who do really well"!

Group Discussion:

- What do you make of the patient's emotion cue?
- How would you have explored the emotion you heard?
- What statements/questions could have addressed the patient's underlying question?

III. Exercise: Role Play Case

[40 min.]

Objective:

Practice listening and responding to a patient's emotion in the clinical encounter.

If you are new to facilitating role plays, refer to 'A Guide to using Role Play in Communication Training' at the front of this document.]

Setup:

Breakout groups of three. Each group gets the same scenario and assigns roles to each participant.

- 10 minutes for conducting the role play
- 15 minutes for feedback to clinician from patient and observer, and debrief of case
- 15 minutes for a group debrief from patient, observer and clinician

Observer

You are observing an outpatient clinic interaction between Dr. Smith and Mrs. Jennifer Jones. Dr. Smith provided you some information about Mrs. Jones before you entered the exam room.

Mrs. Jones is here for vague abdominal pain and new onset constipation. A review of her EMR records indicated no significant medical or surgical history, and her only medications are OTC vitamins. She is current on all immunizations, breast, and cervical cancer screening. Labs done about three months ago revealed mild iron deficiency anemia.

As the "clinician "and "patient "conduct their role play, pay attention to the following in their interaction.

- Emotional cues* expressed by the patient, which may be disguised as information cues.
- Clinician's responses to the cues presented by the patient.

Some skills that the clinician may be using in exploring and addressing emotional cues are:

Exploring the emotional cue	Asking curious questions; eliciting, clarifying, or making an educated guess. Asking about impact, beliefs, triggers
Recognition	Recognizing the expressed emotion
Acknowledgement	Acknowledging the central issue behind the emotion
Confirmation/Legitimization	Convey to patient that expressed emotion or challenge is legitimate
Therapeutic Action	Offering understanding, appreciation/respect, advice, and/or partnership in addressing symptoms, support during care.

Clinician

This is your first meeting with Mrs. Jones; she is a 55-year-old female you are seeing for an urgent outpatient appointment.

Your nursing assistant informs you she is here for vague abdominal pain and new onset constipation. A review of her EMR records indicate no significant medical or surgical history, and her only medications are OTC vitamins. She is current on all immunizations, breast, and cervical cancer screening. Labs done about three months ago reveal mild iron deficiency anemia.

As you form an evaluation plan, especially recommending a colonoscopy, look for emotional cues* that may need to be addressed.

Some skills that could be useful in exploring and addressing emotional cues are:

Exploring the emotional cue	Asking curious questions; eliciting, clarifying, or making an educated guess. Asking about impact, beliefs, triggers
Recognition	Recognizing the expressed emotion
Acknowledgement	Acknowledging the central issue behind the emotion
Confirmation/Legitimization	Convey to patient that expressed emotion or challenge is legitimate
Therapeutic Action	Offering understanding, appreciation/respect, advice, and/or partnership in addressing symptoms, support during care.

Emotion cue definition: A cue is "an action (also a few words) or event that is a signal for somebody to do something." The term cue points to communication process rather than content, in that a cue is a signal from the patient to the clinician, directing the clinician's attention to something. In some definitions of cue, it is specified that a cue from the patient requires a clarification by the provider.

Patient

You are seeing Dr. Smith for the first time as your PCP is not available.

You are Jennifer Jones; 55 years old and have been healthy until 3 -4 months ago when you noticed a vague discomfort in your lower abdomen, and in the last few weeks you have been constipated. Yesterday you noted blood with your bowel movement, and you got scared and requested an urgent appointment.

You have no significant medical or surgical history, and your only medications is vitamins. You are current on all immunizations, mammograms, and pelvic exams.

You saw your doctor three months ago, and had some lab tests done, your doctor sent you a message to see her because tests showed you had a kind of anemia, but you haven't had a chance to schedule an appointment…

Your emotional state (or WHY this appointment is important to you): You fear cancer, since your mother died of complications from colon cancer at age 60. Your voice, tone, intonation, or verbal content may disclose worries, concerns, stress, nervousness, personal preferences, or uncertainties which are of immediate concern.

Your present several emotional cues*, some may be repetitive, until the clinician attempts to explore your cues.

Some examples are below– feel free to create your own!

- I think I am ok just want to be sure …
- I don't know if I should worry or not?
- I thought it was time to come in…
- Wonder if it means anything?
- If (s)he recommends a colonoscopy, you ask – "Isn't there anything else we can do first?"

Some skills your clinician may be using:

Exploring the emotional cue	Asking curious questions; eliciting, clarifying, or making an educated guess. Asking about impact, beliefs, triggers
Recognition	Recognizing the expressed emotion
Acknowledgement	Acknowledging the central issue behind the emotion
Confirmation/Legitimization	Convey to patient that expressed emotion or challenge is legitimate
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Emotion cue definition: A cue is "an action (also a few words) or event that is a signal for somebody to do something." The term cue points to communication process rather than content, in that a cue is a signal from the patient to the clinician, directing the clinician's

attention to something. In some definitions of cue, it is specified that a cue from the patient requires a clarification by the provider.

Reference:

Emotion in the Clinical Encounter. Rachel Schwartz, PhD; Judith Hall PhD; Lars Osterberg, MD MPH, McGraw Hill 2021

Understanding emotions - http://www.atlasofemotions.com

Concepts for Didactic Presentation

Most of our exercises lean on robust interactivity over didactics. However, depending on your students you might choose to provide some background prior to engaging in more interactive work. Here are some suggestions:

Hot Buttons

We all have "hot buttons." They are interactions that take place with certain patients that catch us reacting in ways that we really don't want to. We may recognize the automatic response and wish we had behaved differently. After the initial reaction is over and we have had time to reflect, we can often think of better responses. Although we may later try to justify the behavior, the nagging feeling of regret is a reliable guide to identifying this as a "hot button."

Our responses impair our behavior, our clinical judgement and interactions.

You may not recognize or consciously know it, but you have emotional hot buttons. An event occurs, something happens. Another human being says something to you. You read an email or a post on social media, listen to the nightly news.

Suddenly, it's like a button has been pushed, and you are grabbed by intense emotional reactions. Just a few moments earlier you were doing okay, but then certain kinds of events happen, and, in a millisecond, you're upset, thrown off balance, and irrational. You may find yourself acting out of control in ways that are extremely unskillful, even damaging – to yourself and other human beings.

This phenomenon is called and known as triggering. Triggers are events that tend to catapult you instantly into highly emotional reactions, often way out of proportion to the event itself. After you calm down, you may look back and regret things you said or did while in this altered state of reactivity.

One of the first things you can do is to accept responsibility for your reactions. Accept yourself as powerful instead of as victim. When you seek to identify what is triggering how you feel in the moment, you give yourself the opportunity to feel differently if you choose to. You will also obtain more clarity on what you need to do or what you need to ask for to change your circumstances.

IV. Exercise: Hot Buttons

[30 min.]

Purposes:

- Identify patient behaviors that are "hot buttons" for you.
- Knowing what our "hot buttons" are in order to work at developing alternative strategies for interacting; not needing to rely upon a strategy that is ineffective
- Gaining strength and support from knowing that we all have "hot buttons," and that some are similar, and some are different from those which challenge other clinicians

Setup:

- Breakout groups of three.
- Take a minute or two to list three hot buttons on the fillable chart we have included for your use in Appendix C.
- Share these with your group.
- As you see the "hot buttons" of others, you may want to review your list and add, change, or subtract things from the list.

Strategies to Manage Your Emotions:

Invite participants to share the ways they manage their hot buttons and share best practices with the group. What works for you? Below are helpful examples of ways to use emotion to inform your thinking. Similar ideas and strategies might flow from the group in discussion.

Debrief:

- How do you experience a hot button trigger?
- What are the ways you manage your hot buttons?
- Do you have methods you rely on to manage you own emotions?
- What ways can you utilize perspective taking on your own life and work?

Talking Points:

- Because emotions involve a physical response, your body is often your first clue that you're feeling some distress. The more that you learn how you manifest feelings-for example, sweaty palms, racing pulse, clenched jaw, tight stomach-the more quickly you'll be able to use this early warning system to help you evaluate what's happening.
- Practice mindful awareness of emotions, treating them with curiosity and respect, rather than judgment. Once you are aware of these emotions, manage them. That means introducing space between your (internal) reaction and (external) response. Holding that space takes listening deeply and avoiding going into "problem solving" mode.
- Recognize your emotions, sit with them (even briefly), name them, and be aware of their likely influence on thought processes. Simply accepting one's emotions in a mindful and

nonjudgmental way is valuable. Acceptance may not reduce distress right away, but it allows one to acknowledge feelings and move on from the situation, rather than letting the feelings control one's next actions.

- Cognitive reappraisal can be quite effective at reducing distress in the moment. In this strategy one deliberately redirects one's attention to a different aspect of the situation, an aspect with positive or at least neutral implications.

References:

Emotion in the Clinical Encounter. Rachel Schwartz, PhD; Judith Hall PhD; Lars Osterberg, MD MPH, McGraw Hill 2021
Understanding emotions - A compassionate pause - ScienceDirect.pdf

Encounters with a Difficult Patient

[30 min]

Adapted from AMA Journal of Ethics. *Ethics Case- Do Physicians have an ethical duty to repair relationships with So-called "Difficult" patients?* April 2017, volume 19, Number 4:323-331.

Learning Objective:

To recognize the complex story behind each person's actions. We all have seen patients who are labelled "difficult" for a variety of reasons, and it is helpful to understand both the patient factors and our role in this fixing this label.

The Difficult Patient—Case for Discussion

John is a third-year medical student on his first day with a new service during his surgery rotation. On this particular morning, John is going on rounds with the chief resident, Dr. M, and an intern, Dr. S. As the team walks down the hall to the next room, John quickly glances over his rounding sheet for a 48-year-old man, Mr. C. Mr. C had a toe amputation three days ago and suffers from chronic pain and diabetes mellitus type I. He also has a history of using opioids, and his pain medications are being carefully controlled in the hospital.

Before they enter the room, the intern Dr. S softly says to Dr. M, "Hey, just as a heads up, I heard this one was feisty last night. Apparently, the attending physician came down hard on his request for more analgesia. The patient was not happy with the refusal and gave the nursing staff a lot of trouble." Dr. M responded, "I heard about that. But he's always been difficult; I saw him in clinic last month." The team then enters the room.

As Dr. M begins questioning Mr. C, "How are you doing this morning?" Mr. C starts to moan in pain and offers short responses. Dr. M concludes his questions, "Now we're going to take a look at the toe." Mr. C begins shouting in pain as John and Dr. S remove the bandages. "Please stop!" he moans. Dr. M tries to soothe him, "I promise we'll give you more for the pain; I'll talk to your nurse when we leave. But right now, we need to get this off and take a look at the surgical site." Mr. C retorts, "You've never taken care of my pain! I've been asking for help every day, but you don't listen!"

When John rips open the packet of gauze to apply a new dressing, Mr. C angrily states, "I don't want to be touched, poked, or prodded anymore." John and Dr. S pause, bandage in hand, waiting for instructions from Dr. M.

Dr. M responds, "We're trying to help you, but we need you to work with us." Mr. C flatly refuses and shouts, "Nobody cares about my pain—you have no idea what I've been through." Dr. M silently stares for a few seconds at Mr. C who whimpers quietly. Dr. M turns his gaze from Mr. C to Dr. S, mutters "Let's go—don't worry about the bandage," and walks out of the room. John wonders what to do with the bandage he's holding and how to respond to Mr. C.

Set-up:

- After reading this encounter, begin by using the prompts WHO, WHAT and WHY to help us step back from judgment.
- Ask participants to consider their reasons for calling this patient "difficult."
- Discuss what unconscious biases could be standing in the way of providing care.

Debrief:

- WHAT is the patient's goal, what is the resident's goal?
- WHAT is leading to conflict?
- WHY does this issue matter so much to each of them right now?
- How do these questions WHO, WHAT and WHY impact how the encounter unfolded?

Talking Points:

In most cases, there is no underlying psychiatric condition, the patient's response may reflect ill-treatment by the medical establishment.

Difficult encounters may be attributable to factors associated with the physician, patient, situation, or a combination. Common physician factors include negative bias toward specific health conditions, poor communication skills, and situational stressors.

A physician's past experiences, values, attitudes, and biases will also impact their interaction with the patient.

Patient factors may include personality disorders, multiple and poorly defined symptoms, non-adherence to medical advice, and self-destructive behaviors.

Situational factors include time pressures during visits, patient and staff conflicts, or complex social issues.

To better manage difficult clinical encounters, the physician needs to identify all contributing factors, starting with his or her personal frame of reference for the situation. In analyzing this encounter, think what communication skills, attitude and behaviors the resident could have used in providing appropriate care to this patient.

Communication Skills You Could Discuss and/or Recommend:

If the resident recounted the interaction to you the Attending and asked your opinion in how you would have handled this interaction, how would you describe the communication tools you would have used in this situation? All foundational skills of relationship-building, deep listening, perspective taking and empathy would be discussed.

List process skills on a white board and discuss what portion of the visit would require each skill.

[NOTE: White board split as 'Communication Skills' and 'Behaviors']

Sharing Serious News

[This segment, designed by Gary Buckholz MD and John Michael Maury, represents a three-hour workshop with the following activities]

The phrase "breaking bad news" can have a negative connotation of causing harm. Since we know truth-telling is fundamental to healthcare, and withholding or sugar-coating difficult information can cause harm, we prefer the phrase **"sharing serious news."** Additionally, people don't always experience serious news as negatively as we think they will. When left with uncertainty, people often worry about the very worst-case scenario. What you have to share might not be as bad as their worries. Alternatively, even if the information confirms the worst-case scenario, some people experience a sense of relief because now they have answers and can plan accordingly. A full spectrum of emotional responses is possible even when the news is very serious. This curriculum can serve as a framework for sharing any important information and we will work on how to do this challenging task with compassion.

Learning Objectives:

1. Recognize the importance of inquiry and advocacy to understand the complexity of emotions in a devastating clinical encounter.
2. Demonstrate an ability to address and understand personal emotions in delivering serious or bad news.
3. Practice holding empathic space as the therapeutic response to allow patients to move forward into a new reality in the face of devastating news.

I. Hello Blank, You Look Blank*

*Adapted from an exercise introduced by Dan Sipp of Duke University.

[Large Group | 20 min]

Goal:

The intention of this exercise is to practice identifying and labeling emotions in others and to highlight that it is difficult to accurately read and interpret emotion. While focusing on body language and the tone and inflection in one's voice, participants will have an opportunity to practice heightened awareness, attunement, and active listening. The exercise reinforces a greater understanding of the importance of inquiry and compassionate curiosity when witnessing emotional expression in others.

Set-up:

- Participants will stand in a circle.
- One at a time, each participant will express an emotion of their choosing to the person on their left by saying "hello" and calling them by name.

- The person receiving the hello will react by saying hello in return and labeling the emotion they believe they are witnessing. *"Hello _____. You look _____."*
- Regardless of the emotion the participant truly feels, they will nod in acceptance of the label given to them without any more dialogue.
- This pattern will continue around the circle until all participants have both expressed and labeled an emotion.
- After everyone has gone, use the debrief questions to facilitate discussion.

Debrief:

- Did you find it easy or difficult to express the emotion you chose?
- Did you find it easy or difficult to label the emotion?
- How did it feel to those of you that received a label different from what you were trying to convey?
- Do we all express our emotions in the same way?
- What step might we be missing?

Talking Points:

It is truly challenging to accurately read someone's emotions. We each express emotion in unique ways that go unrecognized by others, running the risk of incorrect labeling. In addition, sometimes emotions present differently than a person feels inside, and our assumptions can get us in trouble. If you are accustomed to the "NURSE" protocol, consider using the N to name the values the person is expressing rather than the emotion as discussed in the Two Minute Rant exercise.

Click here for more information on NURSE.

II. Identify Emotions in Ourselves

[Large Group | 20 min]

Goal:

The purpose of the exercise is to understand our personal emotions when receiving bad news by recognizing how it feels in our body.

Set-up:

- Participants will pair up in groups of two.
- Dyads will take turns sharing a time when they received bad news—this will likely be non-medical but could be a mix within the larger group.
- Details are important to reflect on… what was the scenario exactly? Who was with them? How did they feel? Where in their body did they feel the emotion? Do they still feel that way?
- After everyone has shared, use the debrief questions below to facilitate discussion.

Debrief:

1. Did you notice any themes in your sharing?
2. Did you notice any sensations in your body when you retold your experience?
3. Is anything still alive for you in this experience in this moment?
4. How might your personal experience affect you when you are to deliver bad news?

Talking Points:

To hold space for another when we are delivering serious or bad news, we must begin to understand and hold space for ourselves when we receive bad news. It is important to recognize what we take on when we tell others bad news. Do we want to make it better or fix it? Is that even possible? Is it possible to be present and just allow the individual receiving the bad news to be in whatever emotion they are feeling?

III. Serious News Role Plays

[Large Group | 60 min]

Goal:

In this segment, the SPIKES protocol will be reviewed briefly as it is widely accepted as a structured approach to sharing serious news/breaking bad news. Focus on the Knowledge step (information sharing) utilizing "bottom line up top" and the Emotion/Empathy step for holding space for emotion to provide an empathic response.

If you are new to facilitating role plays, refer to 'A Guide to using Role Play in Communication Training' at the front of this document.]

Click here to access role play characters for this exercise.

SPIKES:

Setting – prepare the best environment for the meeting
Perception – obtain the patient's understanding of their condition
Invitation – ask permission to provide medical information
Knowledge – provide medical information to the patient
Emotion/Empathy – expect an emotional response and hold empathic space
Summarize – outline your recommendations and plan of care

Sharing serious news is often overwhelming for patients and anxiety-provoking for clinicians—we don't want to hurt our patients. The "warning shot" will be reviewed briefly as 1) an approach to decrease this anxiety and prepare the clinician to share bad news in a direct, yet empathic manner and 2) An important step in catching the patient up to the scope of an unexpected chapter in their health story.

When sharing serious news, empathy is generally the best therapeutic response as opposed to compassion. Compassion is our desired sense to help based on our understanding of how people feel—this desire can often result in a premature desire of "how can I help fix their broken 'story'?" when the patient's 'story' or goals need to shift for us to be helpful. This shift is accomplished by holding empathic space.

Due to our own discomfort, clinicians have the tendency to over-explain, lean into medical jargon, and sugarcoat information when sharing serious news. Some people need to hear a lot of detail, while others appreciate hearing only the big picture. When sharing serious news, it is important to start with the 30,000-foot view and put the "bottom line up front," then narrow in on the details if/when desired by the individual patient. Using detailed cases with some jargon, participants will practice providing the "bottom line up front" as a large group.

Set-up:

- Participants will break out into triads to practice role-playing three cases of sharing serious news, with a focus to holding the empathic space and avoiding the tendency to fix the situation.
- Roles will include clinician, patient, and observer.

Role Play Structure

Setup:

Divide participants into groups of 3. Pass out Character charts and allow all participants to review the character they will eventually play as the rounds rotate. Between each round, allow the Character participant an additional minute to review the role they will play. Allow 5 - 10 minutes per role play, call time and allow the observer to facilitate 5 - 15 minutes of feedback. These are emotional role plays for participants, so it is important for the facilitator to recognize the emotion in the room and allow more time for small group feedback and discussion if needed. Feedback can include: "What went well? What might shift if you had a chance to rewind?"

Round 1

Person A – Character

Person B – Clinician

Person C – Observer who will provide simple feedback

Round 2

Person B – Character

Person C – Clinician

Person A – Observer who will provide simple feedback

Round 3

Person C – Character

Person A – Clinician

Person B – Observer who will provide simple feedback

Debrief:

- What helped to create curiosity about the patient emotions?
- Were you able to avoid assumptions in your scenarios? How?
- Where you able to hold empathic space?
- Were you able to avoid any tendencies to fix the situation?

Talking Points:

This is a delicate beginning to breaking bad news. Allow participants to drive this conversation and share the vulnerability they experience.

Storytelling Exercises

"Well…I think we saw each other more wholly, right? Like we saw sides of one another that we may not have otherwise seen. Or we learned about moments in each other's lives that we wouldn't normally learn about. And I think you know, looking back, the choice of the picture each of us picked probably speaks to what we value, and so it connected us in that way…it just left me feeling much more connected. And like, okay, I see a different side of you."

—UC San Diego Physician

The Picture Exercise

[30 min.]

Learning Objective:

Practice telling a story to an audience.

Setup:

- The facilitator stands in front of the class with a blank sheet of paper and says "I want to show you my favorite picture...."
- Describe a photograph to the audience that means a lot to you. It should be emotional but not crippling; it's okay to laugh and cry-but don't choose a photo in which you might get emotionally derailed. Choose something so you can model a level of connection that is deeper than anything they might have experienced so far in the workshop.
- Your description should clearly describe the visual details and give a little insight about why it's so important to you.
- After you have shown the picture, hold the piece of paper to the audience and ask if anyone else has an important picture to share: "it could be about your family or an important moment in your life or work." Then wait. The waiting is key. This is a scary exercise but if you wait silently, someone will get up with a picture and get the ball rolling.
- If the group is small enough, stay in the full group.
- If time is limited, wait until a volunteer has modeled connected storytelling, and then break into groups of four and give each group a sheet of paper. Encourage the groups to show each other their picture, but don't push too hard. This can be a very emotional exercise and typically the ones that don't want to go can only think of a very painful picture. Let them keep this private-they will still learn the principles of the exercise through the connection of others.
- When the groups have finished, have them bring their chairs into a large circle to debrief.

Debrief:

- Let them talk. This is a big exercise.
- Ask them for applications.

Talking Points:

We are connected through stories; they are not incidental to the point we are making, but a vehicle that can open the channel of human interaction that is experienced by everyone in the room—including you! Each of you spoke clearly, simply and compellingly. You weren't trying to be someone else. You weren't overthinking your picture. You know what it looks like and you know we don't know. Out of that limited information, something terrific emerged. You all

became storytellers. You naturally reached for descriptive words and analogies, you were personal and you connected with your audience.

The format of a picture is helpful. You told a lifetime of information in about two minutes because you weren't attempting to tell the lifetime—you were just focused on one moment. Naturally, you had to put that into context for us and a much bigger picture emerged, but the focus of showing us one thing gave us a much broader understanding. Apply this to talking about your research or project. You can't tell us everything. The big fear is that without everything it will be dumbed down. Nonsense. Start with the thing that was the most important for you—one thing, one moment, one discovery, impasse, victory… out of that we'll understand the human story that can hook us to a broader implication. And, if you care about it, we'll have a better chance of remembering it.

 Watch the facilitation demo: https://youtu.be/NFF1CT3khk4

Finding the Story

[90 min.]

The story form is one of the most impactful ways of communicating. This session will introduce the structure and concept of story and help participants craft a story about their project or research to describe why the work they are doing matters. The skills learned in this workshop will have multiple applications including conversation, presentations, writing and preparation for media interviews, speaking to funders, etc. This structure can also be used conversationally in sharing unexpected news to a patient.

This curriculum is also taught in our Communicating with the Public online module, which could be used as pre-work before an in-person session where participants might tell their drafted story and receive peer feedback.

Have participants fill out the 'What's the Story form in Appendix C. You may also download the fillable PDF here from our website.

Learning Objectives:

- Recognize the impact of story as an effective tool in education and communication
- Understand the neuroscience behind storytelling
- Employ the story form to communicate complicated topics
- Practice telling a story, giving and receiving feedback
- Evaluate the story structure in patient encounters to recognize causes of communication breakdowns.

Goal:

Recognize the story structure to communicate complex information in a vivid, engaging manner.

Setup:

- Share Uri Hasson's research surrounding the impact of story as an effective tool for communication.
- Ask the participants to tell you a story that is common knowledge to that group. For our purposes, we used the discovery of penicillin as our practice story.
- Most participants will remember generally one or two elements of the story (that the mold had a protective ring around it that held the key to the discovery - and that this happening at all was the result of a mistake!).
- Highlight what is important about each example that was raised ("protective ring" is a visual that can be imagined; "result of a mistake" is surprising). Memorable things often result from something visual, something surprising or something emotional. Mostly what is remembered is based in fact but connected through the senses.
- Tell one version of the fuller story. The penicillin example is below:

EXAMPLE story

Once upon a time, people around the world were dying of infections - pneumonia, gonorrhea, and even infections from simple wounds. Something had to be done!

A team of scientists led by Alexander Fleming was trying to figure out what could be done, but he went on vacation and when he returned he found his experiments on the staph infection ruined by mold. He was so frustrated…

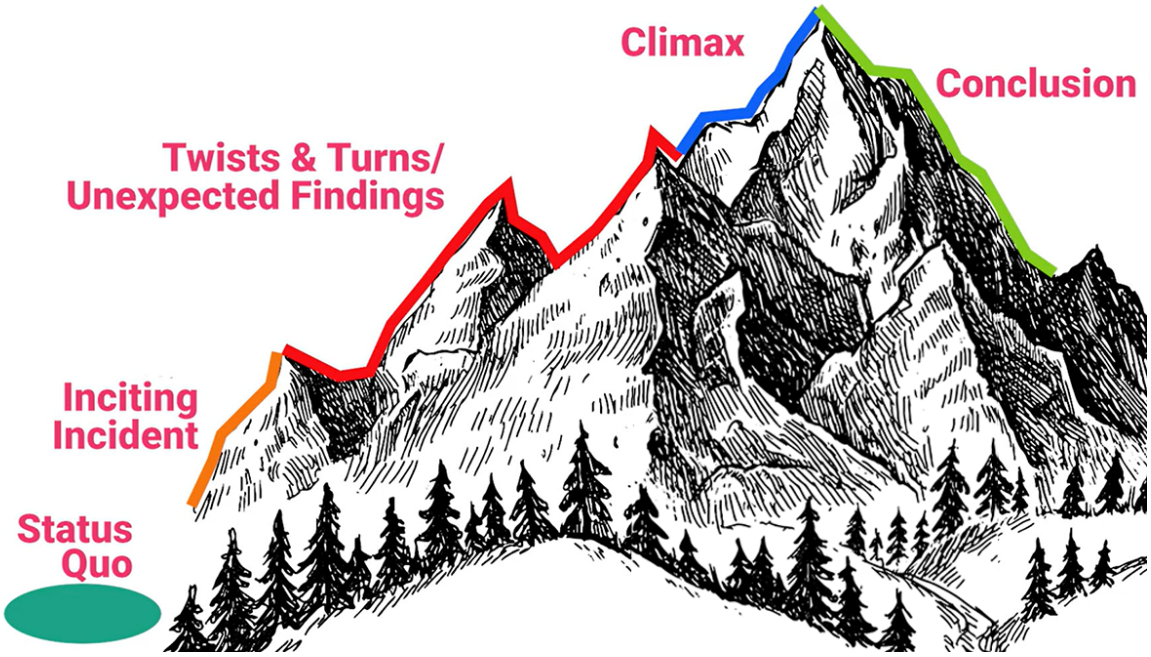
But then, he noticed a mysterious path around the blob of mold - almost like a moat around a castle - keeping the bacteria at bay.

Alexander and his assistants, Stuart and Fred, (if they ask it's Stuart Craddock and Fred Ridley) began to do more experiments - but they met with failure after failure - they needed to come up with a way to siphon off the mold juice and purify what remained - the penicillin - so it wouldn't be chemically unstable! This was hard to do - and after many trials and errors, they were only able to publish on their findings with a passing reference to the potential health benefits.

Their research was picked up by a team at Oxford - but then suddenly the war broke out and resources became scarce. The Oxford team was trying to carry out a program of animal experiments and clinical trials and had to produce 500 liters a week of mold filtrate so they could skim off the mold and keep the broth beneath. They grew it in everything - baths, bedpans, milk churns, food tins - they essentially were creating a penicillin factory - and to manage this they hired a team of girls - they called them Penicillin girls for 2 pounds a week (the average wage was 6 pounds/week) to watch and record the fermentation process. They carried out some successful trials on animals, but it had never been tested on people until Feb 12, 1941. A 43-year-old policeman, who had been injured pruning his rose bushes came to seek help. He was dying from severe infections that had resulted in abscesses in his eyes, face, and lungs. Penicillin was injected into this policeman - and within days he made a remarkable recovery!

And that's how penicillin was discovered.

- After telling the story, ask participants to describe the main elements of the story (beginning, middle, end; plot; emotion; characters; conflict; climax; conclusion; etc.).
- You might consider sharing this graphic as an illustration of how a story structure can be thought about, perhaps, like a "mountain" with all of these elements:



- Recognize the boring ending of the story "and that's how penicillin was discovered." The ending of a story is significant. Why? (It reveals the journey that started at the beginning - and is often the main thing the audience remembers). We often get caught up as storytellers in the struggle - the journey to the climax, which is of course the exciting part - but it is the outcome of the story in which the world has changed that the listener is waiting for.
- You remembered little of the story of the discovery of penicillin - but most of you remembered a couple things - the visual of the ring of blank space around the mold - and the fact that it was a mistake! It wasn't supposed to happen! Those were intriguing - they stuck with you. The ending needs to be similar... and thankfully in rhetoric, we can gather some ideas on how to do that.
- Show slide with 6 common rhetorical endings and ask participants if any of them would like to create a stronger ending to the story just told. Facilitator can also include a few sample endings if participants are stumped:

Resolved ending – the work that Fleming began that seemed at first like a mistake, carried the world into a new age of greater health and wellbeing. (It's very nice – you can hear the happy theme music underscoring this type of ending.)

Unresolved ending – unfortunately, within days the policeman's infection came soaring back and he died two weeks later leading scientists into the next chase to uncover the appropriate dosing that could save the world. (A little shocking – you can imagine the camera pulling back as the doctors learn their policemen has died.)

Expanded ending/Tied ending – While penicillin has saved millions of lives, within only 3 years, a new era dawned called "antibiotic resistance" which 80 years later poses one of the greatest health risks on the horizon – and one that could catapult us back in time to an age where people are once again dying of what were once treatable infections. (You can imagine the scene fast-forwarding to a futuristic hospital and seeing patients with UTIs being rushed to the ICU.)

- Facilitation question: how do these different endings change the story for you? (the storyteller knows the secret ending - and this knowledge can frame the tone, pace, and expressiveness of the storyteller throughout the telling of the story itself. Storyteller Holly Kerby, from Storyform Science, suggests a technique to her students that as they begin to write a story, they first write only the most evocative beginning and vivid options for their ending to help them frame the journey they will write through the rest of their story).
- Direct participants to this page on our website and instruct them to download the form called 'What's the Story?'
- Participants will use this form to craft their own story about their project or research. As a group, suggest they think first about the audience. If the group is using the same audience, the facilitator can write this out in a form generally. If the group are preparing for different presentations, they should write their own ideas on their own story form.
- Facilitate the group to think about the audience as they fill in the top two categories: Who are they? And why would they care about the project you are doing?
- Once participants have answered the audience questions, give them the timing for the rest of the process. Suggest they are aiming to write a 3-minute story.
- Allow 10 minutes to write. Check in to see if they need a few more minutes. Encourage them not to get in the weeds - go with your gut and you'll have a chance to share this first draft with a partner and get some feedback and editing time before you share it with the larger group."
- After writing, participants will go into breakout groups with a partner to share their stories and get feedback. Breakout sessions should be timed for 15 minutes - 3 minutes to share the story, 4 minutes of feedback per person.

- Feedback from the listener: "I really liked this..." - "You lost me here" - "I wanted to know more about..." Listener should also spend a minute examining the ending and helping the storyteller craft the strongest final line or two.
- Following the breakout groups, you might take a short break before gathering the full group (max size 8 - 10) to share stories.

Debrief:

- How did the process of writing a story compare to the way you typically present?
- What did you discover as you listened to these stories?
- What elements of these stories will you remember tonight at dinner?
- How can the understanding of the structure of a story help you think about communication with patients?

Talking Points:

- Facts matter - but facts need a vehicle to help them stick in the minds and hearts of your listener.
- The story structure exists as a regular part of our learning process. It's how we think, how we contextualize and how we remember information. The stories we carry into a situation are all seen through the lens of our personal history, our culture and life

Suggested follow-up activities

1. Online learning course called A New Framework in Healthcare Communication: Foundations, which begins with the story of a patient, her family, and her physician that spans 30 years and includes 21 surgeries. Participants will be given an opportunity to discuss their learning and reflect on their own experiences as patients and healers.
2. In particular, The Clinical Story (module #4 in the above course) discusses clinical applications of recognizing both the physician's and patient's stories.

Narrative Humility Exercises

"I like that there were concrete suggestions as to how to address it, um, because yeah, we kind of know, everybody kind of accepts that it's there you know, the inequality, but nobody really knows what to do about it."

—UC San Diego Physician

Walk in the Park

[20 – 30 min.]

Goal:

The purpose of the exercise is to highlight personal associations related to identity.

Setup:

Invite participants to close their eyes as you read aloud the passage below. Encourage them to visualize in as much detail as possible what you are describing. Be sure to pause frequently in your reading to allow time for people to visualize in some detail what they are witnessing.

> *You're walking through a park. It's a sunny day, the smell of freshly cut grass is in the air. You hear the soft sound of music, you notice a girl playing a guitar, and people are giving her money. You drop a few quarters in the case.*
>
> *As you continue through the park, you pass by a park bench where an elderly couple are engaged in an argument. You pick up the pace slightly, so as not to intrude.*
>
> *Ahead of you a wealthy-looking lady wearing a black pin-striped suit is walking briskly toward you. You notice she's carrying a leather laptop bag. Suddenly someone comes up behind her, knocks her down, and steals her bag and runs off. You quickly approach to make sure she is okay.*
>
> *As you help her stand, you both notice two police officers standing near a food truck and hurry in that direction."*
>
> *Ask participants to open their eyes and take a breath. Let them know you're going to ask questions about their visualization of the people in the story, and to raise their hands if their answer is 'yes.'*

Questions to Ask Participants:

- Who thought the girl playing the guitar was disabled? Who thought she was able bodied?
- The couple on the bench - who thought they were a gay couple? Who thought it was a straight couple? Did anyone see a biracial couple?
- The woman wearing the pinstriped suit: who saw her as white? Black? Asian? Hispanic?
- Who thought the person stealing the bag was a woman? Who thought it was a man?
- Who felt that approaching the police was a natural thing to do?

Debrief:

- What was this experience like?
- What did you discover? What surprised you?
- What did you feel as you answered the questions? Any defensiveness?
- What do our answers reveal about us?
- What is useful about associations? What is the risk?

Talking Points:

If you did not think it was a gay couple or that the girl was in a wheelchair, it doesn't mean you are bad person, it's a reflection of your own environment and of society. From this exercise, we can begin to see our perception of the roles people play in society, and the perception of the "norm" in our society is often white, heterosexual, cisgender and able-bodied.

Drawbridge

[Large Group & Small Groups | 45-60 min.]

Learning Objectives:

Participants recognize unconscious bias and societal rules as foundations of their own perspectives.

Setup:

Have the instructor, or the class, take turns reading the following story out loud:

As he left for a visit to his outlying districts, the jealous Baron warned his pretty wife: "Do not leave the castle while I am gone, or I will punish you severely when I return!" But within a few hours of the Baron's departure, the young Baroness received word that her mother was dying and desperately wanted to see the Baroness.

Despite her husband's warning, the Baroness decided to visit her mother who lived in the countryside nearby. The castle was located on an island in a wide, fast-flowing river, with a drawbridge linking the island and the land at the narrowest point in the river. "Surely my husband will not return before dawn," she thought and ordered her servants to lower the drawbridge and leave it down until she returned.

After spending several hours with her mother, the Baroness returned to the drawbridge, only to find it blocked by a madman wildly waving a long, cruel knife. "Do not attempt to cross this bridge, Baroness, or I will kill you," he raved.

Fearing for her life, the Baroness returned to her mother and asked for help. "I am weak and poor," her mother said, "I cannot help."

The Baroness then sought out a boatman on the river, explained her plight to him, and asked him to take her across the river in his boat. "I will do it, but only if you pay me my fee of five Marks." "But I have no money with me!" the Baroness protested. "That is too bad. No money, No ride," the boatman said flatly.

Her fear growing, the Baroness ran crying to the home of a friend, and after again explaining the situation, begged for enough money to pay the boatman his fee. "If you had not disobeyed your husband, this would not have happened," the friend said. "I will give you no money."

With dawn approaching and her last resource exhausted, the Baroness returned to the bridge in desperation, attempted to cross to the castle, and was slain by the madman.

Alternate Version:

As he left for a visit to his outlying districts, the jealous baron warned his pretty wife: "Do not leave the castle while I am gone, or I will punish you severely when I return!"

But as the hours passed, the young baroness grew lonely, and despite her husband's warning, she decided to visit her lover, who lived in the countryside nearby. The castle was situated on an island in a wide, fast-flowing river.

A drawbridge linked the island to the mainland at the narrowest point in the river. "Surely my husband will not return before me," she thought, and ordered the servant to lower the drawbridge and leave it down until she returned. After spending several pleasant hours with her lover the baroness returned to the drawbridge. Only to find it blocked by a gateman wildly waving a long, cruel knife.

"Do not attempt to cross this bridge, Baroness, or I will have to kill you" he cried. "The baron ordered me to do so." Fearing for her life, the baroness returned to her lover and asked him for help. "Our relationship is only a romantic one," he said. "I will not help."

The baroness then sought out a boatman on the river, explained her plight to him and asked him to take her across the river in his boat. "I will do it but only if you can pay the fee of five marks."

"But I have no money with me!" the baroness protested. "That is too bad. No money, no, ride," the boatmen said flatly.

Her fear growing, the baroness ran crying to the home of a friend and, after explaining her desperate situation begged for enough money to pay the boatman his fee. "If you had not disobeyed your husband this would not have happened," the friend said. "I will give you no money."

With dawn approaching and her last resource exhausted, the baroness returned to the bridge in desperation, and waited to cross to the castle, and was slain by the gateman.

Exercise:

- Ask everyone individually to rank-order the degree of responsibility for the baroness's death of each of the characters: Baron, Baroness, Boatman, Friend, Madman, Mother, [Alternate version: Baron, Baroness, Lover, Gateman, Boatman, Friend]. Have them do this on their own silently – they should not share.
- Send groups of 3 to 5 participants to break rooms to have them try to agree about a ranking order. Instruct them to identify a spokesperson to report out when rejoining the large group.
- After 10-20 minutes, bring participants back to discuss the results of the smaller group debates, the various rankings, and the different perspectives about society and social change the rankings implied.

Use the questions below to facilitate the identification of contrasting views and the assumptions each view makes about the possibilities and legitimacy of action against oppressive conditions. Ask them to consider differences in the ranking of each character, when they are viewed as individuals acting apart from any societal context or as operating within the confines of imposed social relationships.

- What factors influenced your ranking decision? Did you base your decision on behaviors or responsibility?
- What feelings were provoked during this activity and your decision-making process? Why?
- In attempting to reach a group consensus, were you convinced of a different ranking order? Why or why not?
- How does this exercise relate to societal values and norms?
- What change work would need to be done to affect the outcome of the story?
- Suggest to the class that the characters in the story can be equated with social forces in contemporary society as described below. Then ask students to reconsider ranking the characters based on the new symbolization and present-day conditions. This part of the discussion deepens the consideration of the responsibility for maintaining or changing oppressive conditions and the power or powerlessness of the victim in self-determination and in effecting social change.

Baron: Dominant identity. The identity that sets values and rules for the collective. (i.e., White, male, Christian, straight, typically able-bodied, US born, etc.)

Baroness: Oppressed identity. They have little to say about values but are expected to adhere to them. (i.e., Black, female, non-dominant religion, disabled, immigrant, etc.)

Gateman/Madman: Law enforcement or the Unruly forces. They do not necessarily have a direct say in rules and values, but are expected to enforce them–sometimes the values behind the rules are embodied, sometimes not. In the case of the "madman" a conversation about mental health and stigma can emerge.

Boatman: Institutions. This identity is service for a cost: if you have resources you have the opportunity.

Neighbor/Lover: Allies with oppressed identities. They may have good intentions, within my values framework, I'll accept you if you follow the rules–but feel compelled to center their own well-being.

Friend/Mother: Enticements**.** This role represents the things we admire or respect, but in reality or practice they can fail to do us much good. (i.e., The U.S. constitution, Bill of Rights, other patriotic ideals of freedom, etc.)

Debrief:

- What was this experience like? What did you discover?
- Any discomfort? What do you think that stems from?
- When we cultivate awareness of privilege and oppression, that's great…what is next?

Talking Points:

As participants argue for their view, they become clearer about their own perception of the relationship between the individual and society. For most, this activity is fun and non-threatening because it centers on a fictitious historical situation. Nevertheless, when contemporary social relationships are discussed during the last part of the activity, some participants might experience discomfort. They are faced with the recognition that, from the perspective of the victim, current societal rules and relationships cannot be accepted if change is to occur for them. *Tell them to embrace discomfort as an opportunity to reflect and learn.*

Quotes: Isabel Wilkerson, Caste: The Origins of Our Discontents

"Caste is insidious and therefore powerful because it is not hatred, it is not necessarily personal. It is the worn grooves of comforting routines and unthinking expectations, patterns of a social order that have been in place for so long that it looks like the natural order of things."

"In our era, it is not enough to be tolerant. You tolerate mosquitoes in the summer, a rattle in an engine, the gray slush that collects at the crosswalk in winter. You tolerate what you would rather not have to deal with and wish would go away. It is no honor to be tolerated. Every spiritual tradition says love your neighbor as yourself, not tolerate them."

"Choose not to look, however, at your own peril. The owner of an old house knows that whatever you are ignoring will never go away. Whatever is lurking will fester whether you choose to look or not. Ignorance is no protection from the consequences of inaction. Whatever you are wishing away will gnaw at you until you gather the courage to face what you would rather not see."

"The price of privilege is the moral duty to act when one sees another person treated unfairly. And the least that a person in the dominant caste can do is not make the pain any worse."

"Radical empathy, on the other hand, means putting in the work to educate oneself and to listen with a humble heart to understand another's experience from their perspective, not as we imagine we would feel. Radical empathy is not about you and what you think you would do in a situation you have never been in and perhaps never will. It is the kindred connection from a place of deep knowing that opens your spirit to the pain of another as they perceive it."

"Empathy is no substitute for the experience itself. We don't get to tell a person with a broken leg or a bullet wound that they are not in pain. And people who have hit the caste lottery are not in a position to tell a person who has suffered under the tyranny of caste what is offensive or hurtful or demeaning to those at the bottom. The price of privilege is the moral duty to act when one sees another person treated unfairly. And the least that a person in the dominant caste can do is not make the pain any worse."

Move from Awareness to Action

The Beauty in Breaking, Dominic: Body of Evidence by Michele Harper

This curriculum was devised by Chase Crossno MPH. This section is best paired with the subsequent roleplay – and suggested that participants read this chapter as pre-work if possible.

[90- 120 min.]

Goal:

Read a narrative that demonstrates individual, collective, and structural bias and the impact on healthcare delivery and outcomes and practice emotional self-regulation and perspective-taking of a person with whom you do not empathize.

Setup:

- Either assign the reading as pre-work or allow participants 20 minutes to read the chapter suggested above from Body of Evidence, by Michele Harper. You can also use another story or film clip if you prefer and adjust the roleplay accordingly.
- Encourage participants to pay attention to the physiological responses they have as they read the story.
    - Suggested language, "Notice where you feel the reaction in your body and how that reaction shifts as the narrative unfolds. Is it a tightening in your chest? A flush of heat? A pit in your stomach?"
- Encourage the participants to note their methods for regulating emotion.
    - Suggested language, "How do you regulate your emotional reactions? Deep breath? Pushing emotion away with thoughts or other distractions? Justifying it somehow? Allowing it to be there?"
- After reading, instruct the participants to select a character from the story with whom they do not readily empathize. They will spend 5 minutes writing a "mirror monologue" in which the character is having a reckoning with themselves about their behavior during the story.
    - *(Note: a mirror monologue is that moment in a movie we often see in which the character, hands on the sink, is having some "real talk" with themselves in the mirror.)*

Debrief:

- What was this experience like? Where did you feel it in your body? What did you notice yourself doing for distress tolerance?
- What did you discover as you wrote the mirror monologue? What changed about the overall narrative? What questions did it leave you asking?
- In this narrative, whose responsibility is it to step up or step in? What does this say about our expectations of others? Of ourselves? Who does society typically put the person on?

- What is so difficult about empathizing with people that we feel do not deserve it? What is the benefit of trying?

Talking Points:

- **Empathy can be particularly difficult when we think people don't deserve it**. It is at these moments that it is critical to slow down and ask "Who are the players? What do they want? Why do they care?"
- **We often expect the wounded party to do the educating**. This places an additional burden on an already laden person (e.g., a lesbian educating a physician about what is involved in lesbian sex; a black person explaining to a white colleague why other people touching her hair makes her angry.) We must be creative about how to educate ourselves about our blind spots. There are countless resources available online to learn from, and to allow us opportunities for perspective-taking and self-reflection. When perusing such resources, pay close attention to your distress and emotional regulation as a way of understanding your own conditioning and emotional content.
- **Challenges related to identity, discrimination, and all the -isms are morally stressful, particularly when social and systemic factors facilitate wrongdoing.** Moral distress occurs when one knows the ethically correct course of action, but there are constraints that prevent that course of action. In extreme cases, a moral injury can occur resulting in a guilt and shame response resembling the fear and anxiety response manifest in PTSD. That can be difficult to address and eliminate. Moral injury is the damage done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct.

Role Plays: The Beauty in Breaking, Dominic: Body of Evidence by Michele Harper

Goal:

Practice emotional self-regulation and verbal and non-verbal communication strategies to address the impact of individual, collective, and structural bias.

Setup:

Remind participants to pay attention to physiological sensations and their personal methods for distress tolerance. *If you have not chosen our suggested reading, adjust your roleplays accordingly using these suggestions as a guide.*

- **ROLEPLAY 1**

  Have participants pair up and select who will play the role of POLICE OFFICER or CHARGE NURSE and a person to play DOMINIC, THE PATIENT. Instruct the person roleplaying OFFICER/CHARGE NURSE to apologize to DOMINIC. Leave the circumstances of the apology intentionally vague and allow the participants to craft the environment and timing in which the apology occurs. Give them 2 – 4 minutes for this role play.

- **DEBRIEF QUESTIONS**
  - What was that like?
  - When and where did this apology occur? What did it take for the officer/charge nurse to get to the place of apology? And who was the apology truly for?
  - What was the experience of the apology like for Dominic? What happened in your bodies over the course of the 2 minutes?
  - What made playing your character difficult?

- **ROLEPLAY 2**

  Have participants pair up and select who will play the role of DEPARTMENT CHAIR, a person to play DR. HARPER. Instruct the person roleplaying DEPARTMENT CHAIR to reimagine the news about DR. HARPER not receiving the promotion. Give them 2 – 4 minutes for this roleplay.

  (Optional: paste the text in a zoom chat or show it on a slide in the room to remind participants of the exchange.)

- **DEBRIEF QUESTIONS**
  - What was that like?
  - How did power dynamics impact the conversation?
  - Did anyone suggest action? Who led the action items?

- **ROLEPLAY 3**

  Have participants pair up and select who will play the role of LAUREN, THE RESIDENT, a person to play DR. HARPER. Instruct the person roleplaying LAUREN, THE RESIDENT to acknowledge her problematic behavior to DR. HARPER. Allow 4 – 5 minutes for this roleplay.

  (Optional: paste the text in a zoom chat or show it on a slide in the room to remind participants of the exchange.)

- **DEBRIEF QUESTIONS**
  - What was that like?
  - Did racism come up? Who brought it up?
  - What is different between acknowledgment and apology?

Debrief:

- What did we discover during the roleplays? What are our takeaways?
- As we played this out, what strategies did you use for distress tolerance?
- How are we feeling in our bodies now? What can we do to regroup and release any tension or sadness we might be feeling?

Talking Points:

- **Intent versus impact.** Sometimes we just can't "win" in our attempt to overcome a history of oppression and violence…that is okay. There is a collective pain among those who live their lives experiencing countless micro- and macro-aggressions. The reaction to what has happened is very likely not about you, but about a myriad of factors. However, you can take compassionate steps to help with healing.
- **Center INQUIRY with the "Platinum Rule".** The Golden Rule states, "Do unto others as you would have others do unto you." The Platinum Rule takes this principle a step further: "Do unto others as they would have done unto themselves." Do not assume people want what you want or will respond to what you imagine is the "right" or "best" course of action-again, it isn't about you…and sometimes, you simply won't get it right. That is okay…just make your best effort and recognize that the moment will pass and other opportunities will arise.

- **Empathy is limited**. We will never know what it is like to be Dominic, Lauren, or Dr. Harper…OR ANYONE! This is the beauty of the uniqueness of our experiences and the privilege of curiosity to examine and appreciate that uniqueness.
- **Compassionate action is a process**.
    - Pay attention to physiological cues and practice self-awareness and -reflection. What is "me and not me" (my job/responsibility and not my job/responsibility) in this situation?
    - Do some conscious emotional processing (sometimes FAST).
    - Consider the WHO/WHAT/WHY—WHO is this person? WHAT is their goal? WHY is that important to them?
    - Decide what you're going to do (and be honest with yourself about WHO you're doing it for-and, if necessary, remedy that decision based on that reflection).
    - Consider the appropriate timing to acknowledge/address the issue and the language/structure of your action.
    - Act! Be informed, deliberate, catering to the best interests of all parties.

Microaggressions Gallery Walk

[30 – 45 min.]

Goal:

Strategize methods to combat microaggressions.

Setup:

"You can set this up with large sheets of paper on the walls, like an art gallery (thus the title), or more simply just using handouts on tables that allow people to rotate between, "gallery style." Prepare large sheets (such as self-sticking flipchart paper) that have a microaggression statement or behavior and the possible interpretation and impact, such as the following:

Microaggression Statement or Behavior	Possible Interpretation & Impact
"I do not see color. I have several black friends."	"Your experiences as a minority are invalid and I'm not racist." The experiences of a person of color are irrelevant and not different than anyone else's. When a person associates with black people then what they say cannot be offensive.

Place the sheets on a flipchart, dry erase board or wall. Have participants form groups of three. They will read the information then write responses to following three questions on the board:

1. What was the possible intent behind the statement / behavior if we are giving the person the benefit of the doubt?
2. How could the statement / behavior be reframed?
3. How might a bystander helpfully intervene if they witnessed the statement / behavior?

Participants should rotate clockwise until each small group has visited each board.

Example answers to above scenario:

Possible intent: It is important to me to treat people the same.

Reframe: It is important to me to understand what you think and how you feel.

Bystander action: "I do not think that is a helpful perspective. Perhaps, if he/she/they want to share, we can hear specifically what [NAME] thinks and feels?"

Options for Gallery Walk Statements:

Microaggression Statement/Behavior	Possible Interpretation & Impact
"I do not see color. I have several black friends."	"Your experiences as a minority are invalid and I'm not racist." The experiences of a person of color are irrelevant and not different than anyone else's. When a person associates with black people then what they say cannot be offensive.
"You are the doctor? You seem way too young…"	"I don't trust that you are qualified. You do not have enough experience to do your job." Reduced self-esteem and cultivation of imposter's syndrome.
"You want to be an orthopedic surgeon? Wow…girls aren't usually into that."	"Women are not fit for that field. You are not qualified to pursue this career path." Reduced self-esteem and cultivation of imposter's syndrome.
"Wow…you are SO articulate."	"People like you are usually not smart. People that look like you are usually not intelligent or capable of communicating clearly."
"How do you manage the pressure of this job and take care of your children?"	"You're selfish for prioritizing your career over family. Parenting is more important than your career, particularly if you're a woman."
"You can succeed if you try hard enough."	"You are being lazy and if you put in any effort, you may make some progress." Feelings of imposter's syndrome or one's best effort is not enough. Failure to recognize structural and systemic barriers that are different for people with varying identities.
"As a woman, I understand how it feels to be a minority."	"I'm not racist because I'm also oppressed. " All discrimination is the same; your personal experience doesn't matter.

Exclusion from a monthly meeting of colleagues with superior or department chair	Creating feelings of isolation, exclusion, loneliness, and tokenism
Repeatedly not having a resident or medical student assigned to you	Devaluing the individual's research, scholarship, or contributions
Being asked to provide more letters of recommendation than other colleagues; assuming a female or URM physician is a nurse or maintenance worker	Undermining and questioning the individual's qualifications and credentials
Being singled out for comments or asked to lead by colleagues or superiors whenever issues concerning race or diversity arise; given excess responsibilities on department and university committees for diversity	Committing the individual to excess service on diversity, task force, department, and university committees as the face of diversity
Having a suggestion not recognized when presented at a meeting with colleagues but acknowledged when presented a few minutes later by male or non-URM colleague	Resulting in feelings of being ignored, overlooked, unappreciated, under respected, undercompensated, overworked, misrepresented, and devalued

Optional Discussion Questions:

1. Alvin Poussaint refers to the cumulative impact of experiencing microaggressions as "death by a thousand nicks." Do you agree or disagree with this statement? Explain your answer.
2. When people discuss microaggressions, a common response is that they are "innocent acts" and that the person who experiences them should "let go of the incident" and "not make a big deal out of it." Do you agree or disagree with this point of view? Explain your reasoning.
3. If a person from a marginalized group pointed out to you that one of your comments was a microaggression, how would you respond at the time? Would it change the likelihood of your making a similar comment in the future? Why or why not?
4. Derald Wing Sue has argued that the impact of subtle prejudice, such as microaggressions, is more harmful than the impact of blatant discrimination. Do you agree or disagree with this proposition? Explain your answer.

Adapted from:
Feaster, McKinley-Grant, McMichael (2021). *Microaggressions in Medicine*. Skin of Color, Vol 107 No 5.
Wing, Capodilupo, Torino, Bucceri, Holder, Nadal, Esquilin (2007). *Racial Microaggressions in Everyday Life: Implications for Clinical Practice*. American Psychologist, 62, 4, 271-286.

Ministrations

[10 min.]

Read the poem Ministrations by Joanna Pearson MD. Click here to listen as you scroll.

Sometimes the gentlest patient
in the Emergency Room
is from the city prison.
This one too - soft-voiced,
lifting his large dark eyes.
He whispers, "yes, ma'am,"
shy as a deer,
young and brown-skinned
with loosely muscled limbs
gangling off the bed.
His clean, uncoiled anatomy
is almost embarrassing against
pus and pannus, abscess & scarred vein -
everyone bearing his body
like some separate, stricken animal,
its disappointments inevitable.
It seems impolite for us to notice
the fact that we are the same age,
his silver handcuffs, track marks,
the inefficiency of my exam,
a rising smell of hot dung
from the old lady in the next bed.
Once, when realms were not distinct -
celestial and earthly -
angels visited, god-wed
women ministered, bathed the feet of sinners,
doe muzzled the saints' hands,
and this would be the moment
of cloud-break revelation.
There are no figs or honey here,
just betadine and isopropyl pads.

Reflective Writing:

After listening to and reading the poem, spend 3-5 minutes writing your reaction. You might choose to write about elements of the poem that stood out to you, and thoughts that emerged as a result of that language. Or you might choose a more personal reflection and could consider beginning your writing using the prompt: "My patient needs me..."

Uncomfortable Conversations with a Black Man

[25 min.]

Watch the following episode from Emmanuel Acho's YouTube series:

Pro-Life vs Pro-Choice: Overturning Roe v. Wade | Uncomfortable Conversations with Emmanuel Acho

Debrief:

- What made these conversations difficult?
- What techniques and strategies did people use during these conversations that you think were effective? And which would make the conversation more effective?

Optional Content for Deeper Learning in Narrative Humility

[90 - 125 min.]

Here are two other options for you to use as interactive discussions and activities for your teams or student participants:

I. The Bias Diagnosis Assignment: 90 min.

Listen to one episode of The Bias Diagnosis podcast.

The Bias Diagnosis Written Reflection:

Write a response to one of the patients you met during the episode. Share with them what you wish they had heard from a clinician while living through the experience they had with the healthcare system.

II. Middle Ground Assignment: 20 - 25 minutes

Watch (at least) one of these conversations from Middle Ground (there are 5 seasons and many conversations; choose what interests you). Think about the role of emotional self-regulation and perspective-taking in having "difficult conversations," and then write a few sentences answering these questions:

- What made these conversations **difficult**?
- What **techniques** and **strategies** did people use during these conversations that you think were effective? And which would make the conversation more effective?

Leadership Exercises

"…how could I use this to kind of help people as they're coming through so that they're protected, or at least less harmed by the system, because our system does harm to people… I could use this as a way to help them build resilience to kind of explore their own personal strengths, lean into their compassion and empathy for themselves, eventually pushing that out to others..."

—UC San Diego Physician

Feedback and Coaching Principles (with Role Play)

Arranged by Gita Mehta MD

Goal:

In this session we explore skills for receiving and giving feedback, and skills necessary in a coaching conversation—something we all do every day. Activities in the session touch on Leadership Styles and team building concepts. This section that includes Receiving Feedback, Giving Feedback and Coaching Conversations contains didactic lessons that can be included in a PowerPoint, or form the foundation of group discussion. You might also include role plays based on group interests

I. Receiving Feedback

[40 min.]

Step 1:
Begin with a general definition of feedback. An example might be: "Feedback is any information you get about yourself. It's how we learn about ourselves from other people, both at work and from our family. Feedback can be formal, informal, direct, and sometimes so subtle that you are not even sure if it was feedback." Feel free to utilize all or part of this definition, or use one of your own.

Step 2:
Continue with a deeper dive into how feedback works in the professional/medical context. You may consider polling the group for how feedback manifests in their own experience or on their team. You might touch on topics like:

- We are constantly providing feedback, sometimes unconsciously, which may be unwelcome!
- How we accept and provide feedback is critical to our ability to maintain both professional and personal relationships.
- As always, foundational skills of deep listening, non- judgmental observation, empathy and understanding the learner's or colleague's perspective are equally valuable in feedback interactions.

Step 3:
After checking for acknowledgement and understanding with the group, move into framing feedback—both giving and receiving—as a leadership skill:

- Feedback is everyone's responsibility – difficult conversations contribute to growth. Handling the feedback "process" properly is important in building a culture of trust.

- Receiving feedback is more difficult than giving it. If you receive feedback well, it means you aren't defensive; you give yourself opportunity to learn and grow.
- Receiving feedback well transforms how we handle our performance reviews, and how we behave in our professional and personal lives.

Step 4:
Discuss some qualities of effective feedback. Feedback should always be:

- Actionable
- Non-judgmental
- Intended to help the receiver learn and grow

Discuss *blind spots;* poll the group to see what their blind spots are. You may consider the following as talking points:

- Blind spots are things about ourselves that we don't see but others do.
- We all have blind spots because, for example, we are not aware of our "leaky" faces; we can't hear our tone of voice; or we are unaware of our patterns of behavior.
- We need help from others to see our blind spots and be our Honest Mirrors. Honest Mirrors give you a true reflection.
- Don't buy someone's story about you "wholesale," and reach out to Supportive Mirrors who can help you see yourself with compassion and balance.

Discuss *truth triggers;* poll the group to see what their triggers are. The following are aspects that can obstruct feedback:

- Truth – the content of the feedback. Triggers are created by our emotional and cognitive reaction to feedback when it seems wrong or off-target: 'This feedback is wrong, unhelpful or unfair.'
- Relationship – the person giving the feedback. We discount feedback that is given by someone we feel unsafe with, or who lacks credibility in our mind: 'Who are you to give me this feedback?'
- Identity – our stories about ourselves. We reject feedback if it offends our sense of who we are, the story of who we are, or questions our identity: 'I feel threatened by this feedback.'

Explore *how to receive feedback*. Some tips you might touch on include:

- Be prepared, be mindful – Recognize your "feedback footprint"
- Separate the strands – Feelings from the story from the feedback

- If overwhelming, pick one point/reschedule – Let's find a different way to do this as I am getting defensive.
- Accept that you cannot control how others see you – Also, you don't have to buy their story.

Debrief/Reflection Questions:

- What strategies for dismantling feedback are most relevant to you?
- Who has given you feedback well? What was helpful about how they did it?
- Whose feedback receiving skills do you admire?
- Have you ever gotten good advice that you rejected? Do you recall why?

References:

1. Thanks for the Feedback. The Science and Art of receiving Feedback Well. Douglas Stone & Sheila Heen of the Harvard Negotiation Project. Penguin Books.
2. Finding the Coaching in Criticism. The right way to receive feedback. Sheila Heen and Douglas Stone. HBR.ORG January- February 2014. https://www.linkedin.com/company/harvard-business-review?trk=biz-companies-cym

II. Giving Feedback

[30 min.]

Overview:

When it comes to giving feedback:

- We want our learner or direct report to be able to process reactions, analyze the situation, generalize the experience beyond the current situation and shape future actions and lessons from what happened. We also want people to feel challenged and psychologically safe.
- Sharing critical judgements is an essential piece of learning and yet many times we fear sharing our thoughts, fearing that feelings might be hurt or defensiveness might be triggered.

Step 1:

Begin with a general definition of feedback. An example might be: "Feedback is any information you get about yourself. It's how we learn about ourselves from other people, both at work and from our family. Feedback can be formal, informal, direct, and sometimes so subtle that you are not even sure if it was feedback." Feel free to utilize all or part of this definition, or use one of your own.

Step 2:
Continue with a deeper dive into how feedback works in the professional/medical context. You may consider polling the group for how feedback manifests in their own experience or on their team. You might touch on topics like:

- We are constantly providing feedback, sometimes unconsciously, which may be unwelcome!
- How we accept and provide feedback is critical to our ability to maintain both professional and personal relationships.
- As always, foundational skills of deep listening, non- judgmental observation, empathy and understanding the learner's or colleague's perspective are equally valuable in feedback interactions.

Step 3:
After checking for acknowledgement and understanding with the group, introduce the **Appreciative/Reinforcing Feedback** approach. You might touch on these concepts regarding appreciative feedback:

- It is necessary; without it, good performance may decrease.
- Appreciation of specific behaviors provides reinforcement and shows respect
- Be aware of the pitfalls of general praise/compliments:
    - Regardless of the comments being generally positive, the speaker nevertheless sits in judgement.
    - It is possible for the learner to leave without understanding 'why.'

Step 4:
After checking for acknowledgement and understanding with the group, identify these three approaches to giving feedback:

- **Judgmental Feedback** - an older approach that says "here's how you messed up." Very popular in traditional medical training.
    - The old concept of judgmental feedback, the "Blame and shame" method has harmful consequences of humiliation, reduced motivation, a reluctance to raise questions, and disengagement.
    - Shows up as judgmental debriefing, and all of the shaming or humiliating power is with the feedback giver.
    - The only virtue is that the trainee clearly know what issue the instructor thinks is important

  - *RESULT: Harsh or gentle, the truth is solely in the hands of the feedback giver, the error in the hands of the receiver and assumes there is an essential failure in the thinking or actions of the receiver.*
- **Non-judgmental Feedback** - the so-called "sandwich" approach is used to avoid negative emotions and reduce defensiveness, while maintaining trust and psychological safety.
  - Building this feedback sandwich consists of 1) saying something positive to warm up the discussion; 2) stating the feedback you actually wanted to give; 3) then concluding with something else positive to soften the real feedback.
  - While seemingly benign, this method may deprive the receiver from gaining insight and valuable information. While the feedback appears safe, crucial areas of learning can be left untouched, and judgement may still "leak" through.
  - Regardless of the non-judgmental feedback approach being more positive than using judgmental feedback, the assumption is nevertheless "I am right; I have the complete picture; and I will give you the knowledge."
  - *RESULT: this is a protective social strategy using compliment / criticism / compliment; or silence and avoiding correction all together. Folks may not walk away with the needed learning though and may deprive learners of improvement!*
- **Feedback with Good Judgment** is based in an Advocacy-Inquiry approach, where:
  - *Advocacy* is stating what you think, but not about the other person's thinking. The feedback giver's stance is one of curiosity.
  - *Inquiry* is asking open-ended questions, and assumes that you might not have the whole picture. The feedback receiver feels heard.

  Statements you may use in an Observation-Advocacy-Inquiry approach could include:

  - Observation statements might be: "I noticed" or "I observed"
  - Advocacy statements might be: "I think" and "I am wondering"
  - Inquiry statements might be: "How did you see it?" or "Can you tell me more?"

  [Depending on the group size, you may go around the room and ask each participant for examples of one or more statement type. Alternatively, you could describe a feedback scenario and ask participants to respond, and possibly even break them out in dyads.]

For a role play, put participants in groups of two. Define the topic of feedback to be delivered, and encourage participants to frame their feedback in the following ways:

- **Feedback conversations from the giver's perspective may include statements such as:**
  - When you do/say…the effect on me is.
  - I would prefer that you did/said…
  - When I did/said… what was the effect on you?

- **Feedback conversations from the receiver's perspective may include statements such as:**
  - When I hear you say … the effect on me was…
  - I can understand…
  - When I did/said… what was the effect on you?

Debrief/reflection questions:

- What challenges do you face in giving feedback in a diverse workplace?
- How might diversity increase the chances that people will interpret feedback as an act of hostility?
- How would you react if/when receiving feedback from a junior (are you getting a different perspective)?

References:

1. Feedback in Clinical Medical Education. Jack Ende Ende-Feedback-in-Clinical-Medical-Education [33].pdf.
2. Debriefing with Good Judgement: Combining Rigorous Feedback with Genuine Inquiry Feedback with good judgement.pdf.
3. https://thecompletemedic.com/education/debrief-with-good-judgement
4. https://actiondesign.com/resources/readings/advocacy-and-inquiry

III. Coaching Conversations

[30 min.]

Telling someone how to fix a problem is often the wrong approach. You'll foster more learning by asking questions that stimulate reflection, and by coaching people into exploration and experimentation.

Our first instinct is to give advice, and our second instinct is to resist. Humans have the urge to remain the same. The first step is taking off our "Expert Hat" and setting aside our agendas. Acknowledging a person's freedom of choice reduces defensiveness or a response of rebellion.

A coaching-like conversation is an opportunity to support and motivate any person who is at decisional crossroads or is considering making a change. It means putting aside our Expert Hat for the moment and refraining from advising and sharing our own story.

Coaching-like conversations emphasize open listening, respect, and the willingness to engage in a difficult conversation. In these conversations we see the person as a unique individual with the innate resources to solve their own problems.

Instead of seeing people as a problem, we see the whole person in their own right, with a heart/mind/body/spirit. The topic of conversation is interwoven in the person's life—their fully connected life—as no topic exists in isolation. The underlying assumption is the person's strength; their potential and capacity for change. Our role in this situation is to provide a safety net, support, and empower the person.

What coaching is not: Coaching is not therapy, mentoring, managing or training. In a coaching conversation we do provide information, and occasionally advise–with permission. Although some expert approaches can be used in a coaching conversation, they are used infrequently, and only when it could be beneficial.

Specific coaching skills to discuss include open-ended questions, reflections, affirmations, and phrases, and strategies that make a difference in guiding and promoting change.

Reflections convey compassion, improve clarity, deepen understanding, connection, and take pressure off of you to be "right." Different types of reflections help the other person feel heard and valued and help them have more clarity about a given situation. Double-sided reflections encourage a person to look at multiple perspectives, while amplified reflections maximize or minimize the person's statements, magnifying both the effect and outcome, so a person may get more insight into their dilemma.

Framing a person's experience in positive terms moves you from a stance of problem analysis to a conversation where you can engage in brainstorming, action planning and forward movement. By using foundational skills and asking the right question, you may bring on breakthrough awareness, leading to an "A-HA" moment.

Coaching Concepts:

Brainstorming

Brainstorming is an opportunity to co-generate a wide variety of potential approaches to reach the desired goal. It is important to use this time to generate bold or even wild ideas; be visual, specific, and raise as many possibilities as you can. Then you can explore which are more feasible or SMART.

SMART Goals: Setting goals provides a clear focus and direction. The SMART acronym stands for:

Specific: being specific about the actions and behaviors in which the person engages.

Measurable: setting specific criteria that measure progress towards accomplishing the goal.

Action-based/Achievable: breaking down the actions into specific achievable steps.

Realistic: within reach and relevant to one's goal.

Time-bound: with a clearly defined timeline, including a starting and a target date.

Motivational Interviewing

Motivational Interviewing is a counseling approach developed by Miller and Rollnick, which is a technique to elicit motivation for change. It is a person-centered strategy that supports self-efficacy, using listening and empathic skills.

References:

1. Coaching Psychology Manual by Margaret Moore, Erika Jackson, Bob-Tschannen-Moran. Wolters Kluwer 2nd Edition.

Engaging with Differences (with Role Play)

[15 – 25 min.]

Background:

Engaging with differences, otherwise known as leaning into conflict, is challenging and yet can be very rewarding by enhancing relationships and outcomes. It is an important communication skill to achieve optimal shared decision-making with patients and effective team work with colleagues.

Learning Objectives:

- Take stock of the situation and decide whether to engage; know your tendencies; avoid climbing the "ladder of inference;" do your best to create psychological safety; and ultimately create a partnership.
- Evaluate your baseline conflict management style and discuss situations which may require the need to adapt your style.
- Describe the concept of psychological safety and brainstorm ways to create it at different stages of teamwork.
- Practice creating a partnership in tense scenarios by finding the third story.

I. Thomas-Kilmann Conflict Mode Instrument

[20 min.]

Background:

The TKI (Thomas-Kilmann Conflict Mode Instrument) measures five "conflict handling modes," or ways of dealing with conflict: competing, collaborating, compromising, avoiding or accommodating. These five modes can be described along two dimensions: *assertiveness* and *cooperativeness*. Another way to describe the two dimensions is weighing the value of your goals and of your relationship in a given conflict.

From the correlation of these two and the scale of implementation, these are the five modes for handling the presented conflicts:

- **Competing** conflict mode is *assertive* and *non-cooperative*. It refers to addressing only one's own concerns at the cost of the concerns of the other. It is a power-oriented mode—where one uses the power dynamic to get a favorable outcome for oneself. An individual's ability to debate, their position in the hierarchy, or their financial power matters the most. Competing is defensive—it strictly means standing up for your individual beliefs and simply trying to win.
- **Accommodating** mode is both *accepting* and *cooperative*. It is the opposite of competing. While accommodating, the individual in question neglects their own

problems or beliefs to address the problems of the other party. The element of self-sacrifice is highlighted in this mode. Accommodating typically involves selfless understanding, generosity, or charity. At times, accommodating would require you to follow the other person's orders when you would not like to do so or submit to the other's perspective or decisions.

- **Avoiding** is both *unassertive* and *uncooperative*. The individual wants to neither address their own problems nor the problems of others. This ultimately means that they do not want to engage in the conflict at all. Avoiding might be seen at times as a diplomatic move involving bypassing or ignoring the issue. It could also involve putting off the issue until the time is favorable, or simply stepping back from an uncomfortable or hazardous situation.
- **Collaborating** has the most beneficial outcome and is both *assertive* and *cooperative*. This mode is the opposite of avoiding. Collaborating includes a voluntary effort to work alongside the opposition to find a perfect solution that wholly addresses the collective problem. Collaborating involves deep-diving into an issue to locate the critical demands of the concerned individuals or parties. Collaborating between two or more people might take the form of a quest to understand the 'why' of the disagreement. It involves striving to look for creative answers to interpersonal issues and enriching yourself from the other person's insights.
- **Compromising** falls on the *average point on both the assertiveness and cooperativeness scales*. The goal here is to find a mutually acceptable and robust solution that, in some ways, satisfies both the individuals. It comes midway between competing and accommodating. It addresses an issue more directly than avoiding but falls short of investigating it with as much depth and rigor as collaborating. In certain situations, compromising might involve seeking middle-ground solutions, providing concessions, or looking for a quick solution that provides some way forward from the impasse.

Debrief:

- Were you surprised by your baseline conflict management style?
- Is your style mostly compatible with areas of tension in your work?
- What are some scenarios where you might need to adapt?
- When is avoiding potentially a good style?

II. Creating Psychological Safety

[30 min.]

Background:

Psychological safety is the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes. Healthcare can be the ideal setting to achieve optimal psychological safety because it relies on high levels of performance accountability. Leaders can do three things to improve psychological safety:

- Frame "the work" as a learning opportunity (not just an execution problem)
- Acknowledge your own fallibility
- Model curiosity

Goal:

Utilize the four stages of Psychological Safety Framework (Inclusion Safety, Learner Safety, Contributor Safety, and Challenger Safety) to brainstorm ways to improve psychological safety as a leader.

Setup:

- Participants divide up into 4 smaller groups.
- Groups assign one person to take notes and one person to report out.
- Each group is given the Psychological Safety worksheet and assigned one stage. Each group is given 10 minutes to brainstorm ways to improve psychological safety for the example included with their assigned stage.
- After 10 minutes, each group is invited to share with the larger group. Other groups are encouraged to add ideas. After everyone has shared, use the debrief questions below to facilitate discussion.

Debrief:

- Are you thinking of things you can implement in your workplace?
- How can you consider psychological safety when you choose to engage with differences?

Talking Points:

When engaging with differences, it is important to convey the importance of the relationship either because you sincerely value the relationship itself and/or because you can both agree on specific outcomes that you both value and must work together to achieve. Conveying that the relationship is important or identifying shared values and/or desired outcomes as a first step improves psychological safety when engaging with differences.

III. The Third Story

[Large group with breakout into triads | 60 min.]

Background:

We have done a lot of work around learning someone else's perspective and responding compassionately. Anytime you choose to engage with differences, you bring your story (perspective) and the other person brings their story. This session will build on your skills of perspective taking and allow practice in finding the Third Story. The Third Story is a concept developed by Douglas Stone and described in Difficult Conversations: How to Discuss What Matters Most. Finding the Third Story simply encourages appreciating the other person's perspective, apologizing if needed, and gaining agreement on the Third Story— the way to move forward in a partnership based on shared values and/or hopeful outcomes. It is not proving the "right" way and not necessarily agreeing on, fixing, or solving what has already happened. Often the conflict management style that works best in finding the Third Story is compromising.

Setup:

- Participants will break out into triads to practice role-playing three progressively challenging cases of engaging with differences with a focus to finding the Third Story.
- Participants are asked to consider practicing the compromising conflict style and recall and implement concepts of psychological safety, ladder of inference, and describing and inquiring about values.
- Roles will be variable and clearly described on each role-play sheet.

Debrief:

- Were you able to find the Third Story? If not, why? What would be helpful next time?
- Were you able to create some psychological safety early in the interaction?
- Was the Compromising Conflict Style needed? Did that help to implement that style? What was challenging about that?
- Did you find yourself going up the ladder of inference?

Time to reflect (10 min.):

Think about a valuable relationship where you have a difference that causes tension. How can you best engage with that difference?

What can you do to (choose at least one):

- Enhance psychological safety
- Stay low on the ladder of inference
- Consider your conflict management style
- Prepare yourself to be open to the third story

Role Play for Engaging with Differences

Case 1
Person #1

Who: You are a member of an interdisciplinary team which met to build consensus on how to start an important project. Your boss facilitated the meeting. You thrive in these kind of meetings. You were in the middle of presenting an idea and one of your colleagues (Person #2) interrupted you with their own thoughts about the project. In the end, the group circled back to your idea—this felt vindicating, but the path to get there felt very circuitous because of the interruption.

What: Your goal was to help the group by presenting a great idea, gain support from the group, and move it forward efficiently.

Why: You have really been trying to prove yourself in hopes of getting your full bonus this year. You know your colleague was well intended and probably doesn't even realize what happened. You will have to work together on this project moving forward.

Case 1
Person #2

Who: You are a member of an interdisciplinary team which met to build consensus on how to start an important project. Your boss facilitated the meeting. You felt like people were talking over you in the meeting. You feel one colleague (Person #1) was dominating the conversation. Being an introvert, meetings like that are difficult. You prefer to have some space to brainstorm on your own before having to speak up.

What: Your goal was to be given space to present your ideas and gain support from the group.

Why: You are working hard to show your value. You received some difficult feedback from your boss in your last evaluation—you are worried that you could lose your job. You will have to work with this challenging colleague on the project moving forward.

Case 2
Doctor

Who: You are a young physician who recently finished training. You feel you are open to feedback in general, but haven't gotten much since you finished training. You determine medical management for your patients and value shared decision-making. At the same time you are very busy trying to lead the service and teach other learners. You are anxious about your learning curve as an attending. You feel you are a strong team player and take extra time with patients and families. You feel some tension with the APP with whom you work closely and you know you need to check in with them.

What: Your goal is to show others that you are competent and confident in caring for patients. You want to be a leader in your field.

Why: Your mother is a well-known physician in another specialty. She serves in many leadership roles. You hope to have the same positive impact on the world in your specialty that your mother made in her specialty. In that regard, you put a lot of pressure on yourself.

Case 2
Nurse

Who: You are a mid-career APP. You have done a number of joint visits with a physician who is recently out of training. On each visit, you feel the physician takes over and does not leave any room for you to speak up. The physician is busy and moves from patient to patient quickly. You know you have to figure out a way to work together.

What: Your goal is to have space for collaborative visits and feel respected for your experience. Possible specifics may include (or make up your own):

- Physician did not create space for you or other team members to contribute to the conversation.
- Physician offered a medication that will create a disposition challenge or was not indicated in your opinion.
- It feels the physician just wants you to do the documentation… essentially be a scribe.

Why: You feel you have a lot to offer your patients and that the physician could learn from your experience. Ultimately, connecting with patients is where you find meaning and value in your work—this physician is not allowing that.

Case 3
Person #1

Who: You are the son/daughter. You are in San Diego and trying to take care of your family (3 children) and your parents. Your partner works full time and you had to quit your job to support your children and parents. Your mom is in a memory care unit and your father just had a devastating stroke. The doctors are recommending comfort care. They are offering a feeding tube, but they aren't clear whether it would really help. They said it might be a bridge to some partial recovery that would take months. You feel it will not improve the quality of his life and it could make things worse—the doctors described potential complications. Your sibling lives in Boston and does not agree with shifting to comfort care. You resent your sibling for not being more present and on board with the plan of care you think your father would want.

What: Your goal is to convince your sibling that a feeding tube is not a good idea. Ideally your sibling would be more helpful since you're overwhelmed.

Why: You love your parents dearly. You want to honor your dad and make decisions in his best interest. You also love your sibling and want to have a better relationship if possible.

Case 3
Person #2

Who: You are the son/daughter. You live in Boston. You understand your sibling, who lives in San Diego, has provided most of the caregiving and support for your parents. It also isn't your fault that you live out of town—you moved to Boston for your partner and you have built a life there with 2 children. Your mom is in a memory care unit and your father just had a devastating stroke. The doctors are recommending comfort care. They are offering a feeding tube, but they aren't clear whether it would really help. They said it might be a bridge to some partial recovery that would take months. You think your sibling is in the weeds and has trouble seeing the big picture. You are grateful for the care your sibling provides, but your distance allows you to see the big picture.

What: You want to convince your sibling that the feeding tube will allow him the possibility of recovery. It is too early for comfort care.

Why: You love your parents dearly. You want to honor your dad and make decisions in his best interest. Your advocacy for a feeding tube is a show of love. You also love your sibling and want to have a better relationship if possible.

Speaking Plainly

"I'm there to sort of be a mirror and help them like, get where they're kind of naturally getting to and to name that…I love that exercise because there was just so much to it and…it could enact change in a lot of different ways."

—UC San Diego Physician

Half-Life

[20 min.]

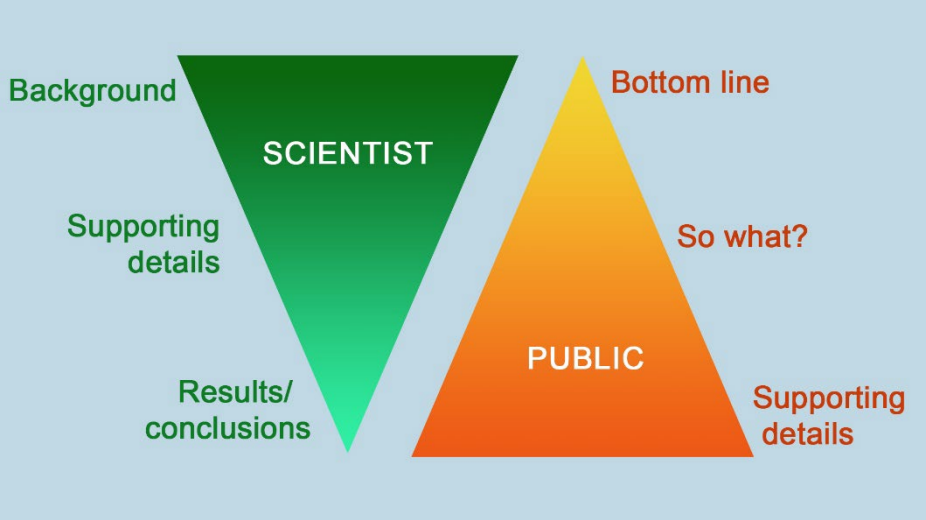


Image credit: Communicating the Science of Climate Change, Physics Today, Somerville & Hassol, 2011

Background:

The diagram above compares how a journalist (orange triangle) communicates a story or concept versus how a scientist traditionally thinks about communication (green triangle). Specifically, a journalist is trained to put the main idea "right up top," and then follow with supporting details that are relevant to a public audience. Scientists (physicians included) usually publish and communicate by providing the background information first, which can be riddled with jargon, clouding the message for the lay public—the setup, details, facts, etc. Then at the very end they provide the conclusion. This exercise helps participants **"flip the triangle"** from green to orange, and distill their message into about a minute.

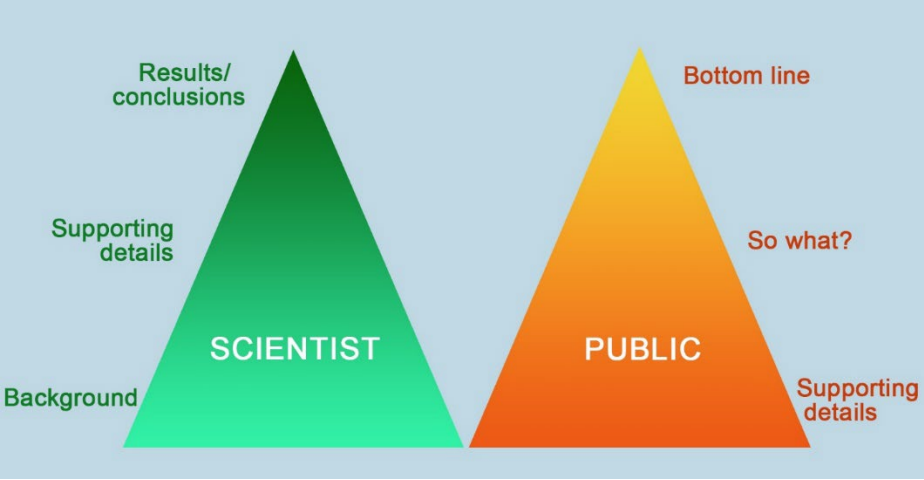
To learn more about these concepts, consider our e-learning course 'A New Communication Framework for Healthcare: Speaking Plainly.'

Setup:

- Define the audience (lay public, member of congress, funder, etc.)
- Define their goal with this audience. What do they want the audience to do, think or feel after they have heard them speak?
- Working in pairs, students will share the story of their project or research for 2 minutes and then revisit the same conversation for 1 minute, 30 seconds and finally 15 seconds. (Or 1 min, 30 sec and 15 sec). The idea is to get to the heart of their message right at the top in an audience-appropriate way.

- Between each timed round, allow the listener to feedback on what stuck with them, and where they get lost in the message. Time feedback for 30-45 seconds so the speaker doesn't get overwhelmed.
- Between each round, side-coach speaker to consider anything important they left out.
- Encourage them to find an analogy or a story that can sum up what they're trying to say.
- Remind them it's not about speaking faster; it's about speaking smarter.
- In a final round, allow them back the full time that you started with. By this point, they should have re-ordered the information so the main points are right at the top.

Here's the **"flipped triangle,"** where healthcare providers communicate like journalists:



Questions for Debrief:

- How did you make adjustments getting to the message more quickly?
- Where was the heart of your message when you had a full two minutes to talk?
- How is this structure different from the story structure?
- When is this structure useful?

Talking Points:

The game illustrates how much we all wait to get to the point. Getting your message right to the top of the conversation helps the listener know the journey they are on. This is especially helpful in putting technical information in context. Journalists call it the lede – and scientists are notorious for "burying the lede." The way information is delivered in a science talk is to present all of the background information first and wait until the end to present the point. While that may be acceptable when writing an article, it's not an effective tactic in conversation, since most people will tune out after about a minute unless there's a compelling story or a clear "so what." Don't "bury the lede" – bring it right to the top of the conversation and build from there.

Flip Talks

[15 – 25 min.]

Learning Objective:

Reinforce the main points of your message that stick with a listener.

Setup:

After playing Half Life, ask participants to gather in a full group. Each person will present their partner's message as though it were their own.

Questions for Debrief:

- What did you learn from your partner's delivery of your message?
- Why did some things stick, and others did not?

Talking Points:

In Half-Life, your partner had an opportunity to hear the same talk 3 or 4 different times. In real life, that never happens. The things that generally stick are clear, vivid and resonant with the listener because they are vivid, relevant and emotional.

The Curse of Knowledge (a.k.a. the clapping exercise)

[5 min.]

Learning Objective:

To recognize the "curse of knowledge" and how quickly it can overtake your perspective.

Setup:

Facilitator will clap the melody of a song that everyone in the room should know. (Suggestions: Take Me Out to the Ballgame, You are My Sunshine, Hey Jude, etc.) Avoid Happy Birthday or The National Anthem as most people when they hear you are going to clap a song that everyone knows will automatically begin listening for these two songs. It's weird, but true.

1. Ask listeners if they can identify the song.
2. If someone knows, have them answer.
3. Reveal the name of the song and clap out the rhythm again.

Talking Points:

What you just experienced is called "the curse of knowledge." This is what happens when we know something so well that we can't remember what it was not to know. It can happen quickly if the information being delivered is connected to something the listener already knows. When you are speaking to someone who doesn't know however, your message can come through like nonsensical tapping...

The goal in communication is to recognize where your listener is coming from and add onto that so that they can appreciate the "music." For more information on this topic, we recommend the book *Made to Stick: Why some ideas survive and others die*, by Chip and Dan Heath. Great reading!

Time Traveler

[20 min.]

Learning Objectives:

Recognize the perspective of someone from a different life experience to speak at an audience-appropriate level. Practice the uses of analogy and effective ordering of information.

Setup (Part 1):

Working in pairs – person A is a time traveler from 300 years ago and person B is from today. Person B is expecting an important call on their cell phone and needs to explain what a cellphone does so when it rings the time traveler doesn't think the speaker is a witch. With all groups working at the same time, let the partners talk for two minutes and then debrief.

Questions for Debrief (Part 1):

- Poll the time travelers: How many of you were talking to a witch?
- Poll a few of these people—what did they say that made you think they were supernatural?
- Talk to those who didn't think their partners were a witch. What did they do or say that made you understand? What analogies did they use? Body language?

Setup (Part 2):

Switch so the opposite person is now the time traveler. This time, the time traveler seems to have broken their finger and the person from today needs to convince them to put their finger into an X-ray machine. Remind them to think about what worked from round one – what are analogies you can use? How can you help this person understand by building on their knowledge? Again, with all groups working at the same time, let them talk for 2 minutes before you poll the time travelers.

Questions for Debrief (Part 2):

- How many of you were willing to put your finger into the X-ray machine?
- What did they say to help you?
- What analogies were used?
- What was different about the body language of the speaker describing the cell phone from the speaker describing the X-ray machine?

Talking Points:

Typically, the last question stumps them. They won't have considered body language here. Watch to make sure this happens, but almost always in the second round the speaker will lean in and use a much more compassionate tone of voice—so in round 2 there are fewer perceived "witches" and more willingness to comply—even when pain is involved. If you haven't already referenced Albert Mehrabian's research on body language/trust, do so here: body language accounts for 55%, tone of voice accounts for 38 % and content only accounts for 7% of what we believe and trust in the first 2 minutes of an encounter.

Watch the facilitation demo: https://youtu.be/DILBKZLlUfw

The Big Idea form

[15 – 25 min.]

Learning Objective:

Develop a clear elevator pitch, introduction, or clear talk using principles drawn from journalism.

Setup:

Run a session where you discuss the using the "Big Idea" to develop the participants' clear talk or presentation.

Have participants fill out the Big Idea form in Appendix C. You may also download the fillable PDF here on our website.

Appendix A: Role Play Guide & Characters

A Guide to Using Role Play in Communication Training

We all use role play as a simulation training method in the medical communication field, with a focus on increasing learner proficiency in acquiring communication and interpersonal skills, along with authenticity, sensitivity to patient needs, self-awareness and developing a reflective capacity.

Despite the multiple benefits of experiential learning, participating in a role play can cause anxiety, and feel artificial and "fake". Learners find the fidelity of the simulation problematic, they feel exposed by the simulation and debriefing in a way that threatens their professional identity, they may feel defensive or shy discussing their performance.

Because of possible resistance it might be important to spend a few minutes upfront to address these issues, to establish buy-in, and provide learner safety.

To normalize anxiety, provide reassurance and encourage risk-taking in a safe environment, you can begin with asking, "what has your prior experience been with role-play?"

> *"Today is a day to try new things without fear of adversely affecting a real patient. It is also an extremely unusual opportunity to get feedback about what you do every day from peers. Don't hold back. Take a chance. It is up to you whether or not you will be open to learning today, or just remain passive."*

Introduction and Pre-brief

Simulation-based learning should be aligned with the clinical context and learner experience-so appropriate topic centric exercises are better. For learner safety, it is critical to create a safe, supportive and learner centered environment with enough tension to induce learning, but not so much to provoke nervousness that anxiety ensues. Therefore, role play is best used in small groups. If all learners in a small group are resistant to doing a role play, you can suggest that each person will do the role play so common ground is established. [Another "trick" is to state that everyone will have the opportunity to do a role play, and it'll only get harder as the day progresses.]

You can maximize learning by using case material that feels familiar and relates to the learners' roles, prior experience, and level of expertise. Alternatively, a facilitator might prompt learners to select and describe their own case relevant to the learning goal of the session. For instance, a learner might identify a time in which they saw a patient show sadness in response to a new diagnosis, in which they could apply the skills of recognizing and responding to emotion. Generally, we find that cases, whether predesigned or learner¬ designed, achieve highest impact when encouraging an individual or group to address a learning goal while maintaining it within the realm of achievable success.

A suggested road map to the set-up process

Establish roles and solicit volunteers

If you are not using a predetermined case, ask "Who is willing to play the provider?" Have the volunteer describe the case in brief, and then elicit: "Who is willing to play the patient?"

Make sure to thank the volunteers for being willing to participate—especially those going first!

One helpful orientation to remember is:

Once the exercise starts, the goal of the entire group is to help the learner succeed.

In the process, the observers will gain insight into their own skills development.

Clarify scenario

It is critical to make sure both players have enough information to play their parts.

- If you choose to have the learner provide the scenario, ask him/her to pick a common scenario in their practice - something they see frequently and that is not too difficult (a "4 or 5 of 10 level of difficulty case. Make sure you clarify the setting (inpatient, outpatient, ER etc.), his/her role (primary care provider, consultant etc.), and the patient's reason for being there.
- If you choose to provide pre-set cases, you will give the participants their instructions, give them a moment to read the instructions, and ask if they have any questions.

Don't start until both learner and patient feel comfortable enough and have what information they need to play the role. Again, be careful not to pick a particularly complex scenario or challenging patient. Don't let the participants procrastinate the role play through endless questions or comments in the set-up process. If someone really seems confused, ask if another observer understands the scenario better and substitute.

Establish ground rules

- Only the facilitator or learner can call a "time out" at any time.
- Let them know that if you call a "time out," it doesn't mean it isn't going well.
- Let them know that if no one calls a "time out," you will allow the role play to run for roughly 3-5 minutes.

Review goals with learner

Ask the learner if there are goals or skills s/he would like to practice. Confirm that both participants are ready.

Physical layout for role play

With in-person small groups, as the facilitator you are ideally seated alongside the learner for ease of intervention and to provide in-the-moment coaching and literal hand-on-shoulder support when necessary.

- Give observers tasks-Give each observer something to pay attention to during the role play.
    - Consider (a) tracking the use of the skills that were outlined, (b) nonverbal communication, (c) rapport-building skill/use of empathy, (d) missed opportunities for empathy, (e) open vs. closed-ended questions.
- Encourage the observers to focus on behaviors and to take notes. At least one person writes down specific empathic statements – the actual words – that the learner uses, and/or specific statements that the patient says that comprise a missed opportunity for empathy.
    - Set feedback expectations- Give them the heads-up about how feedback will be given. You will begin with the learner's self-assessment, moving to the patient, then the observers, then ending with you, and it will be behaviorally specific with reinforcing first, then constructive (remind them of the ideal ratio of 4 reinforcing to 1 constructive).

Running a role play

If none of the participants call a "time out," it will be up to you whether to allow the role play to continue to run without interruption. Deciding when to call a "time out" as a facilitator is often a matter of style- some tend to "time out" frequently, while others leave the majority of the "time outs" to the participants. Here are times to consider calling a "time out":

1. If the learner is not performing the skill (early redirection)
2. If you want to highlight a positive (establishes use of time outs when going well; good for especially anxious participants)
3. If the learner is struggling or stuck
4. For pertinent teaching points (or if too many have passed to remember)
5. The goal is accomplished, or the time limit has been reached
6. If there is laughter
7. Significantly disruptive behavior, other signs of disengagement

When the learner is not using the skills they are expected to practice, there are two options- let them complete the role play without using the skills, or time out early to redirect them to using the skills. There is no right or wrong answer here, simply a matter of personal style. Both approaches have pluses and minuses.

The chief benefit of letting the role play finish without interruption is that the learner discovers during debrief that they have not been using the skills. Note that this requires that they have insight. If they have insight, this experience produces a great "a-ha" moment, especially if they are given the opportunity to re-practice using the skills! Then they can compare and contrast their effectiveness with and without using the skills.

If the learner does not have insight e.g., "I thought it went great!" or "I used all the skills," you'll find yourself in a bit of a pickle. First, you will have the difficult task of trying to find something positive to say AND you will essentially have to deliver (or get the group to deliver) the bad news that they were not, in fact, using appropriate skills.

For this reason, it may be best to time out very quickly if someone is not using appropriate skills. This will allow the learner to name where they think they are. Sometimes the learner has truly lost track, a full suspension of disbelief (excellent!), and you can tailor your intervention accordingly. Sometimes this will elicit resistance from the learner: "but I never do it that way." Then your intervention can be something like,

> *"I know you have tons of experience and comfort in your usual – I'm hoping you'll humor me and try on new skills".*

The advantage with this approach is that by the time you get to the debriefing, you will be truly debriefing their use of the skill. The other advantage is that it can uncover barriers to using the skill sooner, e.g. the learner may say, "I know, it just feels so awkward not to attend to the first problem they present."

It is important to address laughter head on—whether it is coming from a participant in the role play or an observer. Why? First laughter is contagious, and usually interrupts the suspension of disbelief necessary for a role play. Laughter can signal any number of emotions. While it can simply be the expression of pure mirth, it is often the expression of discomfort, which usually bears exploring. The fact that laughter is contagious (and usually also spreads to the facilitator) makes it a lot easier to call a time out to address the group with "why are we laughing?" rather than having to single out an individual with "why are you laughing?" Asking this question of the group, even if it seems obvious to you, makes the discomfort explicit and normalizes it for the group. And if the learner wasn't laughing, it can help alleviate any anxiety they may have that they were being laughed at.

Debriefing a Role Play: Applies both to Time Outs and the End of the Exercise

The following is a suggested road map to the debrief process. The two keys to creating a safe environment for learning are:

Always debrief the learner FIRST

Debrief the effective behaviors FIRST. If you follow these two fundamentals, you will never risk humiliating the learner. Being the learner is a vulnerable position. And health care providers are notoriously self-critical and perfectionistic. Even if they have done a good job, they may be feeling embarrassed and exposed. If you allow other participants to speak first, you will not know how the learner is feeling. If you allow other participants to offer criticism first, the learner may feel even more embarrassed and exposed, even humiliated. Then no effective learning will occur, and subsequent participants will not feel safe.

- Briefly check in with learner (How is it going? How are you feeling?) It is important to respond to their answer by reflecting/modeling these skills for them, which helps the learner feel heard and safe.
- Start with reinforcing feedback
    - Learner first: what are you doing effectively? If they jump to self-criticism, gently steer them back to the reinforcing. "I know it is tempting to jump to what you did wrong, and we will get to that in a minute. Can you start by telling me what you felt you did well?" [Note that the question is not "what did you do well?" – that implies judgment, that there is good and bad. Focusing on behaviors and effect can be perceived less judgmentally.]
    - Patient next: As the patient, what did you feel was especially effective?
    - Check in with each observer: You may similarly need to remind the observers to offer effective feedback only at this point, no criticism! If you have assigned the observer a task, they should frame the feedback according to the task: "With regard to empathy, what did they do effectively?"
    - Your feedback last: Keep your feedback to a minimum- only one or two reinforcing comments.
- Move to corrective/constructive feedback: Note that this should be given in the same order.
    - Learner: What would you do differently? Where did you get stuck? What would you like to hear from the patient?
    - Patient: How did you feel about "X"? "X" should be whatever the learner wanted to hear or have addressed.
    - Check in with observers: You may want to remind them of the ideal ratio of feedback- 4 positive (reinforcing) to 1 "constructive." Again, comments should be framed according to each observer's task. At this point, to reinforce the 4:1 ratio, I won't ask individual observers – after checking in with the learner and patient, I'll just ask the rest of the group generically what they saw. Watch learners carefully during this phase to make sure they are not getting overwhelmed with feedback. If they are, end the feedback early.
    - Your comments last: Again, keep your feedback to a minimum, and don't feel the need to repeat what has already been said.
- Optional: Rewind and Replay. This is always a great option-if there is time!

Closing: Ask learner for takeaways. "What are you taking away from this experience to use next time?" Resist the urge to have the last word. It is also nice to establish a way of recognizing the bravery of the learner through applause or waving hands (applause in sign language) or a simple "thank you."

Types of Role Plays and Variations

Role play can be fully scripted with all players acting from scripts, partially scripted where participants are given certain prompts often after an opening line, or improvised using a character chart of WHO, WHAT and WHY. The learner can also be asked to identify learning goals or share a prior clinical scenario.

WHO, WHAT, WHY

Cases for role play are written in a variety of formats. We like the WHO, WHAT, WHY format, as it is drawn from theater guru Konstantin Stanislavski's method and promotes a deep and quick understanding of the character's circumstances that drive their behavior. In just looking at their own role, participants are forced to respond spontaneously, rather than pre-plan the feelings or reactions. This process is simple – and sometimes scary – but it leads the players to great discovery quickly because they have focused on justifying what their character needs and why. In other words, this process is a pathway to empathy. Included are a variety of WHO, WHAT, WHY characters, as well as cases written in narrative form.

- Other role play variations:
    - Having the learner choose whom they would like to play the patient.
    - Either the facilitator or another participant can be the coach.
    - Role reversal: can be useful if the learner is having trouble empathizing or implementing tools.
    - Switch out learners (rolling role play). Rolling role play can be useful if someone in the audience has a constructive piece of feedback that seems particularly amenable to trying out in the scenario.
    - Demonstration by the facilitator- can role-model at onset, or after practice; useful if none of the participants seems to be able to understand or perform the skill.

The Other Roles of the Facilitator:

Other than setting up, running, and debriefing role plays, small group facilitators have a number of other tasks:

- Keep time: are we keeping on time for the task on hand? Do I need to do something to adjust the pace of the activity?
- Track individuals: are all participants engaged, using verbal communication? Are there any participants who seem lost? Who is actively participating by speaking in the group? Who is not?
- Track group dynamics: how are the individuals relating to each other? Which individuals have made connections to each other? Are there any subgroups that are easily identified (based on gender, race, specialty etc…)? If there are, is any one subgroup more

comfortable or dominating? Are individuals connecting across subgroups? Are there any unspoken rules developing in the group?

Common Facilitation Challenges

Challenging participants:

- **The Naysayer** (the person who is resistant to everything)
- **The Dominator** (the person who dominates the discussion)
- **The Disengaged** (the person who won't participate or is silent or on their phone)
- **The Listener** (the quiet person who may appear disengaged, but might actually just be tricky to read because they are quiet)
- **The Cross Talker** (the person who keeps having side conversations)
- **The Hijacker** (the person who either makes every situation about them)
- **The Stakes Raiser** (the person who keeps elevating the challenge of a situation…but what if?)
- **The Expert** (the person who knows so much they could teach the class, and certainly doesn't need to practice, and who continually challenges the facilitator)
- **The Cerebral** (the person who avoids emotions by analyzing everything intellectually)

Challenging scenarios

- Different levels of learners
- Conflict between participants
- Conflict between a participant and a facilitator
- Facilitator gets triggered

One Approach to Challenging Participants and Scenarios

- **Diagnose what is happening**
    - Observe, and describe in low-inference terms: A) what is happening, trying to stay as objective as possible, and B) how it is affecting you.
    - What data (if any) do you have that the group is being affected?
    - Characterize/name the challenge
    - Hypothesize about the etiology

Intervene in stages

Wait…

- to see if the problem resolves on its own or
- if the group takes care of itself or…if someone else intervenes

Intervene with One or More of the Following

- Respond to the challenging participant or scenario with empathy: "I can see how frustrated you are…" "It must be hard to be here under these circumstances." You can also observe the value rather than the emotion, "I can see how much you care about…"
- Distribute or redirect the conversation to other participants: "Have other people experienced something similar?"
- Roll with resistance. It is not your job to overcome it and fighting it will only increase it. "I appreciate how upsetting/silly/stupid/etc. this seems to you, and I'm not going to force you to participate."
- Take a time out if needed: "Okay. We're going to stop right here for now and take a 10-minute break."

Adaptation for virtual settings

Running a role-play virtually is similar to in-person, but harder to navigate unless you are able to be in the same virtual room. The following adaptations are helpful:

- Invite non-role-play participants to use 'hide non-video participants,' and 'stop audio and video' to allow larger role play participants' tiles on screen to be presented side by side.
- Provide instruction regarding this prior to role play. When running the role play, ask participants if they want you as the facilitator to turn off video, or remain present on the screen as visible support. If you are off-screen, and you need to time-out, you can turn on video, which can act as a signal to conclude the role play. If role play continues despite your appearance, gently interrupt.

Roleplay in Groups of 3

[30+ min.]

Setup & Facilitation:

- Participants work in groups of 3 (person A, B and C). See diagram for rotation:

Roleplay in 3's

Choose person A, B and C

Round 1

Person A – Character
Person B – Clinician
Person C – Observer who will provide simple feedback

Round 2

Person B – Character
Person C – Clinician
Person A – Observer who will provide simple feedback

Round 3

Person C – Character
Person A – Clinician
Person B – Observer who will provide simple feedback

- Hand out one Who/What/Why character chart to each person in the group. With multiple groups, you can use the same 3 characters for easier debrief.
- Allow participants to read their character chart for a minute or so.
- Rotate through Rounds 1, 2 and 3 so all participants have an opportunity to play a character, a healthcare provider and an observer.
- Allow about 2-3 minutes per roleplay. Following each round, allow the observer to feedback for 5-6 minutes with the "actors" in the scene that has just played.
- Feedback as described above should begin with a simple question to the healthcare provider character: What went well? What might you want to change next time?
- Open up feedback to others: What did they do well? What might you suggest for next time?
- Between each round, allow the next character to quickly review their character chart before announcing the beginning of the roleplay.

Questions for Group Debrief:

- What did you gain as a player? An observer?
- What are some things you noticed from doing this exercise?
- How might you take this level of observation into your week?

The following pages contain suggested Role Play Characters that may be used as Who, What, Why cases for a Role Play in 3s exercise.

Role Play Characters

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Suzanne

Who: I'm Suzanne, a working mother with two young children and a widowed father who lives with us. I work two jobs—I cut hair most days at a salon in town and then on the weekends I have a small cleaning business that I run. I don't have insurance because I can't afford it.

What: Get answers about everything going on—my breast, my fear, my kid… I can't afford any of this right now.

Why: I found a lump on my breast, but I think it might just be a cyst and I can't afford a mammogram. My neighbor is a breast cancer survivor and insisted that I come in to get checked, but I can't really pay for anything beyond this visit right now. She's got me worried, which is annoying because I tend to get cysts and I think this is going to go away. I've had it for about a month, so it's more stubborn than most—but I think if you could just give me an antibiotic or something then maybe it will clear up. I've also got problems with my digestion; seem to be having a lot of diarrhea lately and then I take Imodium and then I get constipated. I'd love to get that sorted out too while I'm here. And one of my kids has this weird tic going on—can you let me know what to do about that? I want to get my neighbor's worry out of my head—I don't have time to worry.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Shaun

Who: I'm Shaun, I am a 62-year-old retired university administrator, just lost my wife to breast cancer; I have moved to San Diego to be with my daughter Alicia and care for my 9-year-old granddaughter as my daughter works full-time and really needs my help.

What: I need to decide what to do about my weight.

Why: I have always been heavy, and nothing I have ever done has helped me lose weight. I fact, it is getting worse, and my doctor tells me my "BMI" is too high, and I am a "ticking time bomb". In the last 2 years he has added medication for high blood pressure, high cholesterol, and also, something for early diabetes. I'm always tired and he told me to talk to a new doctor right away about surgery to lose weight after my move to San Diego. I don't know how I am going to tell my daughter I need surgery when I am moving to help her because she needs me. I am also fearful of any surgery, as my mother died on the operation table for surgery for her uterus. I don't want to be pushed into making a decision, and I will have to check out this new doctor to see if I even want to listen to what he has to say.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Elise

Who: I'm Elise and my pronouns are she, her, hers. I'm a college graduate, but not really working in my field, which is art history. I've been making money in our family business, Harmony – we sell CBD products.

What: I've been really depressed and think I need help but I don't know where to turn.

Why: I'm so confused. I've been taking hormones for 6 months now to transition to a woman– but what I think I'm realizing is that I'm not a woman, but a gay man. I've fallen in love with my best friend, Tim, and he is encouraging me to get help before it's too late. I was really bullied as a kid – like in the worst ways – and my mom especially has always been very nurturing – but I've got PTSD about middle school for sure. My family has been really supportive of all my treatments both emotionally and financially and I've enjoyed the prospect of my transition, but honestly, I'm having so many doubts - this week especially. I don't know if this is real, or if it's the hormones. I thought I was clear in my decision, but now I just don't know. It's making me really depressed. I don't want to go further down this path if it's the wrong choice. I'm scared.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Becca

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now. Some of this information may not come out in your role play, but is intended to help you understand the emotions that the character is dealing with in conjunction with their health concern.

Who: I'm Becca, a 45-year old IT specialist working with a government agency. I'm married to Joan and we have an adopted daughter from Nigeria and two cats.

What: Get some answers about why it hurts to eat!

Why: We are in the middle of a huge transition in our lives, moving from the city to a more rural area. Joan's job was phased out of her company and I'm making enough money for her to take a year to write a book she's been dreaming about. I don't know if it's the stress of the move or if there's something physical going on, but every time I eat I get these terrible cramps and really bad gas. I eat a pretty normal diet and try to be healthy with whole grains and the good fats – but honestly nothing makes me feel good. Like I said this could just be stress, but both my parents had bleeding ulcers and I have had acid reflux in the past. I've tried taking the Prilosec and tums and that stuff – but it's just not working. Joan is a worrier – I'm the more stable one emotionally – but even this has me concerned. My mom died of a tumor in her belly (a carcinoid tumor in her ileum) and her first symptom was weight loss and an inability to eat. I'm for sure not losing weight – but the eating thing is troubling.

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now.

Jim

Here are some ways of considering WHO this character is, WHAT they want to achieve in this visit, and WHY that goal matters to them right now. Some of this information may not come out in your roleplay, but is intended to help you understand the emotions that the character is dealing with in conjunction with their health concern.

Who: I'm Jim, a 55-year old plumber, avid sports fan, former smoker, and coach for my son's baseball team.

What: Figure out what's wrong and fix me.

Why: I've been having a lot of problems breathing lately and I feel really exhausted and feverish. I quit smoking 20 years ago, but I'm worried that all the years that I smoked have caught up with me. My mom died of ovarian cancer, and before she died, she made me promise to quit smoking. It took me 10 years to keep that promise. I've got a wicked cough that's keeping me up at night, so I'm exhausted and just feel like crap. I've had some sharp pains in my chest, but they come and go, so I haven't felt like I needed to get to the doctor before now. The fever just hit me in the last couple of days and the Nyquil and Vicks on my chest aren't helping this. My son's team is in the playoffs, so this is a crucial time for me to be there for the kids.

Appendix B: Frequently Asked Questions about Building a Curriculum

How do I begin?

Two of the most important considerations when thinking about facilitating these types of exercises are time and space. These seemingly simple exercises can open people up quickly, so we begin by establishing group agreements.

As you plan for your workshop or course using this guide pay particular attention to the TIME listed in each exercise. We have tried to be specific about our standard format so that you have the time needed to:

- Set up and facilitate the exercise.
- Debrief, allowing group discussion and optional written reflection. Use the debrief suggestions as a guide but do not feel obligated to ask every question.
- Use the talking points as a method of closing the loop on the debrief discussion. The talking points we have included are reflective of discussions we frequently hear from our participants, so use what your participants have said to conclude that exercise before moving on to the next.

If you also have roleplays that you plan to include, you will follow the same procedure – set up/facilitate, debrief, and optional written reflection. Remember, when you model good listening as a facilitator, this is an example of compassionate communication for your learners. When reviewing lesson plans with our Affiliate Faculty, the most frequent issue is trying to cram too many exercises into the time allotted and feeling rushed in the session. Better to rein in your expectations as you plan, so you have ample time to allow for interactivity and participant discussion/reflection.

We have included our 'Developing your Curriculum' form to help you focus your ideas into Learning Objectives and make sure you're building your workshop in audience-specific and engaging ways.

A Word on Group Discussion

Facilitating a group discussion can be tricky. If people do not feel safe, they won't speak. Group agreements help. Paying attention to group demographics help. Welcoming comments from quieter members helps. Expecting contributions from the group helps. AND – it can still be tricky. You might need to reframe your questions. You might need to just allow silence in the room for people to think before they speak. It's hard to allow silence – but you will become more comfortable with it as you do more of these sessions. Your goal is to provide time and space for people to process and speak – and at the same time keep the train on the tracks. Group discussions can quickly shift into complaining sessions, so once the points of the exercise are articulated by participants, move to talking points to solidify those observations and move on.

If you have someone taking over the discussion, you can try a couple "yes, and" techniques:

1. Acknowledge the speaker's need to keep talking with: "Yes, this is an important issue/conversation, and I want to make sure we're hearing from the full group."
2. If the over-sharer is moving off topic, you might want to acknowledge that with, "Yes, there are so many aspects of this conversation we could discuss, and I want to focus now back on X, Y or Z." Then shift your focus to someone else to contribute.
3. If the over-sharer is taking the group hostage, you might speak with them privately about allowing others to contribute for the purpose of trust and group safety.
4. If you've done all the above to no avail, the group will see your efforts, and this is probably part of a larger cultural issue that you can't control in the role you play as facilitator. Just do your best and try not to punish yourself for your facilitation skills after the workshop. Sometimes, there is only so much you can do.

A Word on Zoom

Doing these exercises on zoom can be particularly challenging, and if possible, we recommend live sessions. If you are doing a workshop on Zoom, invite people to turn on their cameras if possible, and utilize the chat for group discussions. If you are sending people to breakout rooms, make sure you are comfortable using them and that participants have clear direction. If you want to do a role play, we highly recommend doing those as demonstrations in front of the full group rather than in a breakout room.

Pre-packaged Workshops:

If you want to move forward quickly as a facilitator, we have a number of pre-packaged workshop PowerPoints available. Used in conjunction with this Facilitation Guide, you should be able to review the suggested activities in those PowerPoints, or quickly swap in your own slides with discipline-appropriate research, examples, or roleplays. These PowerPoints can be used as "plug-and-play" options, or as a foundation to include your own approaches. If you are interested, please contact us via our Inquiry Form on the training page of our website.

Online Modules and Facilitation Guides

Check out our online learning modules 'A New Communication Framework for Healthcare' and 'Communicating with the Public,' which can be found on Coursera. These include optional Facilitation Guides, so you can use the Online Learning as pre-work, and bring students into the

classroom for skills practice. Our Facilitation Guides offer ideas for some exercises, but you might choose to swap out some of those suggestions for different exercises in this book. Visit this page on our website to request a copy of the Facilitation Guides.

Group Agreements Example

Group agreements are a good way to start your session. They help set the tone and feel for what is expected of people, and can represent the first "bonding" exercise among your participants—especially if you allow them to add additional agreements that they all support.

Here's an example of a group agreement set we've used in some of our sessions:

- *Observe deep confidentiality*
- *Be present as fully as possible*
- *Attend to your own inner teacher*
- *When things get rough, turn to wonder*
- *Speak your truth in ways that respect other people's truth*
- *Trust that perfection is not possible. Befriend discomfort rather than resist it*
- *No fixing, no saving, no correcting each other, no presuming my lived experience is the same as another's*

Appendix C: Fillable Forms & Additional Materials to Supplement Exercises

The BIG IDEA Form

The BIG IDEA

Bring Clarity, Relevance and Impact to Your Message!

You can use this form to prepare for: an elevator pitch, the beginning of a longer talk, a conversation with funders, a media interview...or even your family at the holidays!

Before you generate your BIG IDEA with this form, it is important to consider your audience. **Communication only exists if the speaker's message resonates in some way with their audience.** You wouldn't speak the same way to a kindergartner as you would a rocket scientist – so start with them. Recognizing their needs first will help you shape what to include and exclude, and help you consider audience-appropriate language and examples.

WHO is your audience? *A job or research interviewer? The media? A funding source?*

WHY is this topic important to them?

WHO are you? *Relationship to audience and/or your credentials.*

WHY do you care about this topic?

WHAT is your Goal? *What do you want your audience to think, feel or do?*

The BIG IDEA

Your audience might have a different perspective on your topic than you do. You might encounter misunderstanding or even confrontation from a listener. When this happens, you need to have a strategy that 1) shows understanding and even empathy for their position, and 2) bridges the conversation back to your BIG IDEA.

One way is to think about the common ground that you both share. For example, a pediatrician talking to a vaccine-hesitant parent—their common ground is that both doctor and parent are concerned with the health of the child. Let's construct your message in a conversational way.
Consider beginning with language like: *"One thing we BOTH care about is _____."*

You have considered the people involved in this communication scenario and the common ground that exists between you. **Drawing on that information, and in the simplest form, what is this topic about? This is The BIG IDEA.** The BIG IDEA needs to be drawn from your passion about this topic and described in a way that is relevant to the cares and concerns of your audience. For example, as a pediatrician, Evonne's BIG IDEA is that the benefits of vaccination far outweigh the slight chance of side effects you might be concerned with.
Consider beginning with language like: *"The thing I care about most in this area is _____."*

Use the space below (if desired) to expand the BIG IDEA and, if applicable, add your research question.
Consider beginning with language like: *"I / our team are trying to / we wondered if _____."*

The BIG IDEA

What is the most novel aspect of what you are doing? How do you stand apart?
Remember, people are a part of this story.

An example, analogy or metaphor helps support understanding (don't skip these steps)

(EXAMPLE: "An example of this is _____.")

(ANALOGY or METAPHOR: "It's kind of like _____.")

How will the world change? *Remember to include what is at stake. What will happen if this work succeeds or fails?*

The final statement is the only thing many audiences remember. Make it count! *"The most important thing to remember is _____."* (*Revisit what makes you novel and why it should matter to them).*

In speaking or writing, you may choose to expand on some of these ideas, and/or leave some out. You may choose to reorder this writing to engage your audience more directly. It is likely that this template has provided a framework that you might need to tie together with transitions. The intent is to give you a starting point that will make your message not only reflective of your work – but resonant to the audience in front of you. Remember, what you say is only as valuable as how you say it. **How people hear your message determines whether you make a connection – so go back to your WHY and tap into that passion to motivate your reason to speak. Good luck!**

What's the Story? Form

What's the Story?

Speaking about your research in the form of a story can be a helpful way of connecting your message to a range of listeners and readers. This template can help you in that process.

Begin with audience

Your story is only effective if it is relevant to the people that will read or hear it. While you might not know your audience exactly, you can consider the demographics of the people that might engage with this publication or attend this type of presentation or lecture. **If you can be specific, do.** If you can't, think broadly and let those answers help you shape your story.

WHO IS MY AUDIENCE?

WHY DO THEY CARE ABOUT THIS TOPIC?

In the most evocative single sentence, what is this story about?Example: This is a story about cancer treatment that is as unique as the patient.

FINISH THIS SENTENCE **This is a story about ...**

It is possible that in defining what the story is about, you have also defined your research question or the climax of the story. In our example, you can imagine that the arc of the story begins with cancer treatment that at one time wasn't individualized, a research question that asks – can we make treatment better? – a number of twists and turns in that adventure – and a climax in which a study of patients in a clinical trial have had significantly different results in their treatment. The world is potentially "happily ever after" as a result of this process. Again – look at the arc. **What did it used to be? What changed?** Above all – don't forget the importance of people and emotion. Emotion in story is not about "dumbing it down" or watering down the science. It is about helping your audience grapple with the importance and remember your message. Getting to this climax involved sleepless nights and one or two celebrations. **Don't leave yourself or your team out of this story. Let's begin.**

THE BEGINNING defines what used to be – the status quo that your research question disrupts. Set the stage for your audience. Begin with a prompt like: "At one time..." or "Currently..."

What's the Story?

RESEARCH QUESTION: In story, this is the inciting incident, or the event that lifts us away from the status quo. Remember – this is where you begin to include **WHY** you or your team care. Consider beginning with the prompt: We wondered if/we hoped that/we were curious about…

TWISTS/TURNS/UNEXPECTED FINDINGS. Nothing about your work was easy. Consider **WHY** your audience cares about this issue. Let their interests help you determine what to include and exclude. Not everything is interesting – find the most surprising element that led you forward or backward in this work. Consider using any of these prompts: We were surprised to find that/we didn't expect/we were frustrated when…

CLIMAX. All of the twists, turns and unexpected findings led you to one significant moment. You either succeeded or failed in answering your research question. Don't be afraid to describe that moment in vivid detail. You can edit later – but for now, describe the moment of success or failure evocatively. Consider using the prompt: After all of this, we suddenly realized…

ENDING. Remember the beginning and the climax. The world changed as a result of this journey. The change meant something to you and your team. You either found what you were looking for – or you didn't and are now challenged to find a new research question. The ending matters. Make it clear, interesting and evocative. Consider using these prompts: What we hope/Now we believe/We have an opportunity now to…

Depending on the length of your story, you might need to add space to some of these fields. Use these prompts as a guide and once finished, share your story with someone outside of your field. Listen to their reactions and edit based on their curiosity. Enjoy!

Hot Buttons Worksheet

"Hot Buttons" Chart: Take five minutes to fill out the categories on the chart below.

1. Write three patient behaviors that "Push your Buttons"

2. Write the emotion word that describes the way each of these behaviors makes you feel

3. What is the autonomic system reaction you experience for each behavior?

4. Reflect on your usual response to each behavior

Psychological Safety Worksheet

Psychological Safety Worksheet

1. Inclusion Safety	*Imagine there is a new team member who is from a different cultural background. How could someone acknowledge and show sensitivity and appreciation for this new team member?*
2. Learner Safety	*Describe a person that played a pivotal role in your life by creating learner safety, and believed in your ability to learn.*

3. Contributor Safety	*How do you foster an environment of contributor safety in your place of work?*
4. Challenger Safety	*How do you foster an environment where everyone is encouraged to express ideas that challenge the status quo?*

Background on Narrative Humility

NARRATIVE HUMILITY, MORAL DISTRESS, & EMOTIONAL SELF-REGULATION

> *"Like authors and actors…entering into a suffering which necessarily resides outside the clinician's own physical and emotional being depends upon the clinician finding an entry point into that suffering from within her own imaginative self."*
>
> -Narrative Humility, Sayatani DasGupta

A BRIEF HISTORY OF CULTURAL FRAMEWORKS IN MEDICINE & HEALTHCARE

Let's begin with an acknowledgement that each framework we discuss here has utility; the key is to understand how they complement one another and can be used to best suit your and your patients' needs.

The National Medical Association defines **cultural competency as the application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhance a provider's effectiveness in managing patient care**. The term was first used by Terry L. Cross and colleagues in 1989, but it was not until almost a decade later that health care professionals began to be formally educated and trained in cultural competence. In 2002, cultural competence in health care emerged as a field and has been increasingly embedded into medical education curricula and taught in health settings around the world since then. **There is no single agreed-upon definition of cultural competency**, and as a framework it has received continued critique largely for its emphasis on culture as monolithic and patients from other cultures definable by a list of traits, values or characteristics. The framework has a tendency to focus on "the other," and has historically failed to effectively teach skills in self-reflection, intersectionality, and perspective-gathering. Its design also implies an endpoint at which one has mastered knowledge of another culture.

Developed in response to the cultural competency model, **cultural humility is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves**. It is a process, as opposed to a list of facts or details, requiring humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care. The term was introduced in 1998 by Tervalon & Murray-Garcia and, importantly, recognizes the shifting nature of intersecting identities — that even in sameness there is difference — and that a clinician will never be fully competent about the evolving and dynamic nature of a patient's experiences. This framework places emphasis on self-reflection and building self-awareness; it is a life-long endeavor of constant calling in and owning one's own cultural biases and assumptions. The

main drawback with overemphasis on this framework is that it centers culture as the frame of reference for "other."

Not every difference is a cultural one, and thus, **Narrative Humility** shows up on the scene: This framework asks us to consider co-construction of a narrative and emphasizes the importance of story. *How does **who** we are impact **how** we connect and communicate?*

NARRATIVE HUMILITY AND THE IMAGINATIVE SELF

Now we will take a deeper dive into narrative humility and the application of the "imaginative self." Sayatani DasGupta states that, "narrative humility acknowledges that patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story." It asks that we examine the nature of the self, paying particular attention to two core properties of personal identity—individuality and continuity. Individuality recognizes that while we are all human beings navigating social and structural systems, our experience within and between those systems is different and unique in ways that are significant and fundamental to our identity. Continuity is the awareness of the self over time– that we have a past, present, and future that creates a story of who we are and informs how we engage with ourselves and others. This is relevant as we are co-constructing narratives with our patients.

> *"Narrative humility allows clinicians to recognize that each story we hear holds elements of the unfamiliar—be they cultural, socioeconomic, sexual, religious, or idiosyncratically personal."*
>
> -Narrative Humility, Sayatani DasGupta

Narrative Humility:

- Emphasizes equity over equality.
- Asks you to **listen to understand** and **respond authentically** based on this moment.
- Diagnosis dictates the treatment, just as **the elements of someone's story should influence your interaction**.
- Sometimes differences rooted in identity require the most of our imaginative selves. This is largely because of how **social and structural systems impact experiences** and shape people's lives.

Cultural Competency	Cultural Humility	Narrative Humility
Emphasis on **other** Perceived endpoint Centers **mastery**	Emphasis on **self** Life-long practice Centers **culture**	Emphasis on **co-construction** Life-long practice Centers **story**
Useful to understand basic cultural norms; balance with recognition that culture is not monolithic and there will be in-culture differences.	Humility is useful – not to think less of oneself, but to think of oneself. Culture is not the only thing that differentiates individual experiences.	Giving space to the unique live experiences of individuals while recognizing the limits of one's ability to fully understand.

ONE MORE IMPORTANT FRAMEWORK: STRUCTURAL COMPETENCY

Structural competency is the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures. Metzl and Hansen develop structural competency to include the ability to discern not only how social and structural determinants of health influence symptoms, attitudes, or disease, as well how assumptions embedded in language and attitude serve to empower some and disempower others.

It pairs with the work of narrative humility in asking one to be conscious of the larger social and structural landscapes in which stories are being shared or not shared, and consider how broader structural forces might impact a patient's ability to speak honestly in a clinical settings and what could subject patients to harassment or differential treatment.

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