THE CLINIC IS MY WOODSHED: A NEW PARADIGM FOR LEARNING AND REFINING COMMUNICATION SKILLS

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There is a story that circulates among musicians about Charlie Parker, the greatest alto saxophone player in jazz history. As the story goes, the teenage Parker was known locally around Kansas City as a bold and bawdy prodigy when he stepped on to a stage to sit in with members of Count Basie's Orchestra. When the time came for Parker to solo, he tore into a blitz of undisciplined notes, flailing away on the horn without even noticing the other musicians, who, one by one, had stopped playing and were staring at him in disgust. Finally, Jo Jones, Basie's mercurial drummer, took one of his cymbals and flung it toward Parker, crashing it on the ground and bringing the solo to a humiliating end. With his head hanging, Parker trudged off the stage, retreating to his home and swearing to never play again. At some point, he had a change of heart, and took his saxophone and all of the Count Basie records he could find out to a woodshed in the back yard, where he remained days and nights for months, practicing until he could play effortlessly, melodically, and blisteringly fast, becoming a true virtuoso. When he emerged, he went back to the club and asked Basie if he could sit in once again. What happened next was magical. Those who were in attendance later spoke of the event as a revelation – here was a musician playing things they had never heard before, never thought possible on the saxophone, all because of Parker's time "in the woodshed." From that day forward, the term "woodshedding" came to signify a period of focused practice, wherein a musician takes his or her playing to the next level.(1)

Just like the best medical encounters, jazz music is conversational.(2) When jazz musicians improvise, they enter into a musical dialogue with one another on the bandstand. Like verbal exchanges, this musical conversation consists of "words" and "phrases," which musicians call "riffs". The more riffs a musician knows, the larger her vocabulary, and the more eloquent will be her musical statements during the conversation. Jazz musicians use the term "chops" to

refer to the size of one's vocabulary and the facility with which they can use it. Becoming good at playing jazz is therefore a process of developing one's chops, and requires focused practice, both in the practice room, and on the bandstand playing for audiences. Those who become the best never lose this spirit of practicing, continually honing their chops throughout their professional lives.

We suggest that, like jazz musicians, physicians need to spend time in the woodshed honing their communicative chops. However, for medical professionals, the woodshed is not a practice room or isolated place. Rather, clinical environments are our woodsheds, where opportunities abound to build communication skills. Using the woodshed metaphor, below we explore three concepts related to a) practice, b) education, and c) communities that, taken together, represent a paradigm shift for the field of communication skills training.

First, practice is the main path toward building proficiency. In his book "Outliers," Malcolm Gladwell cites 10,000 hours as the amount of practice needed to achieve greatness in a particular specialty.(3) Not all practice hours are the same, though. Studies show that professional musicians practice in a qualitatively different way than novices.(4) The practice of a professional is focused, efficient, mindful, and centers on defined deficiency areas, aiming to fill gaps in the professional's abilities. For example, while novice musicians may learn a song by playing it multiple times from beginning to end, making the same mistakes over and over, professional musicians instead will quickly isolate the specific passages that cause difficulty, and practice just those passages over and over. Using the clinic as the woodshed, physicians can build and refine communicative chops only if they deliberatively plan their practice. Both of us subscribe to focusing on one new or underdeveloped skill (e.g., teach-backs, empathic statements, etc.) with every patient (or nearly every patient) during each clinic session or series

of sessions. By practicing only one skill at a time and in rapid repetition with successive patients, we are able to practice intensively, keeping our rhythm and avoiding cognitive overload given the myriad of medical and administrative tasks we have to perform during an average clinical session.

Second, the woodshed metaphor challenges prevailing assumptions about communication skills education. Whether explicit or implicit, a common notion in the medical communication skills literature is that learners build skill during formal education activities, such as simulation, small group discussions and demonstrations, preceptor sessions, or others. However, when we ask colleagues and friends about how musicians get good at playing an instrument, nearly all reply that this process happens while practicing at home. What then, is the purpose of the music lesson? We suggest that the formal lesson is *not* intended to build proficiency, but rather to set an agenda for what to practice, allow learners to try out what they will be practicing, provide feedback aimed at enabling high quality practice (i.e., isolating the passages that need the most practice), and motivate the learner to practice in between lessons.(5) In contrast to current models, if such a paradigm were to translate to medical communication skills training, formal educational sessions would contain fewer communicative concepts and behaviors, would have space for initial practice, and would help learners to plan how they are going to practice the concept (amid all of their other duties) when they enter the clinical woodshed. For example, rather than teaching "how to break bad news," a scenario which ties together multiple communicative behaviors including supporting emotions, expressing empathy, soliciting the patient's perspective, and planning next steps, in a woodshedding paradigm, the formal lesson would isolate only one of these skills, give learners a chance to practice it in both bad news and other scenarios, identify personal difficulties that they want to improve, and help learners to

devise a realistic plan for repeated and deliberate practice in their own clinical environments. There would be ample time between lessons so that learners could accrue enough practice to become proficient with one behavior before moving on to the next. The essence of the woodshedding paradigm requires educators to acknowledge that skills are built during practice, and practice exists outside of the realm of the formal educational session.

Finally, high quality and sustained practice can be further enabled in the context of a supportive community.(6) If proficiency is built through sustained practice in the clinical woodshed, priority must be given to helping practitioners sustain their practice, and ensure that it is high quality. Two of the greatest tenor saxophonists in jazz history were relentless practicers. John Coltrane was said to fall asleep at night playing his saxophone, and could be heard playing in nightclub bathroom stalls in between sets. Sonny Rollins left an active performance career in 1959 for a three-year hiatus during which he could be seen in the wee hours of the morning playing his saxophone on the Williamsburg Bridge overlooking New York's East River. Jazz musicians tell a story about Coltrane and Rollins honing their craft together. One would pick up the phone at night and call the other, only to play a phrase on his horn into the phone receiver and abruptly hang up. The other would think about it for a while, then call back with an answering phrase. The two would go back and forth for hours, trading musical ideas over the phone.(7) It is important for one to have a community of like-minded individuals in which to share ideas, tell stories, and plan the next round of practice in the woodshed. Not only does this motivate, it also provides ideas about what to practice and how to know if it is working. What if hospitals and clinics protected some of their practitioners' time to observe one another's work, to discuss what was observed, and to plan for practice when returning to the job? What if the organizational structure explicitly supported communities of practice with respect to

communication skills? What if the system recognized that its clinical environments are the woodsheds in which its practitioners develop, grow, and potentially become virtuosos?

Each and every patient encounter adds a unique but brief opportunity to perfect our art. Our life experiences, practice experiences, articles we read, workshops we attend, and many other factors will inform our understanding of the human condition and provide new ideas about how to communicate more effectively with our patients. In order to realize each new idea and build it into our professional persona, though, we need to go back to the clinic, our woodshed, and repeat it many times in order to make it real. In other words, we need to continually work on our "practice" of medicine.

References

1. Crouch S. Kansas City Lightning: The Rise and Times of Charlie Parker. New York: Harper Collins; 2013.
2. Haidet P. Jazz and the 'art' of medicine: improvisation in the medical encounter. Ann Fam Med 2007;5:164-169.
3. Gladwell M. Outliers: The Story of Success. New York: Little, Brown and Company; 2008.
4. Ericsson KA. Acquisition and maintenance of medical expertise: a perspective from the expert-performance approach with deliberate practice. Acad Med 2015;90: epub ahead of print.
5. Davidoff F. Music lessons: what musicians can teach doctors (and other health professionals) Ann Intern Med 2011;154:426-429.
6. Watling C, Driessen E, van der Vleuten CP, Lingard L. Learning culture and feedback: an international study of medical athletes and musicians. Med Educ 2014;48:713-723.
7. Ward GC and Burns K. Jazz: A History of America's Music. New York: Knopf; 2000.