The Case of the Lazy Learners

Case by Dr. Andy Grock

"And that is best available evidence around tetracaine in corneal abrasions. Hopefully that answered your question!" Chris finished his mid-shift teaching with a flourish. He felt confident that his short talk had been well received and educational to the residents working with him in the emergency department that day. Always the enthusiastic teacher he added, "Before going back to work, do you have any questions about this topic or anything else you've been curious about?"

After a few seconds of silence, one senior resident responded, "Quick, someone ask him more questions so that we don't have to go back to seeing patients." After some chuckles from the other residents, a junior resident added, "We only have 3 hours left! Let's try to stretch this out until our shifts are over." The residents laughed again, did not ask any further questions, and then returned to providing patient care.

Chris returned to his busy shift and immediately saw numerous patients had yet to be seen with even more in waiting room. Furthermore, some of these patients had potentially dangerous chief complaints and two had at least one abnormal vital sign. Something about the residents' comments and reactions started to bother Chris, but it wasn't until his busy shift ended that he recognized what about the interaction was not sitting well with him.

After leaving, he began to wonder what would have happened if a patient's relative or someone who was still waiting to be seen had heard those comments, or the department chair, or a hard-working nurse.

Chris also considered the potential implications these seemingly innocent and flippant comments have on how the residents view their profession and their patients. During his residency his mentors had imparted and stressed the old adages – "the sickest patient in the room is the next patient to be seen" and "more patients, more learning." Were these residents not cognizant of these wise sayings? Seeing patients was supposed to be an honor, a noble responsibility, not something residents try to get out of. Imagine if they think these comments are the norm and make them while working in the community. The more Chris reflected, the more he started to doubt the residents' work ethic and dedication.

Chris felt guilty for not immediately addressing and correcting these comments at the time. He had missed a valuable opportunity to coach and demonstrate professionalism to his learners.

Case
Dr. Andy Grock

Objectives / Questions:
Dr. Teresa Chan

Expert Commentaries
Dr. Sandy Dong
Dr. Sean Moore
Dr. Taku Taira

Curated Community Commentary
Dr. Tamara McColl

MEdIC Project Lead
Dr. Teresa Chan
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Questions for Discussion

1. Is resident feedback necessary in this scenario? If so, what would your approach be to providing feedback?
2. Do you think resident burnout is a factor in this scenario? If so would that change how you approach giving feedback?
3. How do you deal with lapses in resident professionalism like this at your institution?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Team Management (ICS2)	Professional Communicator Collaborator

Intended Objectives of Case

1. Discuss and identify learner-specific factors that may lead to the perception of “laziness”.
2. Describe an approach for addressing unprofessional behaviours such as “laziness”
3. Investigate and list your specific institutional policies or local procedures for dealing with professionalism problems.

Expert Response

The Hidden Curriculum

by Sandy Dong MD, FRCPC, MSc

There are a number of issues to unpack in this scenario. The first is that this is an example of the Hidden Curriculum: "the attitudes and values conveyed, most often in an implicit and tacit fashion, sometimes unintentionally, via the educational structures, practices, and culture…"[1] The residents, although seemingly in innocent jest, have, perhaps unintentionally and unconsciously, socialized a poor work ethic. A junior, and more impressionable, learner may come away with the wrong idea of what is acceptable behavior. Worse, a junior learner may repeat the behavior and thus perpetuating and normalizing it.

The Hidden Curriculum manifests in many ways. Recently, I was looking at the website of one the medical schools in Canada (who shall remain nameless). Its professed mission statement featured education and research (in that order). In contrast, in its "faculty news" section on the same page, the achievements highlighted were all about research grants and awards.

The Hidden Curriculum can be anathema to the professionalism that society expects of physicians.[2] The junior medical student may have naïve but admirable ideas of the practice of medicine. "I want to help others" typifies many aspiring medical student application letters. Yet as training progresses, students learn detachment, and before long patients become symptoms and diseases ("The chest pain in bed 8").[3] At its worst, the environment can become toxic and trainees start calling their patients "gomers", or worse.

What we say really matters

Chris pick up another string in the scenario: What would others think of the conversation? I don't think patients and families would appreciate hearing these comments. A seemingly innocuous remark can be all they hear, and for all the wrong reasons. I will give a personal example. One of my relatives was sick in the hospital a few years ago. A family member was at the bedside most of the day, waiting for the medical team to discuss the care. It was late in the day, into the supper hour, when the attending arrived. I believe the attending was simply commenting on how late it was, and possibly commending the family member for staying so long, but the words were something to the effect of, "you're still here?" Unfortunately, the family member interpreted the comment to mean that the attending physician had fully expected the sick relative to have already died, and was irritated that he had not!

As physicians, our words hold tremendous weight and we must always be cognizant of what we say and how it can be perceived, by patients, families, trainees, and colleagues.

My feeling is that the need for feedback depends on some of the context. I would presume that speaking such thoughts aloud in front of the preceptor would indicate some level of familiarity and comfort between learners and preceptor. However, the scenario is an opportunity for Chris to educate the learners on the Hidden Curriculum and to remind them that seemingly innocent remarks can be taken in unexpected ways and have unintended consequences.

Burnout and the "Hidden Curriculum"

There is evidence that cynicism and burnout are associated with the hidden curriculum.[4] Further study is needed to establish causality, as burnout and unprofessional behavior may be maladaptive responses to the demands of residency. I don't get a strong sense of burnout from the text of the scenario. However, if there is evidence of burnout in this resident group or that they are overworked and are too fatigued to go back to the shift, these need to be addressed. I don't think it changes the content of the feedback on communication and professionalism and the incident can be the initiation for inquiring about burnout and wellness.

The Feedback

Unfortunately, the "Hidden Curriculum" is not uncommon, and lapses of professionalism do occur in the middle of patient care areas. I coach residents to be deliberate in what they say and how it can be misinterpreted or the wrong point can come across. Curtains are not soundproof!

Most of the time, it is appropriate to give the feedback in real time. However, more serious lapses in judgment and professionalism do need to be followed up appropriately, either at the end of the shift or the next day, when everyone is less fatigued or distracted by clinical duties. Most institutions have a procedure for removing learners when the behavior poses an immediate threat to patient safety. The exact method of feedback depends on those factors above. In this case, if I was Chris and I had missed the opportunity at the time, I would contact the team and use it as an opportunity to learn about the "Hidden Curriculum".

Expert Response

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About the Expert

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Expert Response

The Art of Feedback vs The Comeback

by Sean Moore MD CM, FRCPC, FACEP

Before discussing clinical education and feedback strategies, it is worth stressing that the emergency physician's primary responsibility is to act in the best interest of the patients in the department. Ensuring safety and the effective delivery of care must always remain the priority for each member of the team. The primary concern, according to Chris, was that he didn't respond to a professionalism issue. Yet, it appears that Chris made the appropriate decision in making sure that there was no further delay in sending his learners back to work. Chris's appreciation of adages like "the sickest person in the room is the next patient to be seen" is worth noting. Certainly, Chris would feel a sense of accomplishment if he knew that his strong work ethic was passed along to the learners under his supervision.

Managing competing clinical and educational priorities is an important aspect of the art of emergency medicine education. It may be constructive for Chris to be clear with his learners about the typical range and expectation of patient flow for a resident on shift. This sets the stage for the climate of the interactions with learners throughout the shift. Patient flow management is a crucial emergency medicine skill, and should not be overlooked by instructors. It is a valid topic to which trainees must dedicate significant effort if they are to achieve mastery.

The behaviors and banter described in this particular scenario require further questioning of the learners, and direct feedback. Some people have the enviable ability to come up with an appropriate response or "comeback" rapidly and others take time to digest information before offering feedback. Each of these has its advantages. One strategy Chris could consider is stopping the conversation and saying, "This isn't the time or the place for this conversation, but I want to pick this up after we make sure the department is in better shape."

It would be worthwhile for Chris to speak with the senior resident and provide him with feedback. An open-ended advocacy inquiry style question might be fruitful. Chris could begin with: "It's considered a privilege to care for patients and an obligation to remain professional around your colleagues and teammates. Your comment about trying to avoid seeing patients was picked up and repeated by one of the juniors. Where did that come from?" This style of questioning, especially popular in the simulation debriefing world is well suited to uncovering frames of thinking or behaviors. It could be that the resident was suffering from burn-out or that they were dealing with some other issue like a recent loss of a patient, but that does not mitigate the need to reflect on the professionalism. It also should be provided as specific feedback and recorded for program directors to potentially see a trend with similar concerns.

It may additionally be helpful to explicitly name the issue of work ethic or professionalism as a teaching discussion point with the whole team at the end of the shift. Chris might begin with: "Lets talk about work flow today and the comments that came up about avoiding patient care for a few minutes." This might lead to discussion of appropriateness of conversations where patients might overhear confidential conversations, patient duty, modelling behaviors, or any number of teaching points. If Chris felt it might be beneficial, he could ask the senior resident to lead the discussion, and later provide him some pointers or specific "words to live by" relating to work ethic.

A culture of collaboration, respect, and dedication to patients, families, visitors, and prospective patients needs to be maintained by each and every member of the health care team. Teaching these behaviors in stressful situations like emergency medicine shifts can be challenging, but provides essential and valued lessons. How and when these behaviours should be taught is debatable. The simplest answer is that they should be constantly taught through role modelling. Specific 'teachable' moments may be use to stress their importance.

Correctly or incorrectly, Chris avoided dealing with the troubling banter amongst his learners at the time of the interaction. His feeling of guilt about it leads me to believe that he needs to clear the air with them. Some clinicians strongly value a friendly, non-confrontational teaching environment, while others stress hierarchy and a more didactic approach.. Whatever an individual's style, appropriate feedback has to be given, even if it is of a difficult or critical nature. If the person delivering the feedback is genuine in their expression of the importance of the issue, these feelings are usually picked up by the person receiving the comments. Sometimes, difficult feedback is better given privately, but is usually best given while recollections of the events are clear. Regardless of Chris's approach, the time and effort spent sorting out difficult feelings or interactions will pay off in the long run for everyone involved.

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About the Expert

Sean Moore (@SeanWMoore1) is an emergency physician from Kenora, Ontario with a focus on simulation evaluation. He is affiliated with the Lake of the Woods District Hospital and the Ornge flight paramedic service.

Expert Response

Understanding the Context and Providing Feedback

by Taku Taira MD

My initial reaction to this case was to generate a list of questions. As a program director, I have seen many instances where egregious behavior appeared suddenly more reasonable when the context, circumstances, and possible interpretations of a resident's behavior were made clear. One of my role models emphasizes the importance of seeking to understand and hear all sides of the story before judging or criticizing. This is especially true where learners are involved. To understand this case, I would want to know more about the residents and their work schedules, the attending and his relationship to his residents, the professional environment and culture of learning, and the busy-ness of the department. Without context, it is hard to interpret the residents' comments and form an opinion about whether feedback is necessary.

The need for feedback, and my approach to it depends on the severity of the issue and the sense of any underlying or ongoing issues with the resident. A resident having a bad day is substantially different from a bad resident, and any feedback should reflect that.

It is not clear from the case that these residents are "lazy learners." Delaying judgment about the character and intention of a person helps us to avoid the bias that comes with those labels. If these residents were not enthusiastic about seeing patients, I would ask myself why. Could it be that these residents have not yet developed a feel for managing the department and were unaware of patient load? Do they need strategies for developing a bird's eye view of the department? Are they having trouble maintaining their charting or making decisions about disposition? Are they trying to deal with a logistical barrier that they need assistance with? Are they truly lazy? Are they unaware that that is how they are perceived? Each of these scenarios mandates a different response, guidance, and teaching.

If Chris chooses to address the comments directly after understanding the context and the educational need, I would suggest framing the feedback in a constructive manner. I would recommend starting the conversation with a statement like "I think it is important that you know that when you make statements like that, it comes across as not caring about clinical care or your patients. This in turn makes you appear lazy, which is not how you want people to see you." This may help open a constructive conversation and avoid an oppositional interaction that does not naturally lead to behavior change.

Although it may be difficult for a single attending to differentiate between a resident with an isolated incident and one with an issue, it becomes clearer when an incident is part of an established pattern. Regardless of whether Chris chooses to provide feedback to the residents in question, I would encourage him to talk about it with the program director. As a PD, it is frustrating to discuss an incident and have a faculty member reveal that it is actually part of a pattern of behavior. Although I can understand a faculty member's reluctance to bring everything to the PD, seeing multiple small pieces of the picture allows the PD to better identify the residents that are struggling and to help them.

Burnout as a Cause of Unprofessional Behavior

It distinctly possible that burnout plays a role in this scenario. An early paper defined burnout as "a progressive loss of idealism, energy and purpose experienced by people in the helping professions as a result of their work conditions."[1] This loss of meaning manifests as cynicism, emotional exhaustion, and feeling of inefficacy.[2] A resident who appears unengaged, cynical, and lacking in empathy may not be lazy and unprofessional. Instead, he or she may be burned-out or suffering depression. In light of the high rate of burnout among emergency physicians,[3] we should always consider burnout as part of our "differential diagnosis."

The educational environment is complex, and studies have shown that it can both contribute to and prevent burnout.[4-6] Many of the elements that contribute to burnout—work hours, shift length, equipment, mental health resources, clinical autonomy, and ancillary staffing—require systems level changes that can only be addressed by departmental leadership.

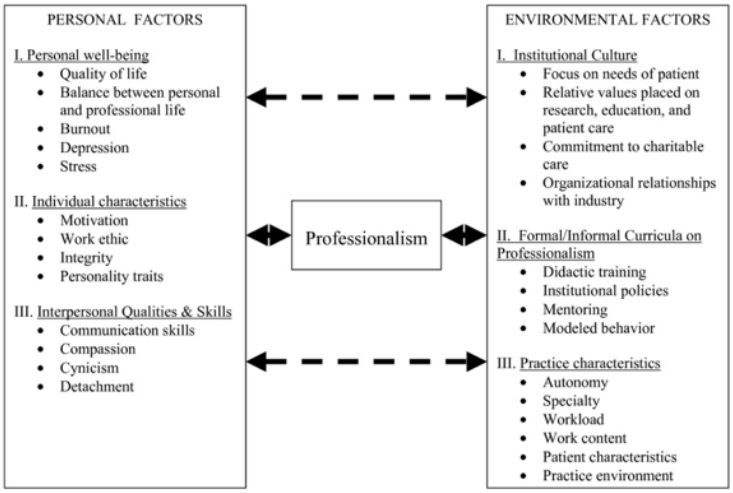
Maslach[2] summarized the prevention of burnout in this way: "If all of the knowledge and advice about how to beat burnout could be summed up in one word, that word would be balance—balance between giving and getting, balance between stress and calm, balance between work and home." This need for balance is especially important when teaching in the clinical environment, and there is a role here for Chris to self-reflect. There were multiple patients to be seen after the teaching session. I have personally received feedback packets where some residents say I don't teach enough immediately followed by another resident who says I teach too much and they can't get their work done. Although we often focus on strategies to tip the balance towards education and away from service, doing this to an extreme can also be a source of stress for residents. Perhaps Chris had lost sight of characteristics of the department and chose an inappropriate time for didactic teaching.

Expert Response

Teaching Professionalism

I think that the most interesting question this case raises is how we can instil professional values and a sense of personal responsibility toward our patients.

West and colleagues used the following figure to represent the factors that contribute to professionalism[7]:



Reading through these lists it is easy to see the parallels between burnout and failures of professionalism. Although there is very little that we can do to address many of the environmental factors that lead to unprofessional factors, there is virtually nothing impeding our ability to address the formal and informal curricula. We can use all of the same tools that we use to address clinical knowledge and skill to our teaching of professionalism: We can use teaching time to talk about professionalism. We can take care to conscientiously role-model professional behavior. Through mentorship, we can guide learners towards professional behavior. Through this approach, we can give residents the ability to better understand how their behavior is viewed, have a clear picture of appropriate behavior, and in turn avoid negative consequences.

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About the Expert

Taku Taira (@TakuTaira) is the Associate Program Director at the EM residency program at LA Country and University of Southern California (LAC+USC). He is primarily focussed on guiding people to meet their full potential. He lives his professional life inspired by others and hope to do the same in return for others.

Curated Community Commentary

By Tamara McColl MD, FRCPC, MEd(candidate)

This month, we presented a case written by Dr. Andy Grock, in which an emergency physician, Chris, questions the work ethic, dedication and professionalism of his residents after an on-shift teaching interaction in which his residents joke about wasting time instead of tending to the patients in the department. Two major themes arose from the online discussion surrounding the case.

The first theme that was voiced by participants was the role of physician/resident burnout in apparent lapses in professionalism. Dr. Loice Swisher quite rightly pointed out that we often blame the individual without acknowledging the impact of the system on that individual. She also notes that the system in which we now work is vastly different from the system in which many staff physicians trained in terms of volume, acuity and emphasis on patient flow. Dr. John Bailitz similarly noted that we must turn our focus on the system when playing the blame game. He felt that our current medical system is responsible for slowly 'draining the joy' from the practice of medicine.

Dr. Alkarim Velji echoed the connection to learner burnout by comparing residency to a marathon and noted that resident social circles often include resident colleagues since they spend a significant amount of their time training together in 'the trenches'. He noted that these 'off-handed comments' may have been a way for the residents to 'let loose during a short academic break' and were less likely to have been a true example of lack of work ethic among the learners.

The second theme discussed by participants was that of resident feedback. Interestingly, commentators raised the question of whether this is a consistent issue of lack of work ethic and lapse in professionalism or merely a single occurrence within the 'safety of an academic session'. Dr. Velji noted, "Enforcing a strict culture of 'all you must do is work, and only work' would drain the life out of these residents." Dr. Natasha Bosma Wheaton agreed that if the general feedback shift to shift is positive, then this isolated incident was likely a sign of burnout, which would require a very different discussion than simply feedback on professionalism.

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Dr. J. Bailitz
Dr. Natasha Bosma Wheaton
Dr. J. Eicken
Dr. L. Swisher
Dr. A. Velji

She noted the importance of teasing out the motivation behind the comments and allowing the conversation to become more of an open forum to voice their emotions and frustrations with academic work, clinical experiences and life in general.

Dr. John Bailitz voiced that we need to change our approach to residents in these situations. "Instead of feedback, we should start with empathy." He recommended that staff physicians should start their shifts by asking their learners how they are doing, not just at work but in life as well. Dr. Swisher similarly encouraged that we take these opportunities to perform a 'mental health check' with our residents and students.

Medicine is a challenging field, both clinically and academically, leaving little time to stop and smell the roses, so to speak. We must always remember, therefore, to look out for one another, as it is equally mentally tasking and we may misinterpret signs of burnout for lapses in work ethic or dedication to our patients. Dr. Bailitz signed off by reminding us that despite the many challenges in our field, we must do justice to the next generation of doctors and continue to lead by example, "Always aspiring to altruism, accountability, duty, honor, honesty, integrity, respect for all others, empathy and excellence in all endeavors."

About

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