# The Case of the Exasperated Educator

Case Written by Drs. Lindsay Melvin & Teresa Chan

**Case**
Drs. Lindsay Melvin & Teresa Chan

**Objectives:**
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**Expert Responses**
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**Curated Community Commentary**
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The day was turning out ok for Justine. She'd gone to the gym this morning at 8am, and now refreshed, she strolled into the Emergency Department right on time to start her 10am shift. Double-whip mocha coffee frappe in one hand, stethoscope in the other, she was feeling pretty good. Having just started as a junior faculty member at Best University, Justine felt energized as she walked in the doors of the busy trauma bays of A.W. Esome hospital wondering what exciting new cases would be thrown her way!

Setting down her bag, she looked over and saw her friend (and fellow recent grad) Charlie looking quite a bit exasperated.

"Tell me more about the chest pain, Bobbi," Charlie grunted. The medical student seemed nervous, shuffling papers and trying desperately to find the answers somewhere in her pile of scrap notes.

"More? Well, I, um, well, it is central... it feels like a knife… um, um, he also had it before, too, but a long time ago..." She pauses. "That's it."

Charlie sighed. He abruptly grabbed the chart, and started flipping through her paper work. Justine thought he looked especially tired, and quickly looked over to the staffing schedule. She thought she had seen him last night coming in as she left her busy days shift…. Wait… Ah-ha! That's right, he HAD worked last night until 2am! And he was back again already for a 7am shift? That was an extremely short turn around for him, Justine noted.

Charlie flipped the medical student's chart to reveal a sparse, very messy, note.

"Is that all you wrote?"
"Yes." Bobbi replies.
"What about the ECG?"
"Um, It was fine. I think…" There was a pregnant pause. "Actually…I don't really know where it is."

"Did you look at it?"
"Well… no. I couldn't find it... um, it isn't with the chart."

If the medical student had been nervous before, now Justine was worried she was going to keel over. Her face had dropped, and she was turning a particularly bright shade of pink.

"Bobbi, this assessment is not complete. Go back and do a better job."

"Okay… but …"

"No 'buts'. Go. NOW."

As the medical student stumbles out of the room, Charlie turned to Justine and shrugs. "Man," he exclaims, rubbing his eyes. "It's good to see you! It's been so busy this morning, and we've already had two cardiac arrests, and now the department is totally backed up…"

Justine raised an eyebrow. "Uhhhhh… What's up with that student?"

"Oh, Bobbi? Yeah, she's pretty rough still…. All her assessments and notes are always only half done, and she never seems to know what's going on. This is the third chest pain she's had now, and this one was no better than the last. I've told her twice to be more thorough and not to rush. But she keeps coming back with an incomplete history."

"Hmmm. Sounds like it's been a tough day," remarked Justine. "But you were a bit tough on her, no?"

"She's really very weak. And it's my third shift with her. I've given her all the time in the world with her patients, and still, she's just not getting it. Of course, I'm going to be honest with her. She needs to stop making excuses, and get the job done…. Why? What was I supposed to say?"

### Questions for Discussion

1. What advice would you give Charlie colleague about handling this interaction?
2. Is this a learner in difficulty? How would you make that determination?
3. What other factors are contributing to this scenario?
4. What are the barriers to dealing with learners in difficulty in daily interactions and how can these barriers be overcome?

## Competencies

| ACGME | CanMEDS |
|---|---|
| Professional Values (PROF1)<br>Team Management (ISC2) | Professional<br>Collaborator<br>Scholar |

## Intended Objectives of Case

1. Outline the components of an orientation to a new clinical environment.
2. Discuss the contextual factors that may affect teaching, assessment and learning.
3. Describe how you would approach a struggling learner and teacher.
4. List features of a learner that is struggling transiently and a learner that is in serious difficulty. Compare these two lists.

# Expert Response

## Time to take out the ED STAT

by Allison Kirkham BA MD MEd (Canddiate)

The emergency department is a rapidly-changing, complex learning environment that poses many challenges to clinical educators.[1] In addition to the inherent ED barriers of sleep deprivation, flow management and overcrowding, we face the unique educational challenges of frequent interruptions, diverse patient presentations, and inconsistent interactions with a diverse group of learners.[2]

Prior to diagnosing a learner in difficulty, we must acknowledge both the communication pitfalls and contextual biases that contribute to challenging faculty-learner interactions in the emergency department.

### ED STAT[3] (by Sherbino et al., 2009)

| | ED STAT mnemonic | Definition | How it applies to our Case |
|---|---|---|---|
| **E** | Expectations | Every clinical environment is different. Prior to each shift, articulate your operational expectations for the learner, including procedural tasks and logistics of patient review. The learner should also have the opportunity to identify learning goals and knowledge gaps. | In this case, Charlie should have taken a moment at the beginning of the shift to orient Bobbi to both the department and his management style. |
| **D** | Diagnose the learner | Whether you are working together for the first time or know the learner well, take a moment to acknowledge their level of training and familiarize yourself with the clinical objectives for that level. Consider any previously identified personal or academic challenges impacting their performance. | Opening up this conversation might reveal that Bobbi has insight into her own problems (e.g. self-identified issues with data collection during history taking). Charlie can then provide specific feedback and coaching tailored to her needs. |
| **S** | Set-up | Particularly at the novice level, ensure that you prepare the learner for success prior to the first patient interaction. Prime them with complaint-specific history questions or review a list of key features they should look for on physical exam. Be specific with expectations for investigations and review. | It would have been useful to prime Bobbi before the encounter she just completed. Priming takes advantage of the teacher's expertise and makes the expectations explicit by guiding a learner through the clinician's reasoning. |
| **T** | Teach | Consider teaching modalities that utilize shadowing and direct observation, when met with a struggling learner. A "see one then watch them do one" approach allows the teacher to model optimal management and then directly observe where the learner is having difficulty.<br><br>Pure shadowing is a particularly effective strategy when faced with an overwhelmed department. The teacher may simply feel like a role of a well-informed tour guide, but learners to value the opportunity to see teachers in action too. This technique (i.e. having the learner 'ride shotgun') allows for flow management while still engaging the learner in a rich learning experience. | During overnight shifts, you may have to switch between multiple teaching techniques. For instance, you might initially have very junior learners "ride shotgun" as you run from room to room.<br><br>When things settle down, you can directly observe the learner, providing real-time feedback. |
| **A** | Assessment & Feedback | Accurate and constructive feedback is critical, but we continue to falter when delivering negative assessments.<br>experience difficulties in knowledge, skills or attitudes. Identify which domain is lacking then provide both an example and specific recommendation for improvement.<br>It is also important to expect and elicit feedback in return! | Charlie might instead say: "Bobbi, you appear to struggle with the differential diagnosis for chest pain. Can you review that ddx for 10 minutes then we will talk about it before the next patient?" |
| **T** | Teacher Always (Role Model) | It is impossible to omit external ED stressors from the faculty-learner relationship but it is critical to recognize when the environment influences our behavior and judgment. Self-monitoring and reflection can assist all educators in discerning whether a learner is in difficulty, or a product of an ineffective faculty-learner interaction. | Insight and self-reflection can be difficult, especially at the end of a night shift. That said, the help of a colleague or mentor can be useful.<br><br>In this scenario, Justine could act as a sounding board for Charlie. With support, he might come to realize his current judgment of Bobbi is erroneous. |

# Expert Response

In the case of an exasperated educator, a *time out* to regroup and set the stage for subsequent patient interactions is warranted. The "ED-STAT" (Emergency Department Strategies for Teaching Any Time) framework developed by Jonathan Sherbino et al. (2009) is a teaching model that can help Charlie & Bobbi get back on track.[3]

Creating the optimal ED teaching environment is challenging. Recommending an ED STAT time out can help Justine diagnose the issues for both Charlie and Bobbi and help them work toward a less exasperating experience.

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## About the Expert


Dr. Allison Kirkham (@AllisonKirkham) is a Chief Resident in the Emergency Medicine program at the University of Alberta in Edmonton, Alberta. She is completing a Masters in Health Professions Education with an academic focus in marginalized populations, professionalism and physician wellness. When not teaching weekend resuscitation courses or undergraduate drama workshops, she can be found in search of the world's spiciest food with her adventurous partner and their giant canine companion, Delta.

# Expert Response

## A Framework for the Assessment of a Learner in Difficulty

by J. Kimo Takayesu MD MS

There are several issues complicating this learning interaction that relate directly to effective communication between the learner and teacher. The differential experience between an expert clinician and a novice leaves a large gap to cover when setting expectations for performance. Understanding exactly what, and how, to teach the novice requires an understanding of their current level of performance and clinical knowledge base.

In the clinical environment, assessment of performance requires direct observation to gather data that is reliable and accurate upon which to base feedback and set further learning goals.[1] Relative to the expert, the novice has limited experience in the variability of presentations, or "illness scripts", for a particular disease, creating a large gap between learner and expert expectations of adequate performance.[2] The expectations informing assessment and feedback must be grounded in reasonable expectations of learner performance to be relevant and effective.[3] The principles of deliberate practice[4] apply throughout the spectrum of performance and, when applied to the novice, should prompt feedback directed at the leading edge of their performance that is based on a clear understanding of their current abilities.

In this case, the learner's disjointed presentation is reflective of poor diagnostic reasoning based on inadequate information gathering[3] and the attending's confusion is magnified because he did not observe the clinical interaction. Fatigue and workflow are also affecting the attending's ability to be emotionally available and intellectually present. When the department gets busy, the need for assistance in clinical care supersedes learning, truncating the time to provide feedback and perform bedside teaching.[5] The clinical pressures of high volume and ED overcrowding limits his ability to directly observe the learner and devote time to exploring her learning needs.

The biggest barriers to constructive criticism are fears that the learner's feelings will be hurt and that the feedback will be taken the wrong way.[6] Learners in difficulty require feedback that is not uniformly positive. Asking the learner for their reflections on their performance can contextualize feedback based on their learning goals, making it more relevant to their personal needs[6] – an essential feature of adult learning.[7] Feedback can be offered effectively using a three step process: set the stage by asking the learner for permission , make both positive and negative observations, and end with a clear recommendation to improve one thing.[6] There is often more than one thing to improve upon in the eyes of an expert; however, the novice may be operating at their leading edge of ability. Changing one thing is difficult; changing more than one thing may be impossible. This is much akin to juggling 5 balls as opposed to 3 (or 2). In this scenario, creating an action plan based on direct observations[6] or one facet of the presentation that demonstrates the student's limitation in diagnostic reasoning[7] is the best first step to improving both the learner's performance and attending's feelings of frustration.

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### About the Expert

As the Assistant Residency Director of the Harvard-affiliated Emergency Medicine (EM) Residency at Brigham and Women's/Massachusetts General Hospitals, Dr. Takayesu designed a residency curriculum using a variety of teaching methods including mannequin simulation, partial task training, seminars, case conferences, and small-group evidence-based learning. He serves as the co-director of the EM clerkship for fourth year medical students, mentoring mentors senior medical students, exposing them to the practice of Emergency Medicine, and providing them with guidance through the application and interview process. As the EM Departmental Simulation Officer, he runs a program for individual resident formative assessment.

# Curated Community

By Brent Thoma MA MD

*A qualitative methodology was used to curate the community discussion. Tweets and blog comments were analyzed, and four overarching themes were extracted from the online discussions. Prior to publication, we sent this analysis to one of our community members to perform a "member*

The comments on the case this week fell into two major themes: addressing Charlie's exasperation with his learner, preventing struggles for learners like Bobbi in the future, and determining how much Bobbi is struggling.

### Addressing the Exasperation

Anne Smith (@annestir) noted that Justine is going to need to approach this discussion with Charlie carefully. In addition to his present state of exasperation with his learner, it sounds like he is lacking sleep, dealing with a tough schedule, and having a difficult clinical shift. She suggested that a good first step might be reducing his load in some way – Amy Walsh (@docamyewalsh) thought covering his teaching responsibilities and/or difficult patients for a while so he could take a break may be effective. From here it would be helpful to determine what might be causing the disconnect between Charlie and Bobbi and whether it is just Bobbi or if he has had similar problems with other students.

### Preventing Future Problems

Amy Walsh (@docamyewalsh) and Anne Smith (@annestir) noted that it is difficult to assess learners in the ED, especially during brief exposures on stressful shifts. However, Nadim

## Contributors

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

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## About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

## Did you use this MEdIC resource?

We would love to hear how you did. Please email teresamchan@gmail.com or tweet us @Brent_Thoma and @TChanMD to let us know.

## Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

## Usage