



## The Case of the Fibbing First Year

Case by Dr. Teresa Chan

### Case

Dr. Teresa Chan

### Objectives / Questions:

Dr. Teresa Chan

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Dr. Andrew Eyre

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### MEdIC Project Lead

Dr. Teresa Chan

Dr. Brent Thoma

### ALiEM Editor-in-Chief

Dr. Michelle Lin

Caroline was struggling with one of her residents. As an assistant professor, her job included reviewing daily shift encounter cards for all of the off-service residents. Brian was an off-service resident who had been very keen to learn. He had, however, demonstrated significant knowledge deficits and multiple preceptors had expressed concern that he was not performing on par with his cohort. Caroline had met with Brian a few weeks ago to discuss her concerns, and they had created a tentative plan for remediation.

Fortunately, since their discussion Brian was reading more regularly, his attendance at teaching rounds was perfect, and his feedback from attendings was improving. However, Caroline still had the impression that there was something 'off'.

"Dr. Caroline?" Brian approached Caroline timidly.

"Yep. Gimme a second..." Caroline said as she intently stared at her computer screen and waved Brian to sit down. She was typing down some final notes on the resuscitation they had just managed.

"No problem," replied Brian, taking a seat.

"I just wanted to present the patient with chest pain that we were chatting about when the patient in cardiac arrest came in. He's been waiting a long time, and he's getting agitated."

Caroline saved her progress on the note, and turned her attention to Brian. "Okay, tell me about your patient."

Brian began telling her the story of Gerry. Gerry was a 56-year-old gentleman who had come in with retrosternal chest pain that had resolved a few hours ago. Brian explained that he had no cardiac risk factors, no personal history of coronary artery disease, and was a thin, fit-looking guy. His physical exam had been "non-contributory".

"Has he ever used cocaine or other drugs?" probed Caroline.

"Ummm...no...no.I don't believe so?" stuttered Brian.

"You don't *believe* so? Did you ask him?"

"Well, no, I didn't ask him...not directly...I kinda asked him about his social habits --you know smoking, drinking, cannabis--so I'm certain that if he had a problem with drugs he would have told me, right? Plus he looks like a pretty clean-cut guy. He is a banker after all..."

Caroline suppressed a sigh. She had repeatedly impressed upon Brian the importance of explicitly asking about social habits, including recreational drugs.

"Alright, well, we can ask again when we see him together. Tell me, Brian, what's your differential for Gerry's chest pain?"

"Well, my differential is the typical things: ACS, PE, pneumonia, aortic dissection."

"When you examined Gerry, did you find a pulse differential?"

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### Questions for Discussion

1. Why do learners sometimes 'fib' when presenting cases?
2. Do you think it is difficult for Brian to admit that he is having difficulties? Why do you think that's the case?
3. Are there things that Caroline has done that may have potentiated his reluctance to ask for help?

"Um...no?"

"You don't sound sure, Brian."

"No."

"Did you do bilateral blood pressures on him?"

"Well, no..."

"Did you ask if the chest pain was maximal at onset, radiating to the back, or ripping and tearing in quality?"

"I asked him how bad the pain was and he said it was really severe so I think it was maximal at onset."

"If you did not perform a thorough physical exam or ask important questions about the type of chest pain he was experiencing then how do you know aortic dissection is part of your differential?" Caroline's frustration was starting to show. She took a deep breath.

"What about risk stratification for the other items in your differential?"

"What do you mean?"

"What's his risk of PE? ACS? You remember all the decision rule scores that we've talked about, like the HEART score for ACS or the Well's score for PE?"

"Well, he is PERC negative so I didn't do the Well's score."

"But he's over 50 years of age, right? So he isn't PERC negative."

"Oh. Yeah. Sorry. So, I guess his Well's score is 0."

"You guess? Did you calculate it?"

Caroline was exasperated. She and Brian had discussed the PE and ACS risk stratification rules in depth during their most recent shift together. She had also suggested multiple resources for him to review and had emphasized the importance of obtaining a detailed history.

Brian seemed to still be deciding how he should answer Caroline's question.

"I don't want you to lie to me" Caroline prompted, trying to remain calm.

"Um...I'm not really lying; I just haven't done the calculation..."

"Then that is what you should say rather than guessing. Maybe you should stop for a moment, and *think* before you present a case" Caroline said with a note of anger creeping into her voice. Seeing Brian's defeated expression, Caroline immediately regretted her harsh words. Forcing a smile, she suggested he go back and try to clarify the history.

"Okay..." Brian mumbled, walking back towards Gerry's room.

## Competencies

| ACGME                       | CanMEDS                                 |
|-----------------------------|---|
| Professional Values (PROF1) | Professional<br>Communicator<br>Scholar |

## Intended Objectives of Case

1. Discuss and identify learner-specific factors that might contribute to 'fibbing' in the clinical environment.
2. Discuss and identify teacher-specific or environmental factors that might encourage 'fibbing' by learners in the clinical environment.
3. List specific things that should and should not be done when dealing with 'fibbing'.

## A Learner's Perspective on 'Fibbing'

by Andrew Eyre MD

While the majority of resident physicians progress smoothly through their various training programs, it is not uncommon in academic medicine to encounter a resident who can be classified as a so-called 'problem learner'.<sup>1</sup> Although numerous definitions exist, Vaughn and colleagues define a problem learner as a "learner whose academic performance is significantly below performance potential because of a specific affective, cognitive, structural, or interpersonal difficulty".<sup>2</sup> That is, a 'problem learner' or 'problem resident' falls below the acceptable standards of knowledge, skills or attitudes or in some combination of these areas. There are numerous and diverse reasons why a learner may perform below expectations. Common examples include knowledge deficits, misaligned educational systems, personal relationship difficulties, substance abuse, sleep deprivation, mental health disorders, family illness, or interpersonal conflicts with colleagues and supervisors. However, it is often far easier to identify the presence of a problem than it is to define the exact nature of the problem or how to solve it. In this case, Brian has clearly been identified as a "problem-learner," yet the faculty does not have a clear understanding of exactly what is causing Brian to perform poorly or have an effective plan to assist Brian in overcoming his deficits.

Recognizing the difficulties that teachers face in comprehensively characterizing a learner's difficulties and the contributing factors, Yvonne Steinert from McGill University developed a framework for analyzing 'problem learners'.<sup>1,3</sup> Her approach encourages faculty to consider the wide array of issues that could be related to any learner's problems. Specifically, this framework (known as the 'KSALTS' framework) breaks the problems down into categories of knowledge, skills, attitudes, teacher, learner and system. Using this system, we can obtain a more complete understanding of why Brian (or any other student) is not performing well in this particular instance. In this case, Brian's poor performance may be due to several problems from Steinert's framework. While he certainly appears to have a frank knowledge deficit, he also has a strained interaction with his teacher, the system has placed him in an off-service rotation away from his colleagues, and the fact that he has chosen to 'fib' raises the issues of honesty and attitude. Although there are clearly a number of important issues to address, Caroline's approach, while quite common, not only fails to pinpoint the exact problems, but also serves to create an uncomfortable and antagonistic teacher/student relationship.

In this case, Brian's history, physical examination, and clinical reasoning skills are clearly below the expectations of the faculty member, Caroline. While the faculty seems to attribute this to motivational issues, it actually appears that Brian primarily struggles from a lack of knowledge. It does not seem that Brian is too lazy to ask the correct questions; rather, it is far more likely he doesn't know which questions needed to be asked, and why they are important. It is highly likely that he learned in medical school that asking about recreational drugs is essential to a 'comprehensive history', but he may not understand enough about the pharmacology of illicit substances to know why it was important to specifically ask about cocaine in patients presenting with chest pain. Unfortunately, Caroline misses potentially valuable teaching opportunities because she is more focused on telling Brian which questions he failed to ask than on explaining why those questions are so critical.

Rudolph and colleagues developed a debriefing model called 'debriefing with good judgment' (also known by some as 'advocacy + inquiry') that can help educators to clarify the underlying rationale behind their students' behaviors, thoughts, and decisions.<sup>4</sup> Although typically applied in the simulation setting, this approach can be effective in the clinical environment. In this model, the debriefer (or faculty member) shares an observation or concern paired with curiosity-driven questions that are designed to uncover the background and thought-processes that led a student to take a particular action. For example, instead of accusing Brian of not taking bilateral blood pressures, Caroline might have said:

"Brian, I noticed that you didn't take bilateral upper extremity blood pressures. This is something I do for any patient I'm concerned could have an aortic dissection. Can you tell me more about how you came to that decision?"

Perhaps Brian would have responded that he forgot or that he didn't know why he was supposed to check pressures in both arms. Alternatively, he might have said that based on an article he had read demonstrating the poor specificity of inter-arm blood pressure differences for vascular pathology, he did not believe it was a necessary part of the physical examination.<sup>5</sup> Each of these responses would have helped Caroline to tailor her teaching to the specific needs and thought process of her student. It can be dangerous for Caroline to simply assume she knows WHY Brian has not performed the history and physical exam the way that she would.

# Expert Response

While it can be extremely challenging to work with a trainee who is labeled a 'difficult student' or 'problem learner', the successful teacher, or mentor, can utilize the frameworks developed by Steinert and Rudolph to acquire greater insight into the exact reasons a student may be struggling. By asking questions and being genuinely curious teachers will be more adept in their ability to diagnose the specific issues and respond in the most appropriate, thoughtful, and constructive fashion to assist their learners in their development and to overcome their deficits.

## Take Home Points:

- "Problem-learners" can experience difficulties in any combination of knowledge, skills, and attitudes.
- These difficulties can be due to a wide range of personal, professional, and systems-based issues.
- Educators should employ curiosity-driven questions to determine a learner's thought process, rationale and specific deficits prior to providing tailored intervention and teaching.

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## About the Expert

Dr. Eyre completed his emergency medicine training at the Harvard Affiliated Emergency Medicine Residency, based at the Massachusetts General Hospital and Brigham and Women's Hospital in Boston, Massachusetts. He currently works as an emergency medicine attending at Brigham and Women's Hospital and is completing a fellowship in medical simulation at Brigham and Women's STRATUS Center for Medical Simulation . There, he works with learners of all levels and from a wide range of specialties.

# Expert Response

## Why 'fib'?

by Alex Sheng MD

### 1. Why do learners sometimes 'fib' when presenting cases?

**"Everybody lies...."**

- Gregory House, MD<sup>1</sup>

Assuming my answer above will not suffice in such a prestigious forum, let us reflect a little deeper.

Physicians sometimes bend the truth, or withhold information, in order to expedite patient care or advocate for a patient. An example of such benevolent deception is when a physician is paged in the middle of the night by a patient who apologizes by saying "I hope you don't mind me calling at this hour" and the doctor replies, "not at all."<sup>2</sup> Moreover, the high pressure environment of the emergency department instills in emergency medicine physicians the ability to "sell" an admission or consult, in which we highlight certain aspects of a patient's case while undermining others in order to optimize patient care.<sup>3</sup>

Whether one agrees with the telling of such "white lies", Brian was not practicing benevolent deception in this case. He was being dishonest for an entirely different reason. But why?

After all, honesty is an essential principle in the practice of medicine.<sup>4</sup> The American Medical Association's Principles of Medical Ethics specifically mandates that a physician "deal honestly with patients and colleagues" and "strive to expose" those who "engage in fraud or deception".<sup>4</sup> As a result, physicians are often rated by the public as one of the most trusted professions.<sup>5</sup> In return, we expect honesty and full disclosure from our patients in order to properly diagnose and treat.<sup>3</sup>

Despite our high regard for authenticity and honesty in medicine, cheating in United States medical schools not only exists, but its prevalence is reported to range up to 58%.<sup>6,7</sup> Medicine as a profession is partly to blame. We, along with the lay public, place such high value on achievement,

competence, and perfection on ourselves and our trainees that it leads to the overshadowing of other equally important qualities, including personal integrity, compassion, and empathy.

The competitive nature of the residency application process in Canada has been criticized for causing a "strain on the moral integrity" of graduating medical students.<sup>8</sup> Similarly in the United States, the increase in medical school class size to mitigate the physician shortage combined with stagnant graduate medical education funding and stasis in the number of trainee spots has led to unprecedented competition amongst medical students seeking residency training. It's a commonly accepted practice for medical students applying to competitive specialties to interview at multiple programs for a different, 'back-up' specialty. During this process, they are expected to show unwavering dedication and commitment in the alternative specialty.<sup>8</sup> Similarly, with the rise of emergency medicine as an ever-increasingly competitive specialty, applicants are frequently applying to, and interviewing at, an unnecessarily high number of programs in order to feel 'safe' about their chances of matching. They are advised to show the same interest for their 'safety' programs as the ones they place at the top of their residency match rank list. Because the emphasis has always been on success and avoidance of failure, honesty is put on the back-burner during the entire residency application process.<sup>8</sup>

I remember distinctly interviewing a candidate, who was simply outstanding on paper. During interview day, however, this person appeared so disengaged to all of the interviewers that we were concerned this student was ill. Afterwards, our group felt disrespected by what we perceived to be rudeness and apathy exhibited on the part of this interviewee. None of us have ever seen such behavior from an applicant. As a result, we ranked the candidate very poorly on our match rank list. In retrospect, perhaps this applicant was the one who was the most authentic.

# Expert Response

So the long answer for why learners like Brian sometimes ‘fib’ when presenting patient cases rests in the unfortunate irony that a profession that promotes honesty has institutionalized dishonesty through its perpetual pursuit of success and perfection.<sup>8</sup>

## **2. Do you think it is difficult for Brian to admit that he is having difficulties? Why do you think that's the case?**

It may be extremely hard for Brian to admit that he is having difficulties given he is immersed in a professional culture that prioritizes perceived competence over integrity. His ‘fibbing’ may in actuality be a maladaptive mechanism in order to hide his insecurities, specifically about his own competence and knowledge base. Perhaps he does not know the physical exam findings concerning for aortic dissection, the PERC rule, or Well’s Criteria. He may harbour self-doubt regarding his ability to take a thorough history and perform a relevant physical exam. ‘Fibbing’ (much like other similar reactions including anger, frustration, appearing flustered, or blank stare), may actually represent a disconnect between teacher and learner.<sup>9</sup> These reactions likely represent particular manifestations of the learner’s internal state of mind such as nervousness. However, to an outsider like Caroline, ‘fibbing’ in this case is likely misinterpreted as dishonesty.

To bridge the divide between teacher and learner, the teacher must first make the learner aware of the how their reactions are being perceived. Once the learner is self-aware, the teacher can explore the reasons behind the particular reaction. Caroline could have said, “Brian, it appears to me that you are misrepresenting some of the clinical data in this case to avoid appearing unprepared in your presentation. In your view, what’s going through your mind when you do that?”

Next, the teacher must be careful not to assume that the learner possesses all of the knowledge and the ability to perform the task being asked. Instead, assess the learner’s experience level, then prime them to consider the questions that will be asked, instead of putting them on the spot. In this case, Caroline could have asked Brian if he is aware of any

clinical decision rules to risk stratify patients who present with symptoms concerning for pulmonary embolism. If his answer is no, Caroline can prompt Brian to look up the PERC rule and/or Wells Criteria prior to evaluating the patient, and apply them to the patient’s case afterwards. Lastly, but most importantly, it is crucial that teachers provide a safe and nurturing learning environment for trainees from the very beginning.

## **3. Are there things that Caroline has done that may have potentiated his reluctance to ask for help?**

Despite Caroline being altruistic in trying to help Brian improve his performance through remediation, there is no evidence to suggest that Caroline actually created a safe and nurturing learning environment. In fact, questions like “You don’t *believe* so?” and the non-verbal cues such as sighing, taking deep breaths, and showing frustration all suggest the opposite. Similar to facilitating small groups, maintaining a safe learning environment is crucial in other environments as well, such as clinical and bedside teaching.<sup>10</sup> If one fails to achieve this, learners will abandon their motivation to learn and cease to challenge themselves. They will modify their patient selection to only those in their comfort zone and present in ways to minimize exposure to the teacher. They become unreceptive to learning. No matter how brilliant of a learning pearl the teacher has at the ready, the teaching moment is lost... or was never there to begin with.

In this case, Caroline should pre-emptively set the stage by expressing that it’s acceptable to not have all of the patient information when first presenting the patient and that he is not expected to know all of the clinical decision rules from memory. Caroline should ask Brian to gather the missing information from the patient and education resources. When Brian returns with the additional evidence, he will have no need to ‘fib’ at all.

# Expert Response

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## About the Expert

Alexander Sheng is currently the assistant residency program director at Boston Medical Center. He graduated from University of North Carolina School of Medicine and completed residency training at Harvard Affiliated Emergency Medicine Residency at Brigham and Women's and Massachusetts General Hospitals in Boston. Dr. Sheng's professional interests include graduate medical education and imaging utilization in emergency medicine. In his free time, Alex enjoys playing tennis, skiing, traveling, and exploring new restaurants.



## Two sides of the Coin: Student vs. Teacher

by Dimitrios Papanagnou MD, MPH, EdD(c)

The Case of the Fibbing First Year highlights only several challenges that will complicate the working relationship between 'teacher' and 'student' in the clinical learning environment (CLE). Mindful collaboration practices between faculty educators (i.e., Caroline) and housestaff (i.e., Brian) are essential in order to effectively achieve the triple aim of increasing the quality of graduate medical education in the CLE; adequately preparing residents for a future practice as lifelong learners; and capturing meaningful experiences to improve future clinical performance.<sup>1</sup> The two-faceted interchange between 'teacher' and 'student' are briefly presented below to clarify the etiology of some of these challenges, as well as offer several guides for the 'teacher' to better prepare for these circumstances.

### The Student's Side

Brian is likely a high performer. Whether he is aware of it or not, he is willing to compromise his integrity because he is too afraid to show his limitations. Unfortunately, for Brian and a small subset of his high-performing peers, they "would rather do the wrong thing well, than do the right thing poorly."<sup>2</sup> And when he finds himself in over his head (i.e., not asking whether his patient abused cocaine, or forgetting to check for symmetric blood pressures), he will hesitate to admit his knowledge gaps, and even refuse to ask for help from his attending supervisor.<sup>2</sup>

Today's high-achieving learner in medicine is highly motivated; competitive; driven to get results; and craves positive feedback.<sup>2</sup> A layer of complexity is further added when the faculty member considers that this learner is a part of the millennial generation. The corporate literature is replete on millennials' performance in the workplace, and suggests that they are committed to developing new skills; are eager to achieve success early; and prefer to work for organizations where they have access to coaches and mentors to facilitate on-the-job learning.<sup>3</sup>

While Brian is a *modern learner* in the clinical learning environment, the supervising faculty member should be reminded that he is also a consumer of education; will

demand clear and frequent feedback; and, at times, will require the necessary guidance on what is acceptable and/or expected professional behavior.<sup>4</sup>

### The Teacher's Side

Caroline will need to be flexible and adaptable to successfully work with Brian. While she may feel it is unfortunate that Brian and members of his cohort think and behave the way they do, "medical education needs to find a way to work within [this] framework."<sup>5</sup> Having a deeper understanding of their learners' experiences will assist faculty preceptors who confront frustrations and challenges highlighted in the aforementioned case.

Fortunately, there are skills and tools Caroline can employ to better guide her interactions with Brian:

- 1) *Improving the faculty-resident relationship.* The quality of the supervisor and trainee relationship is perhaps the most single important factor for effective supervision.<sup>6</sup> A more comfortable, less intimidating relationship that allows for joint problem-solving is more likely to encourage Brian to ask for help and openly admit both his knowledge and performance gaps.
- 2) *Integrating a learning contract.* Typically used in higher education, Knowles described learning contracts as agreements between a learner and a supervisor. These agreements detail what is to be learned; the resources and strategies recommended to support learning; and the objective measures to show that learning has happened and how it will be assessed.<sup>7</sup> As the definition includes a temporal component, learning contracts can easily be adapted for clinical shifts in the Emergency Department (ED). At the start of the shift, Caroline can discuss goals and expectations with Brian, and develop a learning contract specific for his pedagogy, while at the same time, provide scaffolding for his ED experiences on shift. This also has the potential to highlight Brian's



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learning needs for Caroline given he is an off-service resident rotating in the ED.

- 3) *Curate a repertoire of teaching scripts for junior learners.* Efficacious for junior learners and for common ED pathologies, illness-based teaching scripts can include medical content of typical symptoms and exam findings, key risk factors, common pitfalls, risk stratification tools, and additional recommended resources.<sup>8</sup> These can be particularly helpful, especially for off-service residents at the start of an ED rotation. In hindsight, Caroline could have modelled an encounter of chest pain for Brian according to a prepared teaching script.

If we as teachers are thoughtful about the numerous variables which contribute to *why* learners like Brian may choose to “fib”, then we can identify the tools and skills that our learners need to acquire to become effective clinicians and lifelong learners.

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## About the Expert

Dimitrios Papanagnou (@dmitripapa) is an Emergency Medicine Physician and Vice Chair for Education in the Department of Emergency Medicine at Thomas Jefferson University (TJU) Hospital in Philadelphia. He is the Assistant Dean for Faculty Development at the Sidney Kimmel Medical College of TJU. He graduated from the New York University (NYU) School of Medicine. As a Josiah Macy, Jr. Foundation Scholar, he received a Masters of Public Health at Columbia University’s Mailman School of Public Health. He went on to complete his residency in Emergency Medicine at the NYU / Bellevue Hospital Center. He is in the final stages of completing a doctorate in adult education at Columbia University with a dissertation concentration on emotional intelligence in EM physicians.

# Curated Community Commentary

By John Eicken MD

*A qualitative methodology was used to curate the community discussion. Blog comments were analyzed and three overarching themes were extracted.*

The “Case of the Fibbing First Year” stimulated insightful and thoughtful conversation amongst individuals with varying clinical experience. Within this commentary I highlight the key points which may further clarify how to best approach, guide, and assist learners who are struggling and performing below expectation in the clinical environment.

## Support the Troubled Learner

Dr. Kirsty Challen identified the possible relationship between this case and our preceding MEdIC case ([Case of the Pimping Physician](#)), during which a medical student struggled to answer questions in front of her team within an unsupportive learning environment. Unfavorable past learning experiences can cause learners, such as Brian, to become timid, apprehensive, and insecure in their clinical abilities that are disproportionate to their skill deficit. Similarly, Dr. Teresa Chan agreed that unsupportive learning environments which place a strong emphasis on ‘right answers’ can unintentionally lead to learners who are unsure of the correct answer to react by ‘fibbing’. Dr. Nicolas Pineda pointed out the dangers that ‘fibbing’ can have in the clinical environment including compromising patient safety. Nicolas agreed that ‘fibbing’ can be a natural defensive mechanism: “...residents feel so pressured to say what they think we want to hear, that sometimes they lie in order to remove themselves from the conversation as soon as possible.” Dr. Pineda noted that although trainees may ‘fib’ about questions they perceive as trivial (i.e. travel history or social history) there are scenarios where these questions and answers can significantly impact the care of a patient. Dr. Sara Krzyzaniak reflected:

*Struggling residents are keenly aware of their struggle and make every attempt to “prove” competence. My most confident residents are the ones who freely admit they didn’t do something. Creating a culture of “safety in not knowing” is important.*

Dr. Challen noted that once a trainee is aware that he/she is considered a “...difficult or troubled learner...” they can become so nervous in the clinical environment that he/she “...can barely remember their own name.” While teachers need to address trainees’ deficits, they can counteract the negative emotions of the learner by providing positive reinforcement of what he/she has previously done well prior to identifying how he/she can improve. Dr. Kory London acknowledged that Brian is struggling but noted that “...troubled learners need support more than any others. What is the point when you know he is having difficulties to crush him further?”

## Contributors

*Thanks to the participants (in alphabetical order) for all*

## Commenters

Dr. Kirsty Challen  
Dr. Teresa Chan  
Dr. Cathy Grossman  
Dr. Sara Krzyzaniak  
Dr. Kory London  
Dr. Nicholas Pineda  
Michael

Rather than shaming the learner when they are not performing up to expectations (similar to Caroline’s response to Brian), Dr. London suggested demonstrating to the learners how you reach conclusions. This can be achieved by working together with them to calculate a decision score or by sharing a past clinical experience that has influenced how you approach patients similar to the one being presenting. Dr. Krzyzaniak suggested viewing these moments as opportunities to perform bedside teaching and “make the learning a team sport, rather than give the learner a list of items to check off and report back on.”

Teachers and supervising physicians should remember Dr. London’s insightful quote, “Difficult learners are those that we can have the greatest influence with. It takes a lot of patience, but they and the patients they eventually serve, deserve it.”

## Use a Structured Approach to Identify Why a Learner is Struggling

Dr. Cathy Grossman recommended using a structured method known as “Debriefing with Good Judgment” (a.k.a. Advocacy-Inquiry) designed by Dr. Jenny Rudolph.<sup>1</sup> This approach has also been suggested by our expert commentators. This model encourages the trainee to reflect which allows the teacher to identify the etiology (or etiologies) of a learner’s struggles through the use of thoughtful, open-ended questions. If a teacher does not demonstrate thoughtful inquisition aimed at uncovering the root causes of a learner’s deficits it is difficult for the teacher to provide the learner with the tools and resources necessary to support their development. Dr. Grossman provided the following sequence of statements that teachers can use to initiate a thoughtful and fruitful conversation with a struggling learner:

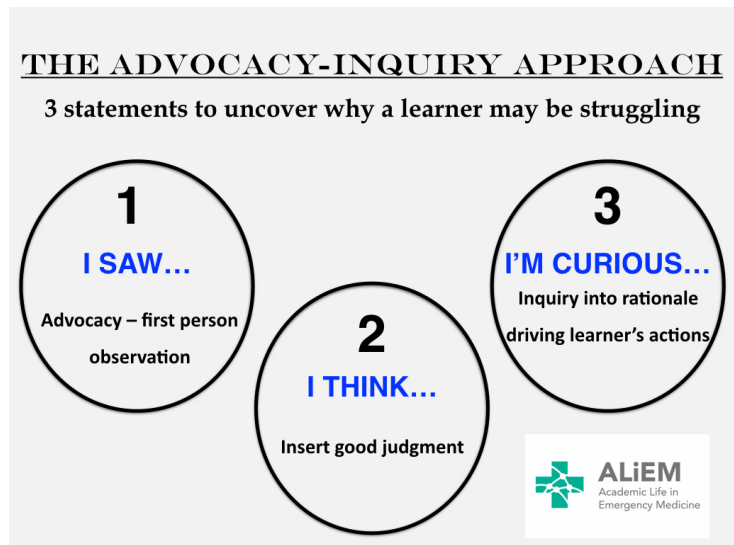
# Curated Community Commentary

- **I saw...** (Advocacy – first person observation about what you observed, stick to the facts of what you saw)
- **I think...** (Insert good judgment here – I am pleased/ concerned/worried about this because \_\_\_\_)
- **I'm curious about...** (Inquiry to find the reasons behind the learners frame or actions)

## Awareness Matters - Are You Paying Attention?

Teachers who encounter a struggling learner should take a moment to reflect upon the current and immediately preceding events because these may be impacting the learner's current performance. Michael identified the possibility that Brian's presentation of the patient with chest pain could be related to stress he is experiencing as a result of witnessing the resuscitation that Caroline just participated in. Alternatively, Brian may be distracted by his patient with chest pain who is agitated about the wait. These events, while likely more 'routine' for Caroline, could be much more distributing to a young trainee such as Brian and may be contributing to his poor performance. Michael noted that supervising clinicians must first 'recognize the possibility' that a separate case, or outside factor, may be causing distress to the trainee. Michael reflected back to the 2014 MEDIC case "The Case of the Debriefing Debacle"<sup>2</sup> which emphasized the importance of providing the learner the opportunity to express how he/she may feel after a case. Michael highlighted that offering the learner the opportunity to express him/herself can be achieved by making eye contact and asking the simple question, "Are you okay?"

Figure 1 Depicts Rudolph's Advocacy-Inquiry approach



## References:

1. Rudolph JW, Simon R, Rivard P, Dufresne RL, Raemer DB. Debriefing with good judgment: Combining rigorous feedback with genuine inquiry. *Anesthesiol Clin*. 2007;25(2):361-376.
2. Chan TM, McColl T, Lockett-Gatopoulos S, Purdy E, Thoma B. *Medical education in cases: Volume 2 (1st edition)*. 1st ed. San Francisco, CA: Academic Life in Emergency Medicine; 2016. <http://www.aliem.com/2016/hot-off-aliem-press-aliem-medic-series-volume-2/>. DOI: 10.13140/RG.2.1.4240.6803; pp. 12-19

## 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 [MEdIC@aliem.com](mailto:MEdIC@aliem.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

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