The Problem

- 15% of medical students/young residents are identified as problem or struggling learners
- It is not uncommon that the ED rotation is the first time in medical school or even internship that a medical student/intern is given significant autonomy and expected to independently think and perform as a physician. This novel expectation of transitioning from “information gatherers” to “synthesizers of information/problem solvers” coupled with the time constraints of the ED are challenging. For these reasons, the ED is often the first time that fundamental learner problems are identified!
- The lack of familiarity and the challenging nature of the ED environment in and of itself may be a significant problem for struggling students
- The “problem” might just lie with the teacher’s lack of experience or preparation

Identifying the Problem (because you’re not allowed to just kill them!)

- Is this a cognitive problem (poor preparation, inadequate fund of knowledge or underdeveloped critical thinking / problem solving skills) or a non-cognitive / interpersonal problem (lack of professionalism, poor communication skills, affective bias, lack of motivation, personality disorder)?
- Cognitive: the “unconscious incompetent” versus the “conscious incompetent” student presents a fertile ground for teaching and coaching that is commonly successful and rewarding
- Non-cognitive: these problems are more difficult to solve especially those dealing with professionalism and affective bias (attitudinal) compounded by the lack of insight associated with underlying personality disorders/traits. The prevalence of such unprofessional behavior (lack of work ethic/ respect for others/ empathy/ integrity/ accountability/ sensitivity) and its perceived impact on the profession of medicine was the impetus to identify it as one of the six core competencies. The basis for such non-cognitive problems may be multifactorial but the possibility of personal stressors or substance abuse must be considered.
- Different learning styles, ie. one size shoe does not fit all, may also impact the learner-teacher interaction due to mismatched learning-teaching styles and learning disabilities must be considered in students that display “processing” problems or basic knowledge deficits.
- Two well known situations referred to as the “halo and millstone” effects can negatively impact the learner-teacher dynamic. The “halo effect” allows very likable students, whose personality blends well with that of the teacher, “to fly under the radar” resulting in glowing evaluations despite subpar performance. The “millstone effect” occurs when a student is singled out for poor performance (potentially unjustly so) such that every little mistake they make (mistakes that EVERY student is making) is identified and magnified to their detriment.
Diagnose the Learner: Defining the Problem (because they won’t disappear by themselves!)

- Many potential problems can be immediately negated by structuring the ED learning environment. Clearly stated (and available) goals & objectives for the rotation for all six core competencies, logistical details (tour) and the role the learners play on the ED team significantly increases the potential that learners will actually meet expectations.

Simple Structured Questions to Start the Rotation:

Ask the learner:
- Is this patient “sick” or “not sick”?  
- Are the vital signs normal? 
- What do you think the most likely diagnosis is? 
- Do you think this patient will be able to go home, go home with close follow-up within 1–2 days, or require admission to the hospital? 
- If you could only order one test for this patient, what would it be? 
- Tell me three things that could kill/harm this patient if not diagnosed today? 
- What does the patient need to understand regarding their follow-up? 
- What did you find most challenging about this patient? 
- What would you do differently the next time you care for a similar patient? 
- What’s the most important thing to remember when caring for a future similar patient?

For the learner to ask the patient:
- What do you think is causing you to feel this way? 
- What are you hoping that we can accomplish for you here in the ED today? 
- When symptoms have been present for more than several days: “What changed to make you decide to come in now as opposed to 12 hours ago or 2–3 days ago”? 
- If I could only fix one of your problems, which one would you want me to fix? 
- Are you supposed to take any medications each day for any health problem? 
- Have you started taking any new medicines, changed the dose of any medicines, or stopped taking any medicines in the past 5 days? 
- Have you ever been in the hospital overnight as a patient?

Learners should know how they will be evaluated and the expectation for “formative” versus “summative” feedback. To close the learner-teacher cycle, students should understand their opportunity to like-wise evaluate their teachers. Providing timely feedback to learners is the key component to changing behaviors and performance. It is unreasonable and unfair to define a learner problem if feedback on the perceived problem has not been provided and the learner given the opportunity to improve.
Documenting the difficult learner experience and developing an action plan can be accomplished using the well known SOAP method.

- **Subjective** - define the primary problem and how it was manifested: lazy, rude, cognitive deficit, scared; gather data from others to support and define the “chief complaint”.
- **Objective** - list the actual behaviors that illustrate the chief complaint from multiple sources; remove subjectivity by focusing on the behaviors and not the person.
- **Assessment** - formulate a DDx based on the chief complaint and supporting objective behaviors; place into the previously defined categories of cognitive, non-cognitive, professionalism and attitudinal.
- **Plan** - develop a plan to insure learner success-this requires learner input and buy-in; do not blind-side the learner - insure that specific feedback on concerning behaviors has been provided multiple times before sitting down to develop a remediation plan that includes deliberate practice, feedback and reflection; the plan should be detailed with specific behaviors and objectively defined areas for improvement clearly listed and the method for reassessment for certification of competence identified.

- **FAD – Fairness, Accuracy and Documentation** are important components of any learner intervention

**Strategies for Difficult Learners (Don’t give up-a young mind is a terrible thing to waste!)**

- **Cognitive** – assign additional reading; point them to a specific website with additional resources, a podcast or a video depending on their style of learning; for procedural competence use videos or simulation; role-model a framework for clinical reasoning – diagnostic and therapeutic; ask them about their study habits – do they have a defined goal, a weekly/daily plan to attain that goal and a measure of success; go with them to the room and provide bed-side teaching and role-modeling with the patient and family

- **Professionalism** - gather information from direct observation and or multiple sources (360 degree evaluation – from nurses, patients, colleagues and supervisors) to identify specific examples of the problem behavior; outline specific expectations regarding “ideal” behavior as a professional who is a member of a health care team; problems with interpersonal behaviors may be challenging to deal with and require extra time and resources because the underlying problem lies within the individual’s innate behavioral patterns and personality traits which may include a lack of insight; strategies include video taping, role-playing, OSCE sessions and simulation.

- **Affective Bias** - affect is inseparable from thinking -emotional intelligence is an integral part of our ability to process information meaningfully and make good decisions; thus certain affective “biases” may negatively influence medical decision making; one of the most powerful affective biases that might influence a physician's
decision making is countertransference based on our own personal beliefs and experiences and the patient’s race, gender, religious beliefs, cleanliness, intelligence, rudeness, etc. Affective bias often leads to errors of omission and failures in diagnosis. Everyone is subject to affective bias (this patient does not meet my own beliefs or standards) but the key to teaching medical students is knowing it exists, recognition that it is occurring and figuring out ways to combat it. A famous quote from one of the founders of our specialty that places our affective bias into perspective, “you have never walked a day in the shoes of your patients”.

- **Motivation** – at the start of the shift determine what the learner’s objectives for the shift/rotation are; what specialty are they thinking about going into – you may want to relate cases to their specialty choice; have they worked in an ED before; are they excited to be here – scared or ambivalent; if nothing else, you can motivate them pointing out that EM is the most important rotation associated with passing Part III of the USMLE/COMLEX and that when their grandmother calls them with an emergency or suffers an emergency at a picnic they’re attending, they may actually make a difference in the outcome based on their experiences during this rotation.

**Teacher Pitfalls (Because we may be the problem!!)**

- Assuming the learner can navigate the ED system
- Teaching too much about a given patient (focus on 2–3 “take home” points)
- Focusing on what interests them, as opposed to what the learner needs to know
- Teaching specifics rather than concepts
- Teaching concepts when directive specifics are necessary
- Usurping care without explaining why
- Failing to be directive when patient care is potentially compromised
- Answering one’s own question
- Failure to explain the difference between personal treatment preference and evidence-based treatment
- Correcting/counseling/reprimanding where others can overhear

**Case Diagnoses:**
Case #1: Unconscious Incompetent
Case #2: Dishonest Unprofessional
Case #3: The Lazy-Disinterested Student
Case #4: The Judgmental Unprofessional

**References**