Resident As Teacher: An Interactive Workshop

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Objectives:

• Discuss benefits of the resident-as-teacher role
• Practice 2 learner-centered techniques for clinical teaching
• Review tips for effectively managing different learners (videos)
• Identify challenges for residents as teachers

Background:

Ideal Clinical Teacher Characteristics: (identified from Clinical Teaching Perception Inventory; Morrison EH 2005)

• Stimulating
• Encouraging
• Competent
• Communicates
• Well-read

Characteristics farthest from Ideal:

• Correcting
• Directive
• Conventional
• Cautious
• Controlling

More than a third of medical student clinical learning comes from residents. Residents are ideally situated to teach medical students, as they are close in age and professional development, spend significant time in direct supervision, and participate in real-time daily clinical decision-making. Teaching leads to better knowledge acquisition than self-study or lectures (“to teach is to learn twice”), and encourages self-directed learning. However, residents are not equipped to teach simply because they work in a clinical setting with medical students. Resident as Teacher training, either by workshop, courses or retreats, appears to improve resident self-confidence, resident teaching ability, and student evaluations of residents, and has positive effects on resident attitudes about teaching.
Learner Centered Technique #1:

**One-Minute Clinical Preceptor/Microskills:**

The Five Microskills of the One-Minute Preceptor (Neher JO, 1992)

1. Get a commitment
2. Probe for supporting evidence
3. Teach general rules
4. Reinforce what was done right
5. Correct mistakes and discuss next steps
6. Identify next learning steps (6th step now often added)

1. Get a Commitment
Ask learners to articulate their own diagnosis or plan. The goal is for the learner to process the information they just collected about the patient. You may need to ask 1-2 clarifying questions but avoid the temptation to ask too many questions and take over.

2. Probe for Supporting Evidence
Evaluate learners’ knowledge and reasoning about the case. You can assist the learners to synthesize loose pieces of information about the case together. Work to identify learners gaps in knowledge or errors in reasoning to know where to build upon their knowledge.

3. Teach General Rules
Teach learners common take-home points and rules of thumb. Your goal should be to provide a brief “pearl” that you have found helpful with patient care and management. Focus on teaching a general rule that can generalize to other similar cases.

4. Reinforce What Was Done Right
Provide positive feedback to your learners about the points of the case where they got it right. Feedback should be case specific and behavior focused. Avoid the temptation to say “Good Job.” Preceptors can give feedback early or interrupt the case to reduce learner performance anxiety and keep learners engaged.

5. Correct Mistakes
Provide constructive or formative feedback to the learner where they got it wrong. Be specific, behavior focused, and constructive (“not best” rather than “bad”).

6. Identify Next Learning Steps
Give recommendations for areas of improvement and additional learning. Practice-Based Learning and Improvement; identify clinical question and resources to answer question.

One-Minute Preceptor Comments from the Literature:

When evaluated by students and residents, the One-Minute Clinical Preceptor was reported to be extremely useful as it improves teaching skills by getting a commitment from learners, providing feedback and motivating learners to do outside reading. (Furney, 2001)

Medical students prefer the One-Minute Preceptor (OMP) to a traditional teaching model. Students enjoy OMP for the quality of feedback that it provides and the involvement of students into the decision making process. (Teherani, 2007).

The OMP starts with open-ended questions that force learners to reveal their process of thinking in addition to patient care information. (Molodysky, 2007).

Preceptors observing a traditional teaching model were more likely to teach generic skills such as history taking skills, presentation skills, and risk factors. Those observing the OMP method were more likely to teach about the illness focusing on a broader differential diagnosis, further diagnostic tests and the natural presentation of disease. (Irby, 2004).
Learner Centered Technique #2:

**SNAPPS:** (Wolpaw, TM 2003)
Difference between OMP/Microskills and SNAPPS: both are learner centered, but SNAPPS is also learner-DRIVEN. In SNAPPS, the preceptor is guide and facilitator, rather than instructor, and all steps are initiated by learner.

S - Summarize briefly the history and findings
N - Narrow the differential to 2-3 relevant possibilities
A - Analyze the differential by comparing and contrasting the possibilities
P - Probe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches
P - Plan management for the patient's medical issues
S - Select a case-related issue for self-directed learning

1. **Summarize briefly the history and findings**
Learners take the history, perform physical exam and present a concise summary to the preceptor. This summary should not be more than 50% of the learning encounter. The presentation should contain only the most relevant information and preceptors can elicit further details from learners as needed.

2. **Narrow the differential to most relevant possibilities and life threats (EM)**
Learners decide what they think is going on focusing on the most likely possibilities and life threats. This requires a commitment by learners. Preceptors should not help expand or revise differential until learners provide their insights.

3. **Analyze the differential by comparing and contrasting possibilities**
Learners present one differential possibility and then compare/contrast it with the others. This conversation with the preceptor allows learners to verbalize their thinking process and stimulates interactive discussion
with preceptors. Learners display their clinical reasoning skills to the preceptors.

4. Probe the preceptor by asking questions about uncertainties
Learners probe preceptors with questions rather than waiting for preceptors to question the learner. Preceptors learn about learners' thought processes and knowledge base.

5. Plan management for the patient’s medical issues
Learners come up with a diagnostic plan to clarify their differential diagnosis. Learners initiate discussions of patient management with the preceptor. Learners must attempt either a brief management plan or suggest specific diagnostic interventions.

6. Select a case-related issue for self-directed learning
One of the most important facets of SNAPPS is the emphasis on a learner’s ability to generate questions to fill in gaps in knowledge. The importance of encouraging the inquisitive spirit in learners is imperative.

SNAPPS Comments from the Literature:

Learner feedback after using SNAPPS: (Wolpaw, 2003)
--Learners appreciate being able to question preceptors and selecting a focused issue for self-directed learning.
--Learners feel capable of assuming active roles in management and identifying learning points that are uniquely helpful to them based on prior rotations and experience.

Preceptor feedback after using SNAPPS: (Wolpaw, 2003)
--Learners came up with more questions using SNAPPS than traditional methods. Questions were appropriate to the case and generate an interactive discussion.
--Learners seemed engaged when asking questions and preceptors enjoyed teaching. Preceptors were relieved of pressure to think of learning points and now respond to students questions.
Challenges for Residents as Teachers: (from workshop discussion)

1. How to avoid upstaging attending during shift?
Define boundaries and expectations with attending at the beginning of the shift—will vary with attending.

2. How to motivate students, especially those not going into EM?
Focus on their interests (procedures, relationships, problem solving), relate cases to their specialty choice, and identify and work on their specific deficiencies.

3. Balancing Service and Education when teaching?
Use ancillary staff as educators in order to give you a break (ECG tech, respiratory therapist, nurses). Take groups of students in to see an interesting patient—allows other residents to catch up. Bedside teaching (seeing patients with student) will increase your efficiency and is very helpful for the student—just don’t put student on the spot in front of patient.

4. How to be an objective evaluator when you just don’t like the student?
Fall back on the competencies. When emotion begins to impact the situation, keep evaluations and feedback competency driven.

5. I don’t know the answer—now what?
Important for students to recognize that nobody knows everything. This will decrease their intimidation, frees them to ask questions. This is opportunity for PBLI: share the resources that you use to acquire new knowledge. The process can be as educational as the final answer.

6. Feedback. Keep it positive, case specific and behavior oriented. PNP (positive/negative/positive) sandwich. Say to the student “I’m giving you feedback now” and “I’m teaching you something now” so they appreciate, remember, and value the moment. Criticize in private, praise in public, and remember that they model ALL of your behaviors.
Resident as Teacher Bibliography


