Teaching the Difficult Learner, April 15, 2015
CORD Resident Track

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Cases

Case #1 (KR):

The setting: A RN working in your area pulls you aside and asks "Who's that terrible medical student working today?" He goes on to say that two families have complained to him already in the first two hours about the medical student failing to discuss what was going on, and another patient was in tears because she believed the student had said that she was too fat and needed to lose weight to solve her knee pain. The nurse also is upset because the MS failed to throw away their exam gloves 3 times, leaving them on the supply cart in the room. You have just arrived to staff, and note that this student is already carrying six patients, most of which have been in the ED for over an hour.
The presentation: Hi, sorry I haven't been able to get to you. I'm trying to get everything together for you. I'm really excited about going into EM and I'd love to talk to you about it today. Do you want to hear about my patients? My first one is a 5 week old baby with a fever of 101.7. He looks great and I'm going to send him home with acetaminophen for that and follow up with his pediatrician. I don't know how to dose that in babies—can you help me with that? My second patient is a 45 year old lady with chest pain. I took a long social history on her because she smelled like alcohol and it turns out she smokes crack! Wow! I've never met a crack smoker before! I think that probably can explain her chest pain and I'm going to send her home, too, with some instructions to stop doing that. Should I take care of those two first and then get back to you? I also have this 45 year old women with sharp chest pain and SOB. She has HTN and smokes but I know that when the pain is sharp in character it's not cardiac.

Case #2 (CDC)

The setting: ED evening shift in August of MSIV year. A MSIV picks up his first patient of the rotation. It is your first staffing shift of the year and you are freaked out. You see that he has picked up an 86 year old syncope patient in room 23. He hasn't staffed it for about 50 minutes, so you go in to make sure they are not dead before he presents. It is obvious from the door that this lady is bleeding—smells like melena, looks like a ghost. She is still fully clothed.
The presentation: "I saw this patient in room 23. She comes in complaining of getting more and more tired for the last two weeks. She seems to not have as much energy to do regular activity every day. She hasn't had any fever, no chest or abdominal pain. No nausea, vomiting, diarrhea. She has diabetes, HTN, and arthritis. She's on metformin, HCTZ, and naproxen. Her exam is pretty normal. I think she might be hypothyroid, so I send thyroid function tests." (Responds that rectal exam was normal when questioned.). Shortly afterwards, the nurse walks by and tells the student that the patient is finally undressed and ready for examination.

Case#3 (ME);

The Setting:

A MSIV students arrives 15 minutes late for their second shift. They introduce themselves and then proceed to tell you that they are going into pathology and really don't understand why they need to do an EM rotation since they'll rarely see a live patient. They go to their work station and proceed to check their email for 15 minutes. Despite there being 9 new patients that need to be picked up, you notice that they are surfing the net for new shoes. You suggest that they go see a patient and they do so begrudgingly.

The Presentation: "I saw this 67 y/o male c/o abdominal pain x 3 hours. He says he thinks it's maybe a kidney stone because he's had those before. That sounded good to me."

When asked for a DDx, the student says: "I didn't really think much about that." When asked what do you think we should do, he replies: "Maybe get a urinalysis and give him some pain medicine?" To your question of what pain medicine, he replies: "whatever, can you just order some medicine and the urinalysis for me, I really haven't figured out the computer yet."

Case #4 :

The setting: ED in the moderate acuity area, mid-day shift. You are the senior level staffing resident or young faculty.

The presentation: "I've got a 32 year old guy with low back pain. I'm pretty sure he is a drug-seeker. He straight up asked me for "dilaudid" before I could even finish my exam. There's nothing wrong with this guy. Plus, I think he's homeless and just wants some food. Why do we even let these "people" into the ED. They're wasting my time!" When asked about their exam findings: "He looks fine to me, I didn't want to get too close because he smells really bad and I bet he has bedbugs. I've seen a bunch of patients this month just like him and none of them were sick."

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) G&O 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:

- 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 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 fi x one of your problems, which one would you want me to fi x?
- 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?
- What does the patient need to understand regarding their follow-up?
- What did you fi nd 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?

- 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-cognitve, 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

<u>Strategies for Difficult Learners (Don't give up-a young mind is a terrible thing to waste!)</u>

- **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, collegues 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.

- **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 specifi cs rather than concepts
- Teaching concepts when directive specifi cs 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