Teaching with Patients

A Professional development session by the Otago Medical School

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Objectives for this session

- Explain why teaching with a patient is used in health professional education
- Identify challenges with teaching with a patient
- Describe at least one technique for improving teaching with a patient

Plan for the session

- Brief discussion of the importance of teaching with patients for the teacher, student and patient.
- Explanation of three practical frameworks that can help increase student learning with patients
- Small group discussion of challenges in teaching with a patient and thoughts for how to lessen the challenges
- Debrief of the small group discussion with opportunity to share ideas
- Wrap-up and final questions or comments
- Evaluation of the session

Why do we teach with a patient in health professional education?

Why do we teach with a patient in health professional education?

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Perspectives on Teaching with a patient

Student perspective

100% agree it's effective

51% agree there is enough

Patient perspective

77% agree it's enjoyable

84% would recommend to others

63% did not feel properly forewarned

Nair, B. R., Coughlan, J. L., & Hensley, M. J. (1997). Student and patient perspectives on bedside teaching. *Medical education*, *31*(5), 341-346.

Making the most of teaching with a patient

- One Minute Preceptor
- Activated demonstrations
- The SNAPPS model

One minute preceptor

Neher, J. & Stevens, N. (2003). The one minute preceptor: Shaping the teaching conversation. *Family Medicine . 35* (6), 391-393.

“Activated” Demonstrations

“When a patient’s problem is unfamiliar to the learner, this is the time for the learner to observe the clinical teacher at work. However, the learner needs a specific assignment to complete while observing (such as “watch how I ask critical questions about alcoholism or abuse”) and an understanding of what is expected in terms of participation. After the demonstration, the teacher needs to “activate” the learner by asking him or her to describe what was observed. A brief discussion typically ensues in which the rationale for the actions is examined and independent study is assigned.”

Irby, D. M., & Wilkerson, L. (2008). Teaching when time is limited. *Bmj*, *336*(7640), 384-387.

SNAPPS model

- **S**ummarise briefly the history and findings;
- **N**arrow down the differential to two or three relevant possibilities;
- **A**nalyse the differential by comparing and contrasting the possibilities;
- **P**robe the clinical teacher by asking questions about uncertainties, difficulties, or alternative approaches;
- **P**lan management for the patient's medical problems;
- **S**elect a case related problem for self directed learning

Wolpaw, T. M., Wolpaw, D. R., & Papp, K. K. (2003). SNAPPS: a learner-centered model for outpatient education. *Academic Medicine*, *78*(9), 893-898.

Small group discussion

- What for you are the key challenges when planning to teach with patients?

- What are some potential solutions to the challenges you have identified?

- Notes on Google Docs: https://docs.google.com/presentation/d/1wkAHz532_DHicI2Z_uxRqt-UvzJiE8Susl5opQr-Anw/edit?usp=sharing

Small group debrief and sharing of ideas

Final comments

Do you know … DYK 9

how to make the most of bedside teaching?

Doctors have been concerned about how to best teach in a busy clinical environment for over 100 years. William Osler was emphatic that:

There should be no teaching without a patient for a text and the best teaching is that taught by the patient himself (1903 p. 50).

The idea that patients are central to clinical teaching is echoed this century:

Any teaching in the presence of a patient may be called bedside teaching (Alweshahi, Harley & Cook, 2007. p 205).

Generally it is thought that the patient bedside is one of the most valued places to learn how to be a doctor (Williams, Ramani, Fraser & Orlander 2008).

With Osler's definition of bedside teaching in mind it can be seen that the *bedside* extends to the outpatient clinic, the GP surgery; in fact any location in which patients are present.

Irrespective of location the real challenge for the busy doctor in the busy clinical setting is finding efficient methods to:

- FIRST: Assess a learner's level of knowledge and skill,
- THEN: Teach quickly,
- FINALLY: Provide feedback on performance.

Indeed one study observed that: "*…the solution may not lie in increasing the time in spent clinical teaching but by optimising clinical teaching opportunities as they arise*". Williams et al (2008).

The following suggestions for enhancing clinical teaching (*bedside teaching*) are adapted from:
Irby, D.M., & Wilkerson, L. (2008). Teaching when time is limited. doi: 0.1136/bmj.39456.727199.AD

FIRST: Identify the needs of each individual learner by asking questions or by doing a two-minute observation of them undertaking a patient focused activity.

THEN: Select an appropriate technique for rapid teaching. Options include

The **one minute preceptor** is a minimally disruptive teaching technique which goes like this:

- Get a commitment – Teach immediately after a learning experience in practice;
- Probe for supporting evidence – Explore the student's thinking;
- Teach general rules – present the student with one or at the most two core principles relevant to the situation;
- Reinforce what was done right – Give feedback that highlights what the student did, or knew that was right;
- Correct mistakes – Ask the student to identify one, or at the most two areas for improvement.

"Activated" demonstrations
When a patient's problem is unfamiliar to the learner, this is the time for the learner to observe the clinical teacher at work. The learner should be given a specific assignment to complete while observing (e.g. "Watch how I ask key questions about alcohol consumption") and an understanding of what is expected in terms of participation. After the demonstration, the teacher needs to **"activate"** the learner by requesting a description of what was observed. A brief discussion typically ensues.

The **SNAPPS model** is a learner centered, outpatient model that includes six steps that the learner controls and which take place after the learner has seen the patient.
Those steps are:

- **Summarise** briefly the history and findings;
- **Narrow** down the differential to two or three relevant possibilities;
- **Analyse** the differential by comparing and contrasting the possibilities;
- **Probe** the clinical teacher by asking questions about uncertainties, difficulties, or alternative approaches;
- **Plan** management for the patient's medical problems;
- **Select** a case related problem for self-directed learning.

This model is appropriate for experienced learners, and encourages them to do most of the work in justifying their thinking and exploring what they don't understand.

Otago Medical School
Te Kura Hauora o Ōtākou

Do you know… DYK 11

How to enhance the clinical setting as a learning environment?

I never teach my pupils; I only attempt to provide the conditions in which they can learn – Albert Einstein (attrib)

The Advanced Learning in Medicine years (4- 6) are embedded in the clinical workplace, a busy environment whose primary focus is the patient.

Such settings may not always seem to be effective for learning, but the workplace provides authentic conditions for students to apply their training.

ASK YOURSELF:

If you were a student, what would make the area you work in an effective learning environment for you?

Attempts have been made to measure the learning environment, each with varying degrees of success. For example, *The Undergraduate Clinical Education Environment Measure (UCEEM)*[1] is specifically aimed at the clinical learning environment and its underpinning assumptions can be used to guide your development of a positive learning environment (Box 1).

BOX 1
The UCEEM underpinning assumptions
Invitational quality

- Opportunities to participate and learn from work experiences
- Interaction patterns and student inclusion
- Student agency and engagement

Organisational quality

- Preparedness of all parties for student entry
- Space and resources

Pedagogical quality

- Autonomy-supportive environment
- Enhancing student reflective capabilities

RESEARCH AND THE CLINICAL LEARNING ENVIRONMENT

Part of a questionnaire in one international study[2] posed the question: 'If you could change **three** things about medical school, what would they be?'

The resulting responses (Box 2) resonate with the feedback from our own medical students and some have implications for clinical teachers.

BOX 2

1. Be aware of the sharp learning curve for learners.
2. It is important to bear in mind that students during their clinical training need more constructive, empowering and empathetic feedback.
3. Many students may be unsure of their role and what to do in the clinical environment, and hence an induction phase or access to mentors may be helpful.
4. Establishing uniformity across curricula through internal consistency and external benchmarking is essential.
5. Be aware that students are under personal, academic and financial stress, and are likely to have multiple goals, such as social, intimacy, financial and career aspirations.
6. Learning is promoted by engaging constructive feedback, promoting empowerment and trust, establishing rapport building and encouraging positive role modelling.
7. Students appreciate access to study materials, such as reading, written documentation and the computer interface.
8. Establish independent student and teacher support systems to support and ensure functional learning.

A project[3] conducted by and among medical students identified the features students valued most in the clinical learning environment (Box 3).

BOX 3

- **Structural factors:** The organisation of the clinical placement
- **Interpersonal factors:** The 'Spectrum of Support' referring to support received on various levels from staff to peers
- **Intrapersonal factors:** The proactivity, preparedness and personality of each student
- **Vocational development opportunities:** Including practical experience or clinical exposure and teaching opportunities

References

- Irby, D. M., & Wilkerson, L. (2008). Teaching when time is limited. *Bmj*, *336*(7640), 384-387.
- Nair, B. R., Coughlan, J. L., & Hensley, M. J. (1997). Student and patient perspectives on bedside teaching. *Medical education*, *31*(5), 341-346.
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- Wolpaw, T. M., Wolpaw, D. R., & Papp, K. K. (2003). SNAPPS: a learner-centered model for outpatient education. *Academic Medicine*, *78*(9), 893-898.