SUPervisor Professional Development Program

SPDP 2: Teaching and Learning in Healthcare Settings

Participant post-workshop reading
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The Supervisor Professional Development Program

At the Royal Australasian College of Physicians (the College) we recognise that supervision is key to the learning of our future physicians. Supervisors play a central role in setting learning priorities and the culture for learning within healthcare settings. This can be challenging in the evolving healthcare setting and includes adapting to and leading change in medical education and managing a diverse array of workforce demands and training responsibilities.

The SPDP comprises of:

1. Three face-to-face workshops, each three hours in length
2. Online learning and resources
Teaching and Learning in Healthcare Settings

This workshop is the second of three in the Supervisor Professional Development Program and has been developed in collaboration with A/Prof Victoria Brazil, Associate Professor at Bond University and Senior Staff Specialist at Royal Brisbane and Women’s Hospital.

Supervision in healthcare settings is complex. It involves dealing with the many challenges of balancing service commitment with teaching of trainees and medical students at varying levels. The workshop offers a range of teaching strategies to manage and overcome challenges supervisors face in a complex healthcare setting. These strategies include, planning for learning, differentiated instructions for multi-level groups, and using effective teaching techniques such as questioning. It also provides opportunities to consider some of the cultural aspects of healthcare settings which impact on learning, including the hidden curriculum, tribalism and the need for effective role modelling.

In order to explore these concepts, we use the story of a medical team as they care for a patient, Mrs Jones. We follow a supervisor, registrar, intern and medical student throughout this booklet to explore some challenges supervisors face and some solutions that can be applied in the healthcare context.

Section 1: Challenges facing educators in the healthcare setting

Outcome

- Outline the challenges supervisors face in the healthcare setting.

Overview

Identify the challenges of teaching on the ward round

- Describe the impact of changes to the healthcare setting over the decades.
- Address the difficulties of balancing service and teaching.
- Actively seek development opportunities in teaching skills.
- Promote the benefits of overcoming teaching and learning challenges in the workplace.
Section 2: Strategies for teaching in a complex environment

Outcome

- Discuss the strategies supervisors can use to maximise teaching opportunities.

Overview

Apply strategies for teaching multilevel groups

- Plan for learning on the ward round.
- Use the teaching at the bedside model and rapid teaching methods to maximise learning.
- Differentiate instruction when teaching multilevel groups.

Section 3: Confronting underlying and system issues

Outcome

- Evaluate personal attitudes, beliefs, and behaviour and their influence on supervisory practice.
- Assess workplace culture issues that can affect education experiences.

Overview

Recognise the cultural environment of the healthcare setting

- Identify what is taught through the hidden curriculum.
- Actively combat negative tribalism.
- Acknowledge that supervisors are role models and model professional behaviour.

Manage and teach through adverse events

- Use adverse events to teach trainees.
- Create a ‘no-blame’ culture.
- Use conflict management strategies to defuse conflict.

This post-workshop reading booklet has been prepared as a companion to Workshop 2: Teaching and Learning in Healthcare Settings and contains important information from the workshop and references for further reading.

It expands on the concepts and models learnt in the workshop to address some of the key challenges facing supervisors in the workplace and strategies to overcome them.
Challenges facing educators in the healthcare setting

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Challenges facing educators in the healthcare setting

Create an environment for ongoing learning and development
There are many challenges that supervisors face when balancing their healthcare service requirements with the multi-level teaching requirements for their role.

1. Changes in the healthcare setting
There have been a number of changes in the healthcare setting over the past two decades that have contributed to the challenge of providing effective teaching to trainees. These include:
   - service provision
   - trainee numbers
   - educational standards
   - accountability
   - patient autonomy
   - increased educational rigour.

2. Balancing service and teaching
The balancing of service obligations and teaching trainees can be difficult. Both take considerable time and effort, and often it is the latter that suffers in a time-constrained environment. Some of the issues include:
   - time pressures
   - competing demands.

3. Finding time for faculty development
Developing the necessary knowledge, skills and abilities to be an effective supervisor can be time-consuming, and takes motivation and effort. The capacity of each supervisor to take the time to professionally develop in teaching skills varies, but is typically limited.

Confronting the challenges
The challenges supervisors face can be overwhelming. However, tackling and overcoming these difficulties can yield great benefits for supervisors, trainees and ultimately, patients.
Challenges facing educators in the healthcare setting

“Clinical teaching is an educationally sound approach, all too undermined by problems of implementation” Spencer, 2003

Effective supervision in the healthcare setting is challenging. There are numerous difficulties and barriers that supervisors must accept and accommodate, in order to be effective in their role. The three most common challenges reported are changes in the healthcare setting over the past two decades, the balancing of service commitment with teaching multi-level trainees, and varied access to supervisor skills professional development opportunities. While these difficulties are vast and varied, learning to work with limited resources in the environment can assist in overcoming challenges.

1. Changes in healthcare settings

There have been a number of changes in healthcare settings over the past two decades that have contributed to the challenge of providing effective teaching to trainees.

<table>
<thead>
<tr>
<th>Service provision</th>
<th>Changes in service provision mean patients spend less time in hospital and are more unwell when they do so.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainee numbers</td>
<td>The number of trainees in post-graduate medical education has increased significantly over the past two decades.</td>
</tr>
<tr>
<td>Educational standards</td>
<td>Increasing importance is placed on curricula for healthcare professionals, particularly in relation to systematic learning of core skills and demonstration of skill acquisition and competency.</td>
</tr>
<tr>
<td>Accountability</td>
<td>The politics of health have increased the accountability of medical professionals.</td>
</tr>
<tr>
<td>Patient autonomy</td>
<td>Patient autonomy has affected all clinical learning environments. Patients are more empowered as they have greater access to information and increased choice of healthcare providers.</td>
</tr>
<tr>
<td>Increased educational rigour</td>
<td>Knowledge about how individuals learn has affected the clinical learning environment and the experiences teachers provide for learners.</td>
</tr>
</tbody>
</table>
2. Balancing service and teaching

Supervisors are required to appropriately balance their obligation of service to their healthcare setting with teaching trainees and medical students at varying levels. In many circumstances there are competing interests, which create a difficult tension between the service needs of the healthcare setting, i.e. demands for research and administration, and the educational needs of trainees. Both take considerable time and effort, and often it is the latter that suffers in a time-constrained environment (Spencer, 2003; Sheehan et al., 2010; Gill, 2003).

3. Finding time for faculty development

There is an increasing demand being placed on faculty members to be creative and effective teachers (Wilkerson and Irby, 1998). Developing the necessary knowledge, skills and abilities to be an effective supervisor can be time-consuming, and takes motivation and effort. The capacity of each supervisor to take the time to professionally develop in teaching skills varies, but is typically limited.

Some of the teaching tasks expected of supervisors include time-efficient ambulatory care, clinical instruction, more small-group teaching, problem-based tutorials, case-based discussions, and new computer-based instructional programs (Wilkerson & Irby, 1998). These tasks will no doubt assist trainees to learn; however supervisors may find numerous teaching expectations overwhelming, particularly if they do not feel they are equipped with the skills.
There are several competencies that supervisors must exhibit and practice in order to be effective in the healthcare setting. It is important for supervisors to be aware of the competencies of effective supervision to enable them to professionally develop and know what is expected of them.
Confronting the challenges

Although time-consuming, it is worthwhile for supervisors to take the time to professionally develop to give them the skills to confront teaching and learning challenges in healthcare settings. Some knowledge and skills that supervisors can learn through professional development programs in the area of teaching and supervising include:

- determining the best teaching model to use in particular situations
- various rapid teaching models (to save time and still be an effective teacher)
- striking the right balance between questioning and telling
- questioning techniques.

Once a supervisor has learnt and practised multiple teaching strategies, they can be flexible in their teaching and adapt the model they use - taking into account the trainee’s needs, their own needs, the patient’s needs, and the timeframe. It may take some time for supervisors to determine what rapid teaching model works best for them, or how to use a teaching model that actively involves the patient in the learning. However, putting in the effort to learn these techniques will yield great benefits for all involved. Evidence suggests that the time taken in effective supervision can be offset by producing more effective and efficient trainees (Kiminster & Jolly, 2000; Skeff, Bowen & Irby, 1997).

Further, Wimmers, Schmidt & Splinter (2006) counter the challenge of reduced patient stays and fewer numbers of ongoing patients in hospitals. The authors report that clinical competence and knowledge of a trainee is more influenced by adequate supervision than by the number of patients seen or length of stay. Therefore, if supervision is conducted well and the learning encounter planned and executed with careful thought, this particular challenge can be overcome and trainees will increase their clinical competence and knowledge.

The challenges supervisors report, in the healthcare setting, are real and justified, and often overwhelming. In the next chapter, there are a variety of teaching strategies supervisors can put into place that will alleviate some of the difficulties they face.
Strategies for teaching in a complex environment

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Strategies for teaching in a complex environment

Apply strategies for teaching multi-level groups

Medical ward rounds have been a central and complex hospital activity for hundreds of years. They require skillful leadership and careful coordination to adequately provide high-quality, safe and timely patient care, while also facilitating patient and carer engagement.

They provide an opportunity for a multidisciplinary team to come together to examine a patient, determine a diagnosis and coordinate a plan of care.

Typically, supervisors are required to teach multiple levels of learners, including medical students, interns and residents – Basic and Advanced trainees. All members of the team require appropriate teaching and learning experiences: however, they will each come from a different background, have diverse interests, goals, knowledge and skills, and will be at different levels of their training. It is clear that teaching multi-level groups on the ward round is complex, but implementing some helpful techniques and applying best practice strategies can assist to minimise the difficulties.

Planning for learning on the ward round

Planning for learning is a critical component to providing effective supervision. There are six questions to assist with planning for learning on the ward round:

- What is the plan?
- Who should do the teaching?
- What do the learners know?
- How can I help the trainees to learn?
- What can be achieved?
- How will I know what has been learnt?

Teaching at the bedside

The ‘teaching by the bedside’ model places greater focus on involving the patient in a learning encounter. Involving the patient is beneficial to trainee’s learning to help them acquire and refine many necessary skills, knowledge and behaviours such as observation, communication, examination and professionalism.

It is important to:

- address patient comfort, including asking permission and introducing the team
- focus teaching
- manage group dynamics and involve all learners.
**Targeted teaching**

There are a number of rapid teaching models that time-pressured supervisors can use to efficiently and effectively provide teaching and learning episodes on a daily basis, including One Minute Teaching, Aunt Minnie, SNAPPS, Activated Demonstration and Bedside Case Presentations (Irby & Wilkerson, 2008; Cayley, 2011).

These teaching models can be adapted and moulded to suit the context and situation.

**Teaching diverse learner groups**

Differentiated instruction is a teaching strategy that respects the different learners in a group and their diverse learning needs, readiness to learn, varied backgrounds and life experiences, various interests and dominant preferred learning styles.

When applied effectively, differentiated instruction enhances learning for trainees at varying levels.

**Questioning techniques**

Effective medical teaching involves the use of appropriate questioning of the learner as a teaching and learning tool.

There are many different types of questions that can be asked, and sometimes simply changing your questioning technique can enhance the teaching point.
Case study scenario - teaching at the bedside

The case study used throughout this post-reading book has been adapted from the case study example in the workshop 2 trigger videos. It describes the interaction between four team members in a medical team and a patient as they embark on a post-take ward round.

This case study aims to demonstrate some of the nuanced situations that occur in post-graduate medical training. There are a variety of themes explored, including how to plan a ward round for teaching, dealing with multi-level learner groups in a high-pressure environment and using the patient as a teaching resource. It is helpful to use the experience of the medical team to reflect on supervisory skills and explore teaching techniques and models that can be incorporated into daily practice.

The team

**Alison** is a consultant physician in general medicine. She has been involved in teaching medical students, junior doctors and trainees for a number of years now and considers herself a pretty good supervisor. However, given her service commitments and interests in research, she constantly feels too busy to put enough time into the teaching component of her supervisory role. She also feels like some of the trainees don’t deserve her time because they don’t have the attitude for learning and respect for senior doctors like she did when she was a trainee.

**Spencer** is a general medical registrar coming up to his second attempt at the FRACP exam, having failed last year. His confidence is quite low and tends to get muddled up when trying to present a patient history and thinking through the differentials.

**Viet** is an International Medical Graduate (IMG) intern. He is a lovely fellow, but very shy. He is difficult to get to know and rarely offers anything of value during ward rounds.

**Ben** is a 3rd year medical student on his internal medicine rotation. He is an avid participant in social media and follows a number of medical educational podcasters on Twitter. He is quite disengaged and doesn’t see the learning benefit of partaking in a ward round teaching session. He is pretty confident that all the information on a given problem can be found online.

**Mrs Jones** has been admitted after a fall, on a background of a number of significant co-morbidities, and already feels a little bewildered after her first night in hospital.
Strategies for teaching in a complex environment

“I desire no other epitaph … than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important work I have been called upon to do.”
William Osler, 1914

The ward round has been a central feature of medical education since first recorded in 1660. The benefits of the ward round are that it provides an authentic experience of the complexity of patient care and professional practice. Supervisors are able to model professionalism, enhance clinical reasoning, and demonstrate the cultural norms of medical practice (Ker, Cantillon & Ambrose, 2008).

Traditionally, the emphasis of training on ward rounds was primarily didactic and information focused. Physicians were required to acquire large amounts of factual information and conventionally this occurred passively through being addressed by a senior doctor (Swanwick, 2014). Some evidence suggests that some supervisors or healthcare settings view the teaching and learning on the ward round as an inefficient use of time (Gonzalo et al., 2014).

In recent times, the ward round has experienced a positive transformation. The emphasis has shifted from traditional teaching methods of acquisition of facts, to applying appropriate adult learning principles that see supervisors facilitating learning, using questioning techniques, providing one-to-one feedback, inspiring self-regulation and stimulating reflective practice (Swanwick, 2014).

Ward rounds provide an unparalleled and vital opportunity for delivering clinical teaching and learning experiences to a multi-level team. Furthermore, medical education leaders recommend preserving and promoting this effective teaching environment.

It is the responsibility of the consultant supervisor to ensure that the ward round is appropriately introduced, structured and led to provide educational opportunities for all trainees. Supervisors are required to model their skills, knowledge, values and attitudes to observing trainees, as well as demonstrate how knowledge is constructed and understood, and how practices evolve (Swanwick, 2014).
Planning for learning on the ward round

“Showing that you are interested in somebody will help them engage in the team better”
Dr Fiona Horwood, RACP Fellow

How can supervisors plan for and optimise the teaching and learning opportunities that arise in clinical practice? Ker, et al. (2009) developed these six questions for supervisors to ask themselves when planning the delivery of an effective teaching and learning episode on a ward round:

- What is the plan?
- What do the learners know?
- What can be achieved?
- Who should do the teaching?
- How can I help the trainees to learn?
- How will I know what has been learnt?

Case study

Alison and her team are about to see their third patient, Mrs Jones, on their busy post-take ward round. Upon entering the room, Spencer, the 3rd-year registrar, immediately begins presenting the patient history. This is his third time presenting a history this morning and his style is not quite what his supervisor, Alison, is looking for. Alison knows Spencer needs to practise presenting patient histories which is why she has been focussing the ward round on his learning needs; however, she’s very frustrated that he still can’t get it together. After Spencer gives a particularly long and detailed summary of Mrs Jones’ case and is not answering her questions correctly, Alison snaps. She berates Spencer in front of the team and the patient: “Alright Spencer, you are coming up again for this exam, you really need to start framing this better or you will fail the Clinical Exam again. You’ve been through this before and you’ve got to have more of a system for framing the history. You’re shelling out a lot of money again and your wife is not going to be happy if you don’t pass this time.”

Spencer is visibly embarrassed.

Alison can’t remember the medical student or intern’s name, but she points to them and asks several questions in quick succession. They feel intimidated and also don’t answer very well. Alison looks at her watch and instructs the team to move on to the next patient. Mrs Jones is left confused and upset.
### Reflection

What would you do to be better prepared for the teaching on this post-take ward round?

Take a moment to consider a recent post-take ward round of your own. Use the 6 planning questions to help you reflect on how it could have been better planned.

- What is the plan?
- What do the learners know?
- What can be achieved?
- Who should do the teaching?
- How can I help the students to learn?
- How will I know what has been learnt?

### What is the plan?

Teaching on ward rounds is most effective when learning experiences for trainees are planned. This is a challenging task in the ‘hustle and bustle’ of a busy ward. However, evidence suggests that planning will yield great benefits for trainees. Taking 5-10 minutes before a ward round to consider learner’s needs, various teaching opportunities, teaching goals and methods to consider, how teaching can be differentiated for each team member, and possible tasks to be entrusted to team members, will increase the efficiency and effectiveness of the educational experience for trainees (Ker, Cantillon & Ambrose, 2009).

### Tips for planning the teaching session

- Estimate the amount of time that you will need for listening to presentations, making decisions and talking to patients. Then work out how much time you have for teaching.
- Know who your trainees are and use their names. This demonstrates respect and can increase the trainee’s self-confidence.
- Send a trainee to assess a new admission ahead of the ward round so that time can be spent on a detailed study of one patient – rather than a superficial skim of many patients.
- Request trainees explore a patient’s understanding of their condition and its management – follow up with the trainee after the ward round to discuss the encounter.
- Structure the session by ensuring all participants are clear on the goals and the learner activities are planned.
- Speak to the relevant teams beforehand to identify patients for presentations who might allow focused teaching points, e.g. history, physical examination, patient management, specific conditions, etc.
The patient – a teachable moment

The patient is too often an untapped resource in clinical medicine. Involving the patient in teaching and learning can be powerful and beneficial to trainee’s learning – it can help them acquire and refine many necessary skills, knowledge and behaviours, such as observation, communication, examination and professionalism.

Teaching trainees with the patient present is important and effective, yet many supervisors are hesitant to do it. Some supervisors worry that their patients might find participating in a teaching and learning encounter stressful, upsetting or detrimental to their health. This may be true in some instances and it is always important to consider the patient’s needs carefully. However, research suggests that patients like to be involved in clinical teaching as it can help them learn more about their condition, makes them feel valued, and feel that despite their illness they are able to benefit others and contribute to medical education (Lynoe et al., 1998).

..........................

Selecting patients for teaching

Trainees can learn more from some patients than others. Similarly, some patients are very happy and helpful participants in the teaching process and are therefore easier to teach with than others.

Patients used for teaching should:

• be friendly
• be available and willing to talk or be examined by trainees at the appropriate time
• have a good story to tell the trainees (this may be about their wider experiences relating to their illness and not just an interesting medical history)
• There should be no significant communication barriers (unless you intend the learning points to be specifically about how to deal with communication difficulties).
What do learners know?

“We don’t really use words like trust and respect often enough, but actually respect for learners and teachers is key to any effective learning”.

A/Prof Victoria Brazil, Emergency Medicine physician

It is important to target teaching to the learner based on their stage of training. The quality of a learning episode can often depend on how much the learner already knows. Supervisors should aim to help trainees build on their knowledge, create new understandings, consider and investigate new concepts, and observe, learn and practise new skills, in the context of the patients they are seeing.

Tips for determining prior knowledge and experiences

Identify the learners’ levels of clinical knowledge, experience and skills by finding out:

- what stage of training they are at
- what clinical rotations they have completed
- what clinical experiences they have had
- their interests.

Tips for personalising teaching

Base your teaching episodes on your understanding of the learner’s prior knowledge and interests. Provide opportunities for trainees to use their prior knowledge and experience when problem-solving, reflecting and applying clinical reasoning processes. Where possible, provide projects/tasks that reflect the learner’s interests.

Prior to the patient encounter ask the trainees to:

- summarise the care plan for a patient on a previous ward round
- focus on particular areas of clinical and professional practice they are not confident in or find difficult to understand
- say whether they had a chance to investigate the patient beforehand
- share a differential diagnosis they had in mind.
**What can be achieved?**

It is important to discuss the learning goals with your learners. Determining the individual learning needs and readiness to learn with each trainee will provide a focus for your teaching and help make the most of teaching opportunities. Adults value learning that integrates with the demands placed on them in everyday life.

**Tips for achieving outcomes**

- Agree on learning goals and elicit trainees’ expectations at the beginning of a rotation.
- Monitor progress of learning goals.
- Acknowledge that different learners will have different learning goals.
- Provide meaningful learning experiences linked to goals and real life tasks and problems.
- Develop a ‘need to know’ in learners - present a case for the value of the information or skill to the learner.

**Who should do the teaching?**

The ward round can be a great opportunity to bring in other health professionals to participate in teaching. This can be a great opportunity to role model teamwork and to meet specific learning goals that other professionals may be able to reinforce in a different way to you.

**Tips for planning multidisciplinary teaching roles**

- Request or agree to other health professionals being involved in teaching on the ward round.
- Define the relevance of other health professionals being involved in the teaching episode.

**How can I help the trainees to learn?**

There are numerous teaching techniques that can be blended to achieve a balanced learning experience to cater to the various learners in a team.

**Tips to engage trainees in learning**

- Direct learner’s observations by signposting to learners what to look out for in a particular clinical encounter.
- Give learners meaningful tasks to engage them and give them a purpose.
- Use a combination of teaching techniques that appeal to a variety of preferred learning styles.
- Differentiate instruction (see page 32).
- Use questioning techniques to lead the trainee toward inquiry before supplying them with many facts (see page 38).
- Use a variety of teaching models and determine what works for you and your learners (see page 29).
- Make time to stop and summarise the learning.
Learning styles

Many learners have a preferred learning style such as visual, auditory, read/write and kinaesthetic (Fleming, 2012; Fleming and Mills, 1992). Learning experiences can be designed to appeal to all primary learning styles by incorporating a blend of tools and techniques, such as:

- Visual: charts, diagrams, and demonstrations
- Auditory: discussions, brainstorming, stories
- Read/Write: readings, notes, lists
- Kinaesthetic: simulations, activities, role plays.

Tips for supervising younger trainees

- Provide a variety of complex tasks that require several actions to complete.
- Provide opportunities to collaborate with other learners.
- Use the most up-to-date technology and references available.
- Recommend reading materials to supplement teaching points.
- Provide structure to teaching encounters.
- Offer mentorship where possible and appropriate.

(Oblinger, 2003)

How will I know what has been learnt?

Debriefing with learners is an important part of the teaching and learning on a ward round.

Tips for assessing learning

- Highlight key points, discuss areas of uncertainty, ask questions, and raise problems that could not be discussed in front of the patient.
- Provide corrective feedback if required.
- Plan with learners what they need to look at or do prior to the next ward round.
- Encourage learners to keep track of their learning by using a logbook.
How do I structure the teaching and learning session on a ward round?

The ‘events of instruction model’ is an eight-step method and is a way supervisors can plan the structure of their teaching session on a ward round.

1. Gain the trainee’s attention - this is to arouse interest.
2. Outline the objectives - to clarify the roles and responsibilities of the ward round and the supervisor expectations.
3. Stimulate recall of prerequisite knowledge - to confirm required background knowledge for the level of the learning.
4. Communicate stimulus material to trainees - give a history of the patient and his/her problems.
5. Give learning guidance - explain how to go about the assigned task.
6. Elicit the performance - get the trainee to do the assigned task.
7. Give feedback on each trainee’s performance.
8. Enhance retention and transfer of what has been learnt - recap and reflect on each trainee’s performance and what has been learnt; recommend suggested activities to build on what has been learnt.

The eight events of instruction (Gagné et al., 1992)

Case resolution

At the end of the round, Alison takes some time to think about her day, particularly her teaching. She reflects on how she could improve and makes the following commitment for future ward rounds:

- introduce herself to her team members prior to the ward round (especially new members)
- endeavour to remember their names (this will demonstrate respect for them and can increase their self-confidence)
- engage all members in the learning experience and prioritise building a relationship with her team members and invest time into getting to know them, e.g. what stage of training they are at, what rotations they have completed, what clinical experiences they have had, etc.
- consider ways of helping Spencer improve in presenting patient history, e.g. role modelling presenting a patient history or giving him feedback on areas to improve
- remember to ask more open questions to find out more information about what her trainees know.
There are many useful learning environments for bedside teaching, including:

- dedicated teaching at the bedside
- dedicated teaching session in the clinical skills lab
- teaching ward round – service plus large focus on teaching
- teaching clinic – service plus large focus on teaching
- teaching operating list – service plus large focus on training
- service ward round attended by trainees (e.g. post take ward round)
- service clinic attended by trainees
- service operating list attended by trainees.

Dedicated teaching activities allow better planning and preparation and allow the teacher to design the session around the needs of the learner. They are time-consuming and limit the clinician’s role in patient care. Service activities maximise patient care, but can be of limited use for more systematic learner-focused teaching. However, they are important opportunities for opportunistic teaching and learning and for role modelling. With some attention to the learner, the effective teacher can maximise learning while minimising disruption, even in the busiest of clinical settings.

The final page of this chapter includes a lesson plan template that can be used to assist planning for ward round teaching.

**Teaching at the bedside**

“The bedside is the perfect venue for unrehearsed and unexpected triangular interactions between teacher, trainees and patient... physician teachers should be vigilant about grabbing teachable moments” (Ramani, 2003, p.114)

**Bedside teaching model**

Janicek and Fletcher (2003) provide a best practice, ‘teaching at the bedside’ model that groups the clinical teacher’s skills into three domains: attending to patient comfort, focused teaching and group dynamics. This model is a useful tool for planning your bedside teaching and also for reflecting on your bedside teaching practice.
## Bedside Teaching Model

<table>
<thead>
<tr>
<th>Domain</th>
<th>Method</th>
</tr>
</thead>
</table>
| **Attend to patient's comfort** | • Ask patient permission ahead of time.  
• Introduce everyone to the patient.  
• Brief overview from primary person caring for patient.  
• Explanations to patient throughout, avoiding technical language.  
• Base teaching on data about that patient.  
• Genuine, encouraging closure – e.g. “thank you for helping us teach future physicians”.  
• Return visit by a team member to clarify misunderstandings (if required). |
| **Focus your teaching** | **Diagnose the patient**  
This can be done at the bedside by:  
• trainee presenting patient’s history  
• trainee conducting physical examination  
• supervisor obtaining information from patient.  
 **Diagnose the learner** (know your learner)  
• Observing – communication skills, physical exam skills, etc.  
• Questioning.  
 **Targeted teaching** (target teaching to learner’s specific needs).  
• Possible models for targeted teaching are included in the next section of this booklet.  
Note: remember to include the patient in the targeted teaching time. Consider involving the patient as a teacher. |
| **Group dynamics**      | Crucial to the success of a bedside teaching encounter is keeping all learners actively engaged in the session by:  
• limiting time of the session  
• limiting the learning goals – individual and group  
• including everyone in teaching – all members should have a role  
• including everyone in debrief and feedback. |

Adapted from Janicek and Fletcher (2003) ‘Model of Best Bedside Teaching Practices’
Case Study

After a particularly poor post-take ward round, Alison considers her bedside teaching. Using the best practice ‘teaching at the bedside’ model, she reflects on the encounter with Mrs Jones. The following are her notes from her reflection; she has noted the negative aspects of the encounter along with how she can improve.

| Attend to patient's comfort | Focus your teaching
|----------------------------|---------------------------|
| - I forgot to ask the permission from the patient before the ward round. | Diagnose the patient
| - I was in a rush and didn’t introduce myself or my team. | - Spencer gave the patient history, but not very well.
| - I didn’t offer any explanation to Mrs Jones about what we were discussing. | **Diagnose the learner**
| - No one in the team thanked Mrs Jones for her involvement in the teaching episode. | - I know Spencer quite well. I know that he failed the FRACP clinical exam last year because he isn’t very good at giving a patient history. I also know that his wife puts a lot of pressure on him. I shouldn’t have brought up his wife or the exam during the ward round in front of the team. I need to give him some feedback about how to improve in presenting a patient history and consider role modelling this in the next ward round.
| | - I couldn’t remember the names of the intern or medical student. I must find out more about Viet and Ben: they were very disengaged and I didn’t involve them enough.
| | **Targeted teaching**
| | - Role Model: Knowing that Spencer struggles with patient history presentation, I could have used this time to demonstrate how to take and present a clear and well organised history. I will try to find some time to do this on the next ward round.
| | - Feedback: I need to give Spencer some corrective feedback on his patient history presentation and also apologise to him for snapping at him. There are some positive aspects of his presentation, which I must also tell him.
| | - Patient: I did not involve the patient at all in the teaching, which is a wasted opportunity.
| | **Group dynamics**
| | - I did not engage Ben and Viet at all in the bedside teaching session – I was too frustrated with Spencer and we ran out of time.
| | - I didn’t discuss any learning goals with any of the three team members and forgot to make a time to debrief the session. I’ll try to catch them in the tea room to discuss.
Using the best practice ‘teaching at the bedside’ model, reflect on your own teaching at the bedside encounter from a recent ward round.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Attend to patient’s comfort</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Focus your teaching</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group dynamics</strong></td>
<td></td>
</tr>
</tbody>
</table>
Targeted teaching

“The complexity involved in practising medicine must be tackled with appropriate educational strategies in the training and education of undergraduate and postgraduate students.” (Abela, 2009)

Given the challenge of finding sufficient time for service and teaching obligations, supervisors need to consider using time efficient teaching techniques in their everyday encounters. There are a variety of teaching models that can be used in the healthcare setting that are time efficient and effective.

The table on the following page outlines a number of rapid teaching models supervisors can adopt to target trainee learning on the ward round (Irby & Wilkerson, 2008; Cayley, 2011). Each model has a slightly different focus and can be adapted and moulded to suit the teacher and differing needs of the learners.

<table>
<thead>
<tr>
<th>Signs of a good teaching and learning episode</th>
<th>Signs of a poor teaching and learning episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Well planned</td>
<td>• Haphazard</td>
</tr>
<tr>
<td>• Adequately covers curriculum outcomes</td>
<td>• Not covering the curriculum</td>
</tr>
<tr>
<td>• Novices observe tasks performed by an expert and/or practise tasks in front of the expert</td>
<td>• Novices asked to perform tasks in which they are unprepared or unsupervised</td>
</tr>
<tr>
<td>• Feedback provided</td>
<td>• No feedback given</td>
</tr>
<tr>
<td>• Encourages best practice</td>
<td>• Encourages ‘getting the job done’</td>
</tr>
<tr>
<td>• Learners feel encouraged and valued</td>
<td>• Learners feel overwhelmed and disrespected</td>
</tr>
<tr>
<td>• Learners ask questions and offer ideas freely</td>
<td>• Learners are too scared to speak unless spoken to</td>
</tr>
<tr>
<td>• Patient permission was gained, patient feels valued and respected</td>
<td>• Patient permission was not gained, patient is embarrassed</td>
</tr>
<tr>
<td>• Supervisor is approachable.</td>
<td>• Supervisor is hard to talk to.</td>
</tr>
<tr>
<td>Model</td>
<td>Instruction/ explanation</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>“One minute teaching” model</td>
<td>Useful model for targeted instruction.</td>
</tr>
</tbody>
</table>
|                               | Five steps:  
|                               | • Get a commitment about what the learner thinks is going on with the patient.          | **Telling/instruction:**  
|                               | • Probe for underlying reasons or alternative explanations.                              | **choose a general principle to teach**  
|                               | • Teach a general principle.                                                             | Mini lecture, demonstration of skill, etc  
|                               | • Provide positive feedback.                                                            | **Telling/Feedback:**  
|                               | • Correct errors and make suggestions for improvement.                                  | *“You did a good job of...”* *“You might like to also consider...”* *“Why don’t you do some research on that and we can discuss it before our next ward round”* |

**Aunt Minnie model**  
Designed to promote rapid pattern recognition for learners in ambulatory care settings. The model is built on the premise that if the woman across the street walks and dresses like Aunt Minnie, then it probably is Aunt Minnie, even if you can’t see her face.

The learner sees the patient, takes a history, does a physical examination on the basis of the main complaint.

- learner presents the main complaint to the supervisor and the presumptive diagnosis
- teacher independently sees patient, while the learner writes up notes
- supervisor and learner discuss the case.

**SNAPPS model**  
Six steps for the learner to control (after the learner has seen the patient). This model encourages self-directed learning.

- summarise history and findings
- narrow the differentials to two or three
- analyse differentials
- probe by supervisor – questions, difficulties, alternative
- plan management of the patient’s medical problems
- select a case-related problem for self-directed learning
| ‘Activated’ demonstrations | When the problem is unfamiliar to the learner, the supervisor can ask them to observe something specific. After the demonstration, the supervisor can ‘activate’ the learner by requesting a description of what was observed/learnt. 

Supervisor and trainee have a discussion and a rationale for actions is examined. This can lead to assigning independent study. 

This model makes visible the supervisor’s clinical expertise |
|---|---|
| **Activated** demonstra| Supervisor: “Have you encountered alcoholism and abuse before?” 
Trainee: “No.” 
S: “Ok, I want you to watch and listen closely how I ask critical questions about alcoholism and abuse” *(specific assignment)* 
**Patient encounter**
S: “What did you notice about how I asked questions? What did you observe me do? Can you describe the encounter?” *(activation)* 
T: **answer**
S: “I asked the questions in that way because...” *(rationale)*
S: “Can you do some research into questioning patients about sensitive issues and we will discuss this before our next ward round.” *(independent study)* |
| Case presentation at the bedside | The hospital bedside is a great location for effective and efficient teaching. 

Key to this model is ensuring the learner is well prepared and the patient is comfortable and aware they will be talked about, and to not be alarmed or frightened. It is also a great opportunity to use the patient as a teacher. |
|---|---|
| Supervisor: *(patient name)* this is Dr Smith, we’re going to be talking about you for a few minutes, we may check some things with you along the way, and if something doesn’t sound right please say something.”
Trainee: ** presents case to supervisor in front of patient**
Supervisor, patient and trainee: **discussion about missing information, decisions that need to be made, asking questions** |

(Irby & Wilkerson, 2008; Cayley, 2011)
Reflection

Consider a recent teaching and learning encounter on a ward round. Outline how you would improve that learning episode using one of the above rapid teaching methods.

____________________________________________________________________

____________________________________________________________________

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____________________________________________________________________


Being realistic

It is impossible to deliver high-quality teaching in all clinical situations. Negotiating with learners and colleagues about how to work as a team to balance service and teaching commitments is vital. For example, if you inform a trainee before a busy post-take ward round where you have many patients to see, and may not have time to stop for teaching, they will recognise the need to put the patients and service needs first. Ideally, tell the trainee in advance that you expect them to observe what goes on and that you will meet later in the day, perhaps over coffee, to discuss any learning points. This will ensure the trainee has clear expectations of the learning episode and when they will have an opportunity to ask questions and discuss the cases.
Teaching diverse learner groups

“In a differentiated [teaching session] the [supervisor] proactively plans and carries out varied approaches to content, process and product in anticipation of and in response to [trainees’] differences in readiness, interest and learning needs.” (Tomlinson, 2001)

Differentiated instruction is a teaching strategy that respects the different learners in a group and their diverse learning needs, readiness to learn, varied backgrounds and life experiences, various interests and dominant preferred learning styles.

This strategy sees supervisors recognise that one size does not necessarily fit all when it comes to teaching and learning in the healthcare setting. It involves providing learners with multiple options for acquiring and applying knowledge, developing skills and making sense of ideas, so that each trainee can learn most efficiently and effectively.

### Using differentiated instruction to enhance teaching and learning

<table>
<thead>
<tr>
<th>Approach</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Be proactive</strong></td>
<td>Supervisors need to proactively plan a variety of ways to address a range of learners’ needs.</td>
</tr>
<tr>
<td><strong>More qualitative than quantitative</strong></td>
<td>Adjusting the nature of a task or instruction to meet a learner’s needs is a more effective teaching strategy. Simply giving a more senior team member more work, and a junior learner less work, is not an effective way of meeting the learner’s needs.</td>
</tr>
<tr>
<td><strong>Focussed on assessment</strong></td>
<td>Conversations, group discussions, work in practice, observation and formal assessments are not just ways of ‘seeing who gets it’ but are also ways of gathering evidence of learning to inform progression decisions.</td>
</tr>
</tbody>
</table>
| **Multiple approaches**                       | There are at least three curricular elements supervisors deal with:  
  • Content – input, what trainees learn  
  • Processes – how trainees go about making sense of ideas and information  
  • Product – output, how trainees demonstrate what they have learned.  
  By differentiating these three elements, supervisors offer different approaches to what trainees learn, how they learn it, and how they demonstrate what they have learned. |
| **Trainee centred**                           | Learning experiences are most effective when they are engaging, relevant and interesting. Instruction and information must build on prior understandings and not all learners will have the same prior knowledge. Supervisors need to help learners take increasing responsibility for their own growth by guiding them to think on their own, accept responsibility for their own learning, and be active in making and evaluating their decisions. |
Whole group instruction is an efficient way to share information and can be effective in many circumstances. It establishes a common understanding and a sense of community by sharing discussion and reviewing together.

Some learning activities should also be pursued individually, and then shared together as a group. This can be conducted in waves, for example, coming together as a group to discuss information, going away to investigate individually, and coming back together again to discuss and review.

<table>
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<tr>
<th>Whole group and individual instruction</th>
</tr>
</thead>
<tbody>
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<td>Whole group instruction is an efficient way to share information and can be effective in many circumstances. It establishes a common understanding and a sense of community by sharing discussion and reviewing together. Some learning activities should also be pursued individually, and then shared together as a group. This can be conducted in waves, for example, coming together as a group to discuss information, going away to investigate individually, and coming back together again to discuss and review.</td>
</tr>
</tbody>
</table>

(Tomlinson, 2001)

Brandt (1998) offers a number of characteristics for what he calls powerful learning. The diagram below offers supervisors some questions to ask and concepts to consider when planning for differentiating instruction for multi-level learners.
Reflection

Consider one of your recent ward round teams. Outline how you could improve that learning episode by differentiating the instruction for your multi-level team.

Effective teaching and learning for multi-level trainees will involve a combination of appropriate questioning techniques. The next section explores the various questioning techniques that supervisors can use.

Questioning techniques

“The wise man doesn’t give the right answers, he poses the right questions”.

Claude Levi-Stauss

The use of good questioning techniques is a very valuable teaching skill. Effective medical teaching involves the use of appropriate questioning to the learner as a teaching and learning tool. There are many different types of questions that can be asked, and sometimes simply changing the style can enhance the teaching point.
**Case study: the ward round**

Mrs Jones has now been in hospital for 3 days and Alison and her team are about to see her on their ward round. Spencer has been working on presenting clearly and does a good job at presenting the findings from the various tests and investigations that have been conducted. Alison poses a few questions to the team after Spencer’s presentation of the findings.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Issues</th>
</tr>
</thead>
</table>
| **Alison:** “so, Viet, do you think that these findings may have contributed to the syncope and the cause of Mrs Jones’ fall?”  
**Viet:** “yes, I do”  
**Alison:** “Ok..., how do you think it contributed to her syncope?”  
Viet thinks through and discusses a number of causes based on the clinical findings. The discussion reveals that Viet has a thorough understanding of the causes of syncope. Alison provides some encouragement to him and thanks him for his input. | **Use of questioning**  
Alison initially poses a closed question, when she realises this, she re-asks the question in a more open way.  
This open, probing question, allows Viet to demonstrate his knowledge of syncope and the causes, in the context of this patient. |
| **She then directs some questions toward the medical student, Ben.**  
**Alison:** “So, Ben, Spencer said that Mrs Jones is on an ACE inhibitor and an ARB, what do you think about that?”  
**Ben:** “I think that can be quite bad for the kidneys, probably contributing to her renal failure”  
Alison: “Good. So they might have contributed to the renal dysfunction. Do we usually use the two agents together?”  
**Ben:** “No I don’t think so.”  
**Alison:** “Can you provide a reason why Mrs Jones is on both of these medications, given the side effects?”  
**Ben:** “No, I don’t think she should be on both of them, but I am not sure exactly why”  
**Alison:** “OK, well there is evidence for why, I’m happy for you to look it up and we can discuss it before tomorrow’s ward round.”  
**Ben:** “OK, thanks.” | **Providing feedback**  
Alison’s positive feedback makes Viet feel valued and respected as a learner.  
**Teaching to the learners stage of training**  
Alison wants to engage all members of the team in this discussion.  
Her question to Ben is an open question; however, it’s a little bit vague and implies ‘guess what I am thinking’.  
**Extending learner knowledge**  
Alison asks a closed question here; she’s leading up to her next question, which is a justifying one.  
Although Ben isn’t sure of the answer, Alison is happy that he was able to say he didn’t know and instructs him to find out more.  
She is very clear about when they will discuss the topic again. When proposing follow-up, it is vital to the learning experience that she remembers to discuss with Ben what he discovered. |
Socratic questioning

The Socratic questioning method in medicine involves a supervisor asking a series of questions in a stepwise and logical sequence to provide a teaching and learning journey for trainees (Oh, 2005). This method teaches learners to think critically by using their prior knowledge of medicine in new contexts. Once the learner has progressed as far as possible, the supervisor can offer a teaching point to further enhance the trainee’s learning (Oh, 2005).

Benefits of the Socratic methods

- Challenges and builds on learner’s prior knowledge and skills – enhancing their critical thinking skills.
- Diagnoses learner’s level of understanding – assesses learner’s needs.
- Engages learners, encourages focussed and self-directed learning.
- Takes trainees on a journey of learning and can make pertinent teaching points.
- Determines the level of knowledge of each learner.
- Helps plan future teaching and learning episodes.
- Offers learners opportunities to address concerns, fears and areas of improvement.

Questions can be classified as either open or closed. Neither open nor closed questions are ideal for all situations. An effective teacher will be comfortable with both question types, and in most teaching and learning episodes a combination of the two will be required (Turner et al., 2010). The following table outlines the differences between open and closed questions and provides some examples of the two styles.
Differences between open and closed questions

<table>
<thead>
<tr>
<th>Open</th>
<th>Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples</strong></td>
<td></td>
</tr>
<tr>
<td>This child has pain in his ___ what do you think is going on?</td>
<td>What is the most common cause of ___?</td>
</tr>
<tr>
<td>What are some of the causes of ___?</td>
<td>Do you think this child has ___?</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Have unlimited correct answers</td>
<td>Limited correct answers, often only one (yes/no)</td>
</tr>
<tr>
<td>Can reveal the learner’s understanding</td>
<td>Require recall and recitation of knowledge</td>
</tr>
<tr>
<td>Provide an opportunity to assess the learner’s problem-solving skills</td>
<td>Can provide an opportunity for trainees to apply the knowledge they have in a clinical setting</td>
</tr>
<tr>
<td>Explore higher levels of thinking</td>
<td>Don’t allow for deeper evaluation of learner’s knowledge</td>
</tr>
<tr>
<td>Can be time-consuming</td>
<td>Can be appropriate when time is limited</td>
</tr>
<tr>
<td>Can strengthen the learner’s thinking process</td>
<td>Can be intimidating or embarrassing for the trainee</td>
</tr>
</tbody>
</table>
A variety of questioning techniques can be used to stimulate the acquisition of knowledge. The following table outlines some questioning techniques, the circumstances or settings they can be used in, and examples of their use.

<table>
<thead>
<tr>
<th>Questioning style/ technique</th>
<th>Useful for</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Probing</strong> – often factual questions that elicit facts (scientific, medical, patient information, skills) and how they apply in the clinical situation.</td>
<td>• quickly assessing specific knowledge base of trainees and if they can apply their knowledge in a clinical setting.</td>
<td>“Explain the correct way to examine the _____?” “What are the 3 main causes of ____? And how do they apply to this patient?”</td>
</tr>
<tr>
<td><strong>Clarifying</strong> – often follow probing questions, involves clarifying what the trainee has said, usually in answer to previous questions.</td>
<td>• ensuring the learner was clear • obtaining clarity and/or more detail for the team • ensuring the answer to a question was correctly understood.</td>
<td>“You said the patient has ____. Can you elaborate on that?”</td>
</tr>
<tr>
<td><strong>Broadening/ hypothetical</strong> – involves changing the specifics of a given case to make it more challenging or interesting.</td>
<td>• assessing other areas of trainees knowledge • enlarging the differential for a current problem • reviewing the general management of an acute problem.</td>
<td>“What if the patient were 35 instead of 65, how would that change the management?” “What if the patient had not responded to the treatment?”</td>
</tr>
<tr>
<td><strong>Justifying</strong> – involves asking questions about specific treatment plans or medication side effects.</td>
<td>• determine the depth of the trainee’s understanding.</td>
<td>“Why have you come to that conclusion?” “Can you justify the medication, given the side effects?”</td>
</tr>
<tr>
<td><strong>Alternative</strong> – involves asking for different options.</td>
<td>• helping trainees to recognise that there are many correct ways of treating patients • reviewing the natural history of the disease process.</td>
<td>“Is there any other explanation for the symptoms?” “Is there another way this condition could be managed?”</td>
</tr>
<tr>
<td>Questioning style/ technique</td>
<td>Useful for</td>
<td>Examples</td>
</tr>
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<td>-----------------------------</td>
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</tr>
</tbody>
</table>
| **Targeting** — targets medical knowledge or management questions to specific team members based on the difficulty of the question. | • teaching multi-level groups  
• using senior trainees to teach junior trainees. | “Ben, how do we decide if a patient with _____ needs to be admitted?... Viet, what is the most common cause of____? Spencer, what are some of the possible complications of ____ that we should watch out for in this patient?” |
| **Multi-Answer** — provides a number of learners the opportunity to answer the same question. | • teaching multi-level groups. | “Here we have a patient presenting with _____, what is the most likely diagnosis?”  
“OK, we have heard what Viet thinks, what do the rest of you think?” |
| **Anticipating** — seeking trainee’s understanding of possible negative outcomes. | • helping trainees to consider the prevention of adverse events (e.g. as a result of clinical errors or system issues). | “What could go wrong?”  
“What preventative actions could you take to reduce the risk?” |

**When questioning has a negative impact**

“On the surface, the aim of pimping appears to be Socratic instruction. The deeper motivation, however, is political. Proper pimping inculcates the intern with a profound and abiding respect for his attending physician while ridding the intern of needless self-esteem. Furthermore, after being pimped, he is drained of the desire to ask new questions…” Brancati FL (1989)

Questions are among the most powerful teaching tools and adopting best practices can significantly improve teaching and learning, however, when poorly executed, questions can stifle learning by creating confusion, humiliating students, and limiting creative thinking.

‘Pimping’ is a questioning technique which involves aggressively asking a series of unanswerable or difficult questions, putting students on the spot. The practice of pimping, also defined as ‘teaching by intimidation’, is largely a negative experience for learners and can lead to an environment that is not conducive to learning (Kost & Chen, 2014).

On the surface, pimping appears similar to the Socratic Method, and the two terms are sometimes used interchangeably. However, there are clear differences in the means and goals of the two approaches.
## The Socratic method versus pimping

<table>
<thead>
<tr>
<th>Features</th>
<th>Socratic method</th>
<th>Pimping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Using interpretive questions that have multiple answers.</td>
<td>• Singling out one person in a group environment.</td>
</tr>
<tr>
<td></td>
<td>• Questioning is purposeful - there is a goal of each question asked of the learner.</td>
<td>• Asking a series of intense, difficult questions.</td>
</tr>
<tr>
<td></td>
<td>• Promoting open discussion in which one viewpoint is compared to another.</td>
<td>• Using the power of status to embarrass and humiliate the learner.</td>
</tr>
<tr>
<td></td>
<td>• Probing trainees' thoughts in an effort to get them to explore their beliefs and assumptions.</td>
<td>• Passing humiliating comments.</td>
</tr>
<tr>
<td></td>
<td>• Questioning followed by discussion, reflection and feedback.</td>
<td>• Using questions that have specific, factual answers, so there is a right answer and many wrong answers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pushing the learner to emotional as well as intellectual limits.</td>
</tr>
<tr>
<td>Goals</td>
<td>Key goals are to:</td>
<td>Key goals are to:</td>
</tr>
<tr>
<td></td>
<td>• enhance critical thinking skills</td>
<td>• shame or humiliate the learner</td>
</tr>
<tr>
<td></td>
<td>• promote independent thinking</td>
<td>• maintain the power hierarchy</td>
</tr>
<tr>
<td></td>
<td>• engage learners</td>
<td>• help students learn to think on their feet and handle pressure</td>
</tr>
<tr>
<td></td>
<td>• improve performance</td>
<td>• challenge beyond normal expectations</td>
</tr>
<tr>
<td></td>
<td>• diagnose the level of the learner and teach them appropriately.</td>
<td>• obtain ‘the right’ answer instead of improving reasoning skills</td>
</tr>
<tr>
<td>Types of questions</td>
<td>Probing leading - making connections</td>
<td>Rhetorical questions</td>
</tr>
<tr>
<td>Example</td>
<td>‘Why do patients get hypotensive when pyelonephritis is treated with antibiotics?’</td>
<td>‘What is the the Jarisch-Herxheimer reaction?’</td>
</tr>
<tr>
<td></td>
<td>‘Could you put that another way?’</td>
<td>&lt;‘i.e. Guess what I’m thinking’&gt;</td>
</tr>
<tr>
<td></td>
<td>‘Could you expand upon that point further?’</td>
<td></td>
</tr>
</tbody>
</table>
The implications of pimping

Pimping can evoke negative emotions in learners and affect students’ mental health, having an impact on their confidence, loyalty to the institution and care of patients (Scott et al 2015). Failure to give the right answer to the question can leave the learner feeling embarrassed, humiliated, and defeated.

Pimping is not recommended in physician training because it perpetuates a culture of ‘teaching by humiliation’; Khost and Chen (2004) argue that it should not be tolerated. Teaching by intimidation and humiliation in this way may foster a culture of bullying (Hoosen A et al 2004).

For optimal learning to occur, the environment should be free of fear and unnecessary anxiety where trainees learn from role models in a positive and friendly atmosphere. Supervisors need to be aware of the implications of pimping as a behaviour that perpetuates an unhealthy culture and develop strategies to change those behaviours.

Tips for avoiding pimping:

• Create a supportive learning environment by establishing mutual respect with your trainees.
• Remind learners that it’s okay to answer with “I don’t know”.
• Use questions appropriate to the learners level of ability.
• Avoid “Guess what I’m thinking” questions.
• Ask both open and closed questions.
• Provide adequate wait time for the learner to think and respond.
• Be supportive, encouraging and constructive when responding to answers.
• Follow a weak or incorrect answer (or an “I don’t know”) with another question that helps the learner find a better answer.
• Tell learners your goal in asking questions - your goal is to teach, not to embarrass.
• If you do humiliate a learner, apologise and reflect on how you can avoid doing the same thing going forward.
Lesson plan for teaching on the ward round

The following lesson plan template for teaching on the ward round can be used by supervisors to make notes when planning the various aspects of a ward round teaching session.

<table>
<thead>
<tr>
<th>Teaching and Learning Goals (Individual and group):</th>
<th>Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(learning outcomes, curriculum outcomes, what are you trying to teach?)</td>
<td>(how will you know the trainees have learnt something? E.g. observation, questioning, debrief session after the ward round)</td>
</tr>
</tbody>
</table>

| Background: | (establish the learner’s prior knowledge/skills base) |

### Teaching Encounter

<table>
<thead>
<tr>
<th>Before: Brief trainees</th>
<th>During: Diagnosing the patient</th>
<th>After: Debrief and feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Give each learner a meaningful role, consider involving other health professionals, set learning goals and features to look out for, and role model asking patient permission)</td>
<td>(Role model introducing yourself and the team to the patient. Consider how you will diagnose the patient - who will present the patient history/conduct physical exam?)</td>
<td>(Provide individual feedback – positive and constructive, debrief how the session went, what the findings mean, what could be done differently next time, what could learners look at or do prior to the next ward round?)</td>
</tr>
</tbody>
</table>

**Targeted teaching**

(Choose a teaching method that best suits the goals of the session – e.g. the One minute teaching model, SNAPPs, etc. Base teaching on the patient and involve the patient in the teaching, actively engage all learners, role model thanking the patient)
Confronting underlying and system issues

The environment..................................................................................47

Unsurfacing the hidden curriculum......................................................47

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Recognise the cultural environment of the healthcare setting

The environment

Understanding the complex cultural environment of the healthcare setting will enable supervisors to create a supportive environment for their learners and address any negative, hidden messages which may be transmitted. This will result in positive changes to the way healthcare teams operate. The hidden curriculum, tribalism and supervisor role modelling all may influence the cultural environment, both positively and negatively. By acknowledging these underlying issues, supervisors can begin to counter any negative effects on the learning of trainees.

Unsurfacing the hidden curriculum

The hidden curriculum refers to the unwritten and unintended aspects of an educational program, such as the learning of norms, values and beliefs covered through the learning environment. The antidote to the hidden curriculum is to have explicit policies, curriculum standards and assessment strategies which are valued by supervisors and trainees and recognised as tools to guide learning.

Learning within the hidden curriculum usually occurs through actions, discussions and relationships within the environment.

Tribalism

Healthcare professionals naturally bond and identify strongly with their own professional groups, their own tribe, within an organisation. This can create a positive and cohesive environment which fosters unity and can lead to positive outcomes. However, there is a dark side of tribalism in that it can also create an “us” and “them” mentality, which can have negative effects on patient care, and can also create stress, conflict, work dissatisfaction and feelings of being undervalued.

Supervisors are role models

Trainees develop their professional identities and competencies through the observation of more experienced physicians. They not only develop their skills and knowledge of the medical field, but also their values and professional qualities.

It is therefore important for supervisors to be aware of the professional attributes they model and the messages they explicitly and implicitly convey to trainees during their clinical training.

Intentionally being a positive role model for trainees will not only have beneficial effects for trainees now and into the future, but will also result in exemplary patient care and an exceptional healthcare setting.
The environment

“There is a lot conspiring the environment which you need to step away from and fix before you get a good teaching environment”.

Dr Jess Brown, RACP Fellow

Culture is a hidden power in the healthcare environment and is rooted in its traditional roles, hierarchies and systems. A hospital’s culture is influenced by many factors of the hidden curriculum, tribalism within teams, and the professionalism of the senior physicians, who are the role models within the setting.

Unsurfacing the hidden curriculum

“a great deal of what is taught - and most of what is learned - in medical school takes place not within formal course offerings but within medicine’s ‘hidden curriculum’” (Hafferty, 1998)

The hidden curriculum plays a large role in how trainees learn in the healthcare setting. The experiences, knowledge, interactions, and informal and formal learning encounters all contribute to the professional identity that individual trainees construct within the situated learning environment. Hafferty and Franks (1994) state that there are three overlapping levels of curriculum – formal, informal and hidden.
The hidden curriculum refers to the unwritten, cultural based learning, described as ‘hidden’ because it is usually unacknowledged. There are both negative and positive aspects of what can be taught and learnt through the hidden curriculum. The hidden curriculum often teaches values and moral judgements and may be found within the assessment strategies, culture and social messages of a healthcare setting. Learning within the hidden curriculum usually occurs through actions, discussions and relationships within the environment. For example, trainees will absorb information about the hierarchy that exists within medicine and therefore which group contributions are perceived as more valuable in the workplace. This sends messages which indicate how a trainee should interact with various groups in the setting including peers, other healthcare professionals and patients (Hafler et al, 2011).

Creating a better understanding of the hidden curriculum will allow organisations to become more sensitive to the unspoken and informal dimensions of organisational culture. This understanding can sensitise supervisors to the existence and impact of unintended messages, particularly if these messages are previously unseen and unintended by the supervisor or unrecognised and misinterpreted by trainees.

Knowing the hidden messages being transmitted is important because such knowledge provides the foundation for leveraging positive messages and minimising negative messages and their unintended outcomes.

Some unintended outcomes of negative messages within organisational culture include:

- high rates of staff turnover
- low morale
- decreased productivity
- decreased trainee satisfaction
- poor organisational performance.

### Case study - the hidden curriculum

At Alison and her team’s hospital, a fortnightly journal club was created as professional development for all medical staff. After a few months, Alison stopped attending the sessions, and a month later so did Spencer. Alison and Spencer did not feel they were able to secure time away from their clinical and research activities in order to attend the sessions.

Viet and Ben noticed the drop in attendance of both their senior team members and other senior staff at the hospital. They interpreted the decline in senior staff attendance as an indication that journal club was not really of much value to them, and so stopped going as well.

(Adapted from Hafler et al., 2011)
Tribalism

“Birds flock, fish school, people tribe”. Logan, 2008

The healthcare setting can be a tribal jungle. Often, healthcare professionals naturally bond and identify strongly with their own professional groups, their own tribe, within an organisation. Bonding with a tribe can feel good and can lead to positive outcomes.

The various groups of a healthcare setting - medical teams, nurses, pathology, etc, work with each other behaving like tribes. Sometimes, they work together cautiously, putting other tribes down, and even at times engaging in open hostility. It is unfortunate that many healthcare professionals do not see themselves as a larger tribe of healthcare professionals whose primary goal is quality patient care.

While there are advantages to healthcare tribes bonding with each other, the negative aspects outweigh the positives. Excluding other tribe members and making derogatory comments about other tribes is commonplace in the healthcare setting. Senior members of the tribe use tribalism to build their team through highlighting that ‘our tribe is best and yours isn’t’. This can have damaging effects on staff and patient care (Brazil, 2014; Logan et al 2008).

This paradigm can be further explained through social identity theory, whereby individuals have a need to belong, and a person’s sense of who they are is based on their group membership (Stets & Burke, 2000). In order for an individual to increase their self-image they must enhance the status of the group to which they belong. One way of enhancing the status of their group and bonding the group is to discriminate, make derogatory comments or promote incorrect stereotypes, against other groups.

The effects of tribalism in healthcare

“My toughest days at work are when the dark side of tribalism comes out”. A/Prof Victoria Brazil, ACEM Fellow

Tribalism can disable a team’s functioning and produce an inefficient and ineffective healthcare system. It creates a barrier to effective communication, good teamwork and effective patient handover. It also promotes hierarchy between junior and senior doctors and nurses. When tribalism and power gradients are in effect within a healthcare team, and all members of a healthcare team are not effectively communicating or sharing important information about the patient, patient care will suffer as accurate decisions will not be made.

Some major issues with tribalism in the healthcare setting include:

- Some individuals may not feel valued and may feel left out of the decision-making process – nurses, allied health workers or junior doctors who may have more information than those making the decision about the patient, for example, the senior doctor.
- Speaking up against a power gradient or challenging a member of a different tribe is challenging and requires courage – without these challenges a poor decision may occur.
- If responsibility for patient care is seen to lie with one group, and not with the greater healthcare group, errors may occur and may have adverse outcomes.

All of these may result in less than optimal patient care and, for staff, stress, conflict, work dissatisfaction and feeling undervalued (Tang et al., 2012).
Combatting tribalism

It is essential that supervisors and other healthcare professionals work towards reducing the negative effects of tribalism in the healthcare setting. Supervisors should endeavour to combat tribalism for the sake of optimal patient care as well as modelling to trainees appropriate and professional behaviour.

Logan et al. (2008) reveal that there are five levels of tribal functioning. At the lowest level are teams that undermine each other and are highly ineffective. The highest level, stage 5, is the most effective, where tribes do not see themselves in competition with each other but in competition with what is possible. Stage 5 tribes are to be encouraged and role modelled in the healthcare setting.

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**THE FIVE STAGES OF TRIBAL CULTURE**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Relationship to People</th>
<th>Behaviour</th>
<th>% of Orgs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team</td>
<td>Stage 5 “LIFE IS GREAT”</td>
<td>Innocent Wonderment</td>
<td>2%</td>
</tr>
<tr>
<td>Stable Partnership</td>
<td>Stage 4 “WE’RE GREAT”</td>
<td>Tribal Pride</td>
<td>22%</td>
</tr>
<tr>
<td>Personal Domination</td>
<td>Stage 3 “I’M GREAT (AND YOU’RE NOT)”</td>
<td>Lone Warrior</td>
<td>49%</td>
</tr>
<tr>
<td>Separate</td>
<td>Stage 2 “MY LIFE SUCKS”</td>
<td>Apathetic Victim</td>
<td>25%</td>
</tr>
<tr>
<td>Alienated</td>
<td>Stage 1 “&lt;ALL&gt; LIFE SUCKS”</td>
<td>Undermining</td>
<td>2%</td>
</tr>
</tbody>
</table>

From Tribal Leadership, Logan, King & Fischer-Wright, 2008.
In the healthcare setting, many tribes operate at the stage 4 level. The ‘us against them’ mentality is promoted as it is seen to build and bond team members. However, the destruction it causes is overlooked. Developing and reinforcing the ‘us against them’ mentality will stop healthcare tribes moving to becoming a Level 5 Team, teams that do not require this kind of tribal bonding to work well (Brazil, 2014).

**Tips for combatting tribalism**

- Take every opportunity to build relationships within the healthcare team.
- Find opportunities to build bonds across tribes.
- Introduce yourself to other team members and those of other tribes.
- Prioritise building relationships away from the ‘hot zone’ - away from the patient.
- Practise negotiation skills and use a chair. e.g. rather than standing up when negotiating with someone, try sitting down. This changes the dynamics of the conversation; and evidence shows that people feel more valued and heard, and perceive that more time has been taken to understand their needs. It is also a great way to take the ‘heat’ out of the negotiation.
- Find out what other healthcare tribes have in common with your tribe.
- Promote belonging to a wider ‘healthcare tribe’.
- Acknowledge that your own tribe is great – the affirming bonds that are created within teams drive people to be better and do better.
- Acknowledge that other tribes are great too.
- Consider constructive ways of contributing to negative conversations about other tribes - perhaps it’s a systems issue more than a tribal issue and some systems issues can be resolved if the tribes choose to work together instead of against each other.
- Shut down derogatory comments about other tribes.
- Avoid outbursts on social media when frustrated.
- See other healthcare teams’ point of view.
- Understand the features of highly functioning teams.
- Use conflict resolution strategies.
The hidden curriculum in any given healthcare setting encompasses an enormous variety of potential intellectual, social and environmental factors. The following case study will help to illustrate the concept of the hidden curriculum and tribalism, and highlights the importance of positive supervisor role modelling in everyday work settings.

**Case study: the tea room**

Alison and her team have finished their ward round and are in the tea room, providing a perfect opportunity to discuss some of the teaching points of the ward round.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Viet takes tea orders and leaves to make them for his team. Once he has left the room, Alison, Spencer and Ben begin discussing Viet. Alison thinks he’s too quiet and doesn’t offer much on ward rounds. Spencer thinks he must just be introverted, and Ben tells the team that he is having a lot of troubles at home which might be why he’s so quiet. Alison tells Spencer to, “keep an eye on him”, and proceeds to discuss and ask him questions about Mrs Jones, their patient. | **Missed teaching opportunity**
Viet has been identified as a trainee in difficulty. He has missed out on a learning opportunity by the team discussing Mrs Jones’ case while he is making the tea.  

**Messages about how the team works**
Talking about Viet’s personal life and performance at work behind his back is disrespectful and breaks down the trust within the team. Alison should discuss her concern with Viet and determine a course of action to address the concern, rather than gossiping about him to other team members in the tea room. Alison has demonstrated that she is likely to talk about any of her trainees behind their back. It also demonstrates to them that avoiding problems is acceptable.

**Delegating responsibility**
Delegating the responsibility to look out for Viet demonstrates that she doesn’t have time to deal with her trainee’s well-being. |
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spencer proceeds to tell Alison about where they are at with Mrs Jones; he tells Alison that, not surprisingly, the Cardiologist hasn’t reported back on Mrs Jones’ Holter. Alison agrees that it’s not surprising and makes more derogatory comments about the Cardiology team; “...if they can’t ‘cath’ it...” Spencer tells Alison the Cardiologist in charge of completing the report is Dr Paul Smith. Alison rolls her eyes and says, “don’t hold your breath, he was my Basic Trainee, he’s hopeless, things don’t change do they”. Spencer agrees and says he’ll keep calling them to get the report.</td>
<td><strong>Tribalism and role modelling</strong> Both Alison and Spencer make derogatory comments about another healthcare ‘tribe’ – the Cardiologists. This role modelling of tribalism tells the medical student that it is ok to speak negatively about other healthcare teams. Having a common enemy can be a bonding experience for team members, but is very destructive to the healthcare setting and to patient care. Instead of putting down the Cardiology team, Alison could have role modelled professionalism and leadership. She could have acknowledged the frustration, remained positive and suggested a solution e.g. “while it’s frustrating that it takes so long to get the reports from Cardiology, we know that they are just as busy as we are, and I am sure they are doing their best. Perhaps you could work on developing a relationship with the Cardiology team – have you introduced yourself to any of them, without chasing a patient’s report?” This would reinforce that it is not OK to speak about other teams negatively and that teamwork and relationship building with other teams is important. Alison also makes a negative comment about a specific Doctor who was her Basic Trainee. Making these comments breaks down the trust within her team and is disrespectful. If Alison is comfortable speaking so destructively about one of her previous trainees, her team members will always wonder what she says about them behind their back.</td>
</tr>
<tr>
<td>Viet returns with the tea. Alison looks at the time and announces she needs to leave as she has some grant work to complete.</td>
<td><strong>Supervisor priorities</strong> Alison sends a message here that her grant work is more important than the debriefing and feedback session, that is, more important than the teaching and learning opportunity for her trainees. If the consultant supervisor does not see it as important, nor will the trainees. It’s also a missed opportunity for Viet to discuss some aspects of the case with Alison. <strong>Hierarchy</strong> Alison only addresses Spencer during the session; Ben and Viet are commonly not engaged in the session or are absent making tea for the rest of the team. This demonstrates the hierarchy that exists in the medical team and indicates to Ben and Viet that they are less valued than Alison and Spencer.</td>
</tr>
</tbody>
</table>
### Scenario

As she leaves she says, “oh, um, it was better today, it was good”; Spencer replies, “OK, thanks”.

### Issues

#### Feedback

This was not a good attempt at providing feedback. It was very vague and demonstrated that providing effective feedback is not something Alison has time for. It also does not allow Spencer to find out what he did well so he can continue doing those things in the future.

Now that Alison has left, Spencer, the most senior person in the tea room, thinks he should take the opportunity to do some teaching. He asks a few closed questions to the group, which don’t elicit much information out of Viet or Ben.

He tells them that they, “can’t do much without the Holter report from Cardiology, but who knows when that’ll happen, they are so incompetent”.

He then looks at the time and says, “I better get to my clinic”, as he gets up and leaves.

#### Implicitly delegating teaching

Alison implicitly delegates the teaching of the more junior staff to Spencer. Alison should have explicitly delegated this task to Spencer, rather than assuming he would continue the debrief and feedback session.

#### Tribalism

Spencer reinforces the tribalism here by making another derogatory comment about the Cardiology team.

#### Role modelling

Spencer, like Alison, demonstrates that he doesn’t really value this teaching opportunity; he values his clinic work over the teaching of the trainees. Alison has set the culture through her role modelling, and Spencer has picked up on this and mimics her behaviour.

### Supervisors are role models

“As [supervisors], part of our job is to be the role models and mentors that will shape the character of tomorrow’s medical profession.”

Dr Nancy Wilson Dickey, President of the American Medical Association

Trainees develop their professional identities and competencies through the apprenticeship model in the healthcare setting. That is, through the observation of more experienced physicians, they not only develop their skills and knowledge of the medical field, but also their values and professional qualities.

It is therefore important for supervisors to be aware of the professional attributes they model and the messages they explicitly and implicitly convey to trainees during their clinical training.

Trainees learn from both positive and negative role models, through observation, reflection and reinforcement (Passi et al., 2013). Positive role modelling can be effective when used as an intentional teaching and learning strategy and is linked to clinical practice, that is, when a teacher explicitly describes their behaviour and decisions in the clinical setting. It can also be effective when it is unplanned and informal, that is, trainees observing the ‘everyday’ behaviours and interactions of skilled physicians.
Key attributes of positive role models

The table below outlines the key attributes of effective role models in healthcare settings. (Côté & Laughrea, 2014., Passi et al., 2013; BMA, 2005).

| Clinical Attributes | Role models must have an excellent level of clinical knowledge, skills and humanistic behaviours, such as effective physician–patient relationships, through demonstrating empathy, respect and compassion for patients. |
| Teaching Skills | Role models need to be skilled teachers. They should teach with a trainee-centred approach – including developing rapport with trainees and creating a positive and supportive educational environment. Good role models have the ability to explain complex subjects, promote reflective practice and demonstrate a positive attitude towards trainees. |
| Personal Qualities | Supervisor must demonstrate a number of personal qualities in order to be effective role models, including integrity, compassion, enthusiasm, interpersonal skills, positivity, good leadership and honesty. Being an inspiring physician is also an important attribute of a clinical role model. |

These attributes, which are associated with being an excellent role model, are skills that can be acquired and behaviours that can be modified (Wright et al., 1998). Through reflection and intentionally improving on these attributes, clinical teachers can enhance their performance as role models (Cruess et al., 2008).

The effects of positive role modelling

**Future teachers:** Not only is effective role modelling important from the perspective of producing competent and professional physicians, but also for creating effective future clinical teachers. Evidence suggests that future teaching styles and skills are highly influenced by learning experiences. It is essential that supervisors, as role models, acquire all the necessary attributes of a good medical teacher so they can then pass these on to their trainees, who are the future clinical teachers.

**Patient care:** Curry et al. (2011) identified that the modelled behaviours of calmness, good communication skills and comforting approaches impact positively on patients. White et al. (2009) reveal that role modelling has a significant influence on the development of patient-centred values. Furthermore, demonstrating team-working skills and respectful attitudes when interacting with colleagues, and applying teaching skills when interacting with junior staff, also benefit patient care (Curry et al., 2011). Therefore, clinical teachers who intentionally choose to be positive role models to junior staff consequently have a positive effect on patient care.

**Career influencing:** Trainees’ career choices are highly influenced by role models during their clinical education years. In postgraduate education, career-influencing role models were identified as those who encouraged active participation and taught advanced skills (Watts et al., 1998; Ravindra & Fitzgerald, 2011). Many positive career-influencing role models do not deliberately intend to recruit trainees to their specialty, but inherently do so through their enthusiasm, dedication and genuine love of their work.
The influence of negative role models

Just as trainees learn from positive role models, they also learn from negative ones. Negative role modelling occurs mostly through the hidden curriculum (Murakami et al., 2009) and can adversely affect the professional behaviours and career choices of trainees. However, evidence shows that trainees are able to easily identify negative role models and are aware that they should not imitate their behaviour (Wear et al., 2009).

Negative role modelling includes the persistence of hierarchy and exclusivity by senior doctors, the existence of gender issues, and negative tribalism, that is, senior staff members criticising other departments and institutions.

Tips for being a positive role model

• Develop a conscious awareness of role modelling.

• Consider the attributes you exhibit compared to those of a positive role model.

• Specifically think about being a role model when interacting with learners (role modelling should not just be demonstrated through implicit behaviours, but should also be explicit, as it is important for teachers to make an intentional effort to articulate what aspects they are modelling).

• Be aware of the profound influence you exert on recruitment to specialties and that the level of enthusiasm you display for your job is a compelling factor.

• Develop strategies to ensure the organisational structure supports a culture of excellence in doctor role modelling (this may involve developing innovative faculty development initiatives and establishing valid methods of evaluating the performance of faculty in addition to the provision of opportunities for self-improvement through faculty development).

• Collaborate and share ideas to develop excellence in role modelling.

In summary, intentionally being a positive role model for trainees will not only have beneficial effects for trainees now and into the future, but will also result in exemplary patient care and an exceptional healthcare setting.
Confronting underlying and system issues

Manage and teach through adverse events

The adverse event

Physicians need to be prepared to respond appropriately to adverse events. It is important to promote learning from mistakes and to create a 'no-blame' culture in medicine focussed on prevention. It is also important to identify situations that can cause conflict in the healthcare setting, including adverse events, and to develop strategies for managing conflict.

Teaching adverse events

Supervisors must be equipped to manage adverse events and be able to use them as a teaching opportunity, where possible. There are often many contributing factors that lead to an adverse event and it is important to focus on solutions to the negative factors rather than blaming individuals. It is also necessary to share experiences of adverse events, to learn from mistakes and make changes where appropriate. Furthermore, it is important to support colleagues and debrief with colleagues in the aftermath of an adverse event.

A 'no-blame' culture

It is important to help create a 'no-blame' culture in the healthcare setting so that when errors do occur, lessons can be learnt to prevent their recurrence. Most errors in medicine are committed by good, hardworking people trying to do their best, and therefore, identifying who is to blame is a distraction from establishing the solution.

Strategies for conflict resolution

Conflict within inter-professional teams in the healthcare setting is common and can have devastating effects on the team’s functioning. It is imperative that healthcare professionals are able to identify the causes and sources of conflict, acknowledge barriers to resolving conflict, and practise strategies to overcome and avoid conflicts, in order to reduce their negative impacts.
The adverse event

“An important element of how adverse events are handled is effective communication between health care providers and patients and their families”. Manser & Staender, 2005.

Adverse events pose considerable challenges in the healthcare setting. The need to respond appropriately and deal with their aftermath can be difficult for all involved. It is important to promote learning from mistakes and to create a ‘no-blame’ culture in medicine. It is also important to identify situations that can cause conflict in the healthcare setting, including adverse events, and to develop strategies for managing conflict.

Teaching adverse events

Most high-risk industries consider learning from accidents and near-misses vitally important for safety and improvements within the area of work. For example, if there is an aviation accident, it is exhaustively investigated, and the lessons learned are circulated throughout the industry, with important changes made mandatory by regulatory authorities. In comparison, learning from adverse events within the healthcare setting has generally been underused (Vincent, 2003).

Usually, a chain of events that lead to an accident or a near-miss has a wide variety of contributing factors. It is crucial to the safety and improvement of healthcare that these incidents are proactively investigated to reveal gaps or inadequacies in the health care system (Vincent, 2003; Vincent, 2001).
The Swiss Cheese Model

The ‘Swiss cheese model’ is a metaphor commonly used to describe system failures, such as medical mishaps in the healthcare setting (Reason, 2000). In a complex system, such as the healthcare setting, hazards are prevented from causing human harm by a series of barriers. Each barrier has unintended weaknesses, or holes – hence the similarity with Swiss cheese. These weaknesses are unpredictable, that is, the holes open and close at random. For a catastrophic incident to occur, such as causing harm to a patient, the holes all need to align. This model highlights the health care system, as opposed to the individual, and accidental error, as opposed to deliberate action.

Preventing adverse events

Error prevention can be planned by means of proactive tools, such as audit. An audit is an iterative approach to assessing, evaluating and improving the quality of healthcare through the systematic review of practice. This may take the form of a review of patient care irrespective of the outcome (e.g. a weekly or monthly random selection of case records to review whether the care was acceptable, could have been improved, or whether a change in the care would have altered the patient’s outcome).

To find out more about conducting an audit and to see some examples, access the RACP research projects resource online at: https://elearning.racp.edu.au.
The following table summarises the major influences on clinicians in their daily work and the systemic contributions to adverse outcomes, or indeed to good outcomes. This framework is based on Vincent (2001).

<table>
<thead>
<tr>
<th>Area</th>
<th>Effects</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional</td>
<td>• Regulatory context. • Medico legal environment.</td>
<td>Insufficient priority given by regulators to safety issues; legal pressures against open discussion, preventing the opportunity to learn from adverse events.</td>
</tr>
<tr>
<td>Organisational and management</td>
<td>• Financial resources and constraints. • Policy standards and goals. • Safety, culture and priorities.</td>
<td>Lack of awareness of safety issues on the part of senior management; policies leading to inadequate staffing levels.</td>
</tr>
<tr>
<td>Work environment</td>
<td>• Financial resources and constraints. • Policy standards and goals. • Safety culture and priorities.</td>
<td>Heavy workloads, leading to fatigue; limited access to essential equipment; inadequate administrative support, leading to reduced time with patients.</td>
</tr>
<tr>
<td>Team</td>
<td>• Verbal communication. • Written communication. • Supervision and willingness to seek help. • Team leadership.</td>
<td>Poor supervision of junior staff; poor communication among different professions; unwillingness of junior staff to seek assistance.</td>
</tr>
<tr>
<td>Individual staff member</td>
<td>• Knowledge and skills. • Motivation and attitude. • Physical and mental health.</td>
<td>Lack of knowledge or experience; long-term fatigue and stress.</td>
</tr>
<tr>
<td>Task</td>
<td>• Availability and use of protocols. • Availability and accuracy of test results.</td>
<td>Unavailability of test results or delay in obtaining them; lack of clear protocols and guidelines.</td>
</tr>
<tr>
<td>Patient</td>
<td>• Complexity and seriousness of condition. • Language and communication. • Personality and social factors.</td>
<td>Distress; language barriers between patients and caregivers.</td>
</tr>
</tbody>
</table>
## Case study

Mrs Jones is a 67 year old woman with a history of ischaemic heart disease and hypertension. She was admitted to the ward after a fall and complained of hip pain. An X-ray showed that Mrs Jones had not broken her hip. Mrs Jones had no recollection of the fall and the ward round team determined that she suffered a syncopal episode and ordered a Holter monitor. Cardiology took three days to report the Holter result back to the team.

### The adverse event:

Three days after Mrs Jones was admitted to hospital she suffered another fall that led to a broken hip. Nursing staff were not aware that Mrs Jones should not be moving around unassisted and when they tried to call the ward team no one was available. The fracture resulted in Mrs Jones’ hospital stay increasing from 3-4 days to several weeks.

### The holes that lead to the adverse event:

- the Holter report took too long to get back from Cardiology. If it had arrived sooner, it would have revealed that Mrs Jones was having prolonged pauses on her ECG
- nursing staff and the clinical team did not engage in open communication about Mrs Jones. If they had communicated effectively, more precautions may have been taken when Mrs Jones was out of bed to ensure she did not fall
- the ward round team were not available to respond to the nurse’s calls and no back-up plan was in place.

## Supporting staff after adverse events

“[some positive features of supporting staff after an adverse event include] diffusing the situation, not being negative, not blaming anyone, acknowledging people’s feelings, involving the team, engaging them and getting them to give different points of view; and explaining the process of a root cause analysis”

Dr Malcolm Turner, RACP Fellow

News of a major adverse incident can spread rapidly, and is sometimes very unhelpful and harmful to those who are involved. Adverse events can cause feelings of anxiety, shame and isolation. Clinicians are trained to be resilient, but it is essential that colleagues are supportive when a problem occurs and to help limit the damage to those involved.

Few healthcare professionals discuss adverse events with colleagues, despite an expressed need for professional reaffirmation, validation and support. Supervisors should be open about errors and their frequency. Talking openly about past mistakes is helpful for junior team members.

Clear guidelines for discussing errors with patients should be backed up by an institutional policy on open disclosure.

The institution should also offer training in the difficult task of communicating with patients and families in the aftermath of an adverse event. Basic education in the law and the legal process surrounding medical incidents should also be offered and may reduce some of the anxiety about possible legal action.

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### Online communication resource

To learn about communication skills and frameworks to help you work through everyday conversations with patients, including during adverse events, access the RACP online communication resource video scenarios at: [https://elearning.racp.edu.au](https://elearning.racp.edu.au).
A ‘no-blame’ culture

“*The management of errors requires an acceptance of error with consideration given to the relationship between individual human behaviour and the factors that influence this behaviour*”

To make errors is to be human, and therefore human error can never be totally removed from medicine. The key is to create a ‘no-blame’ culture in the healthcare setting so that when errors do occur, lessons can be learnt to prevent their recurrence (Walton, 2004). Most errors in medicine are committed by good, hardworking people trying to do their best, and therefore, identifying who is to blame is a distraction from establishing the solution. Human errors are often facilitated or amplified by actions, decisions and plans made within the system. As such, it is a much more productive use of time to identify error-prone situations and implement or change systems to prevent the error happening again. Analysis of adverse events almost always identifies the case as systems’ problems rather than apportioning individual blame. While it is important to promote a ‘no-blame’ culture, it is also important to note that system issues usually accompany breaches of professional responsibility. Such system issues that are affiliated with professional responsibility may include weak regulations, weak reporting requirements and inadequate training. For the sake of patient safety, professional responsibility and accountability must also fit into the ‘no-blame’ culture (McNeill & Walton, 2002).

Patient safety requires a health system delivering safe and quality healthcare and an accountability system. As a way forward, the following steps are required:

- professionalism in the workplace needs to become part of the safety agenda
- methods for managing and responding to intentional violations by individuals in the workplace need to be debated and designed, including building in sanctions for routine violations and rewards for workplace compliance
- teaching clinicians about the inevitability of mistakes is already happening, but we also need to teach them how to respond to mistakes (McNeill & Walton, 2002).

Disciplinary outcomes for doctors are generally determined by peer review and focus on the actions taken after the mistake rather than the mistake itself. Clarifying accountability mechanisms and educating professionals about their ethical obligations will help them identify systems problems with the appropriate solutions, and professional issues with the appropriate response.

The management of errors in the healthcare system requires an acceptance that error cannot be fully eradicated. When managing errors, consideration must be given to individual human behaviour and the factors that influence this behaviour (Reason & Hobbs, 2003). This should involve the introduction of designated incident reporting systems that enable open communication about safety concerns and experiences of error to those responsible for safety and quality. These incident reports then equip organisations with the necessary information and capacity to proactively implement changes.

The fear of blame often inhibits participation in incident reporting. People are reluctant to be open and honest about their experiences of error because of the fear that they will be found at fault and held individually responsible or punished for the adverse event. As such, the fear of blame and retribution are seen as major cultural barriers to incident reporting (Waring, 2005).

Supervisors must promote a ‘no-blame’ culture in order for healthcare settings to learn from their mistakes and improve patient safety.
Strategies for conflict resolution

Conflict within inter-professional teams in the healthcare setting is inevitable and can often disable a team’s functioning. Adverse events are sometimes the cause of conflicts and sometimes conflicts are the cause of an adverse event. There are a number of strategies that individuals can apply within their team environment in order to help defuse and resolve conflict (Zucker, 2012).

Make it safe to talk

A safe conversation is one in which both parties feel comfortable expressing their thoughts and feelings without negative ramifications and without feeling threatened. Demonstrate respect and caring about the other person’s interests.

• Embrace a mutual purpose: You have to care about the interests of others as well as your own.
• Offer mutual respect: The instant someone perceives disrespect in a conversation, the interaction is no longer about the original purpose – it is now about defending dignity.

Active listening

“Seek first to understand and then to be understood” is a pertinent phrase in conflict resolution. Through active listening and really hearing how the other person interprets a situation and what their true intentions are is a great place to start the conflict resolution conversation. Good listening in a conflict situation requires an open and honest interest in the other person, and a willingness and ability to keep the spotlight on them to hear their viewpoint.

Respect and validation

Respect for the other person and their viewpoint is essential. Simply listening and responding with, “yes, and…”, is validating to the other person and tells them you respect them. It is important to remember that someone doesn’t need to necessarily be ‘right’ in a given situation, but both viewpoints can be embraced and a solution formed. This strategy also involves humility, which is the foundation by which good communication transpires and respect is enacted. Working together to find a solution to the conflict or issue can generate creative and innovative problem-solving skills and minimise the destructive influence of conflict in teams.

Don’t make assumptions

It is easy to add meaning to another’s behaviour without checking if our conclusions are right. Often these assumptions can be destructive to individuals and teams. To prevent leaping into assumptions about another’s intent, ask the following three questions:

1. Actions: “What did the other person actually say or do?”
2. Impact: “What is the impact of this on me?”
3. Assumptions: “Based on this impact, what assumption am I making about what the other person intended?”

Once the assumption is identified, it is most important to check with the person if this was their intent. In many instances, it probably isn’t, and the situation can begin to be resolved.
The following diagram is a step-by-step problem-solving approach to conflict management (Zucker, 2012).

1. Make the Approach
2. Build Understanding
3. Share Perspectives
4. Agree on Solutions
5. Plan Next Steps
6. Reassess and Revise

Learning to identify and resolve conflict in a timely manner will improve the functioning of healthcare teams and ultimately improve patient care.
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Conclusion

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Conclusion

This booklet focusses on the complexities of being a supervisor in the healthcare setting. It explores the many challenges supervisors face, as well as a range of strategies to manage and overcome the challenges. It also discusses some of the cultural aspects of healthcare settings that impact on learning, including the hidden curriculum, tribalism and effective role modelling.

There are two other SPDP workshops currently available for supervisors of College trainees to attend:

**Workshop 1 - Practical Skills for Supervisors**

The Practical Skills for Supervisors workshop has been designed to assist supervisors with creating a culture for learning and delivery of effective feedback, particularly in difficult situations.

The objectives of the workshop are as follows:

- Develop strategies to create a culture for learning
- Describe the impact of feedback on behaviour and performance
- Increase confidence in giving effective feedback to trainees
- Increase confidence in dealing with challenging trainees

**Workshop 3 - Work-based Learning and Assessment**

The third workshop, Work-based Learning and Assessment, focusses on strategies supervisors can use to integrate learning and assessment into the workflow.

The objectives of the workshop are as follows:

- Discuss the purpose and importance of work-based learning and assessment
- Analyse the cycle of planning for learning and assessment
- Identify the challenges and solutions associated with work-based assessment in a complex environment
- Draw on evidence of learning and achievement to determine overall performance and progression.

Please contact supervisor@racp.edu.au for further information.
References

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References


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