"MiPLAN" to Teach with the Assistance of Our Patients

A Workshop for the SGIM Annual Meeting 2012

Presenters: Chad Stickrath, MD; Mel Anderson, MD; Christopher Knight, MD; Eva Aagaard, MD
Co-creators: Dennis Boyle, MD; Clifford Zwillich, MD; Danielle Shimek, MD

Session Summary:

While educators espouse the benefits of teaching in the presence of the patient and faculty and trainees report they would like to see this method of education increase, studies show that the proportion of teaching that occurs in the presence of the patient continues to diminish. Furthermore, faculty feel inadequately prepared to teach in this setting. We have developed a model for teaching learners with the patient present based on constructivist learning theory, the principles of adult learning, and the expertise of master clinician educators. This model, named "iPLAN", encourages teachers to focus on 5 areas as the learner presents in the presence of the patient (the "i's: introductions, interruptions, in the moment, inspection, and independent thought") and then provides an algorithm for teaching after the presentation (the "PLAN: Patient care-centered, Learner-centered, Attending-centered, and Next steps"). This workshop will utilize role play, small group sessions, and videos to offer the rationale for teaching in the presence of the patient, to explore the iPLAN model for enhanced patient care and education in this setting, and to provide pearls for teaching and providing feedback with the patient present.

Learning Objectives:
By the end of this session, attendees will be able to:

- Explain the rationale for teaching in the presence of the patient.
- Recognize the barriers to teaching and learning in presence of the patient.
- Discuss strategies and techniques to enhance their abilities to teach effectively in the presence of the patient.
- Employ the "iPLAN" model to make teaching in the presence of the patient fun, effective, and simple.

Approximate timeline:

- Welcome, introductions and overview: 5 min
- Experience with and rationale for teaching in the presence of the patient: 10 min
- Discussion
- Introduction to "iPLAN": 10 min
- Practice Introductions: 10 min
- Role plays
- Videos during and after the bedside presentation: 35 min
- Discussion
- Difficult learners and situations: 10 min
Wrap-Up and Evaluations 10 min

Reading List


Additional References:


**MiPLAN for Effective Clinical and Bedside Teaching - Worksheet**

*Chad Stickrath, MD; Mel Anderson, MD; Christopher Knight, MD; Eva Aagaard, MD*

<table>
<thead>
<tr>
<th>M</th>
<th>Before Patient and/or Teaching Encounters Begin</th>
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<tr>
<td></td>
<td><strong>Meeting</strong>: all team members (teacher and learners) get to know each other, discuss mutual expectations for time together (how care, teaching, and learning will occur, set agenda), consider establishing a formal or informal learning contract</td>
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<tr>
<th>i</th>
<th>Before and During the Patient Presentation</th>
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<tr>
<td></td>
<td><strong>Introductions</strong>: introduce team/agenda/purpose to patient before beginning of presentation</td>
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<td><strong>Independent thought</strong>: encourage independent thought to teach and assess clinical reasoning</td>
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<td><strong>In the moment</strong>: be a focused listener</td>
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<td><strong>Inspect</strong>: demonstrate astute patient observation through visual PE, visual psycho-social exam, engagement of entire team</td>
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<td><strong>Interruptions</strong>: minimize interruption in the presentation</td>
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<th>After the Presentation</th>
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<tr>
<td>L</td>
<td>Teaching algorithm, (look for opportunities with P, if none → L → A → N)</td>
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<tr>
<td>A</td>
<td>Choose ONE</td>
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<tr>
<td>N</td>
<td><strong>Patient centered teaching</strong>: Role-modeling through clarification of the history, PE findings, correcting clinical reasoning, and communication</td>
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<td><strong>Learner questions</strong>: stated and unstated, Socratic opportunity</td>
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<td><strong>Attending’s agenda</strong>: medical topic teaching, EBM, other attending-identified areas of learning</td>
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<td><strong>Next steps</strong>: feedback, debrief, identify areas for deliberate practice, identify learning points to revisit as a team, next patient</td>
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Prior to Any Patient Care or Teaching Activities: A **Meeting** Among Teacher and Learners Should Take Place

1. Current Practice: Do you currently conduct a meeting with your learners prior to other activities?
   a. If yes: When? Where?
   b. If yes: How is the meeting conducted, what is discussed?

2. Discuss in your small group and list the strategies that you could employ in a meeting with your learners to accomplish your assigned goal:
   a. **Goal 1**: Creating a Safe Learning Environment
   b. **Goal 2**: Setting the Stage for a High-yield, Learner-centric educational experience
   c. **Goal 3**: Laying the Groundwork for Future Feedback
   d. **Goal 4**: Establishing an Effective Method for Delivering Patient Care
e. Goal 5: Communicating Important Logistical Information

During the Patient Presentation: the "I"s

3. Which "I" is the most challenging for you?

4. What strategy can you employ to help overcome this challenge? –or-- What new strategy will you implement during the patient presentation to improve the efficiency or efficacy of care?

After the Patient Presentation: the P L A N

5. Which PLAN teaching strategy do you most frequently employ?

6. In the future, what proportion of patients seen at the bedside with the team will you employ a patient-centered, or learner-directed teaching strategy (instead of jumping first to your own attending's agenda)?
## Overcoming Common Barriers to Effective Teaching with the Assistance of the Patient

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<th>Commonly Reported Barriers</th>
<th>Potential Solutions</th>
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| **Teaching to Multiple Learner Levels** | 1. During the "introductions" session, the team is introduced to the concept that everyone on the team will teach each other and that the modes below will be used.  
2. Immediately after the patient presentation is complete, the attending sequentially asks higher level trainees if they have anything to add to the presentation, differential diagnosis or treatment plan. As a part of the “P: Patient-centered teaching,” the attending asks higher-level trainees to explain their thought process, or approach, to the active issue(s) at hand. Thus, the attending allows the higher-level trainees to teach and then the attending can add pearls that are more advanced for the higher-level trainees at the end (if any exist).  
3. As a part of the "A: Attending-centered teaching," the attending has a multi-leveled teaching repertoire for issues that are taught commonly. (e.g.: For pneumonia, the attending might start by demonstrating pertinent physical exam findings (student/intern teaching), progress to antibiotic options (student/intern), and finish with a discussion of the benefits of utilizing a procalcitonin-based algorithm (intern/resident).) |
| **Takes Too Much Time to do Bedside Teaching** | 1. Gonzalo et al. recently found that following a workshop to improve and increase bedside teaching that teams spent more time on rounds at the bedside, without an increase in the total time spent on rounds.¹  
2. Simultaneously listening to a patient presentation, gathering additional information (including important physical exam findings), assessing learners, and then implementing a patient care plan at the bedside may actually save time overall. During the encounter at the bedside, the attending typically gathers all the information they need and thus they usually do not need to return to the patient’s bedside. In addition, the attending and trainees can discuss patient care decisions and begin implementing plans immediately after the presentation (instead of waiting for the attending to go to the patient bedside later and then confirm or alter plans). This allows the patient to receive needed care in a timely fashion and allows the trainees to proceed with plans immediately after the patient presentation.  
3. Attendings need to remember that the goal is not to teach all elements of the PLAN for each patient, but rather to use this as a sequential algorithm.  
4. Limit teaching points to 2 per patient. |
Patient Privacy or Discomfort

1. While it is important, especially in multi-patient rooms, to ask the patient's permission to round at their bedside and to use curtains, door, or barriers to maximize privacy, numerous studies show that patients strongly prefer that their care be discussed among the team in their presence. In addition, these presentations have been shown not to increase patient anxiety.

Disorganized or Struggling Learner

1. Providing effective, efficient patient care and teaching can be challenging when faced with a struggling or disorganized learner presentation. These situations underscore the importance of preparing learners during introductions. (During introductions, teacher may say: "Bedside communication can be challenging, especially with our complicated patients. My goal is to give you (x) minutes to complete your presentation. There may be times, however, when I might need to interrupt you to clarify meaning or help pull you through the rest of your presentation if time becomes limited." If the teacher has provided the expectation that they will rarely interrupt the presentation, except when things get challenging, or confusing, they may find that laying out a scaffold for the learner to work within during the presentation is helpful. (e.g. Teacher, "I am sorry, let me interrupt for a minute. This is tough and can be a bit confusing. Is there anything else in the past medical, social, or family history that is relevant to why the patient presented today?" Learner: "______." Teacher, "What pertinent physical exam findings did you note?" Learner: "________." Teacher, "What diagnostic studies that are pertinent to why this patient presented do you have results for?")

Attending Lack of Confidence ("I am not a Master Clinician")

1. Lack of confidence among attendings is widely reported as a common barrier to teaching in the presence of the patient. Emerging data suggests that learners value most the clinical teachers who describe their thought processes and approach to the active issues. Thus, attendings -- as capable clinicians -- are typically able to walk learners through their thought process as a part of the iPLAN "P" teaching. This type of teaching is valued more highly than vast amounts of factual knowledge or the ability to report every clinical trial relevant to a topic. In addition, if attendings don’t know an answer to a question, or are unable to comfortably address a learning topic on the spot, it offers the ability for them to role-model modesty ("I don't know") and lifelong learning ("I will look that up and we can talk about it tomorrow").

Patient on Contact Precautions

1. When the team is large, consider just gowning and gloving for the presenter (student or intern), supervising resident, and attending. Other team members can listen at the doorway and, if a notable finding is present, gown and glove selectively (e.g. to feel the cancerous lymph node). For instances of airborne precautions, speaking and hearing the presentation are quite difficult – these may be patients for whom discussion outside the room (without the masks) may be needed, followed by examination and teaching at the bedside while properly masked.

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