

Teaching on the AMU ward round

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Abstract

AMU ward rounds can be busy, and many consultants feel they are 'too busy to teach'. Yet the AMU is a rich learning environment. If we take the starting point that teaching is not the same as learning, how can consultants facilitate learning during a busy AMU ward round?

Opportunistic teaching requires some planning but can easily be incorporated in to the business of the working day. Good educational practice requires some knowledge however. This article aims to give physicians some understanding and tips on teaching on the AMU ward round.

Introduction

I have spent some time pondering the 'problem' of AMU ward rounds. The problem relates to the fact that the morning ward round has two – on the surface of it – conflicting priorities. One is the work that needs to get done. The ward round needs to be efficient, focus on the patient and the organisational need to keep patients moving through the system. The other priority is the education of doctors in training (and sometimes medical students), all at different stages, sometimes looking bored, all standing around the notes trolley. Sometimes, a consultant can feel under pressure to 'perform'. This is one of the hardest things a new consultant has to get used to!

Consultants, as 'experts', have a key role in facilitating learning and developing the experts of the future. As team leaders, they also need to ensure the efficient working of the team. So how can these two apparently conflicting priorities be met?

Teaching and learning are not the same thing

One helpful starting point is to understand that teaching and learning are not the same thing. Learning is 'internalisation of knowledge'. It is best conceived as a process rather than an outcome. Teaching is oneway, but not the only way, of facilitating this.

Postgraduate medical education is a mixture of learning from:

- Daily work /taking responsibility
- Feedback (which includes 'what happened next' as well as patient and colleague responses)

- Clinical conversations
- Opportunistic teaching
- The study of written or web-based material
- Projects /presentations
- Formal teaching sessions

However, for successful learning to happen some key factors have been described¹ including: wanting to learn; needing to learn; learning by doing (practice, repetition and experience); and making sense of things or 'digesting'. All these factors occur simultaneously and also affect each other.

Another helpful starting point is *the explicit definition and expectation of learning* for trainees at the start of each AMU post. This is for two reasons: first, because trainees frequently report poor 'teaching' during placements even if a lots of learning takes place; and second, because being explicit is one educational strategy necessary in today's educational climate.

In her fascinating article, 'Generational changes and their impact in the classroom: teaching Generation Me'², Jean Twenge outlined the empirical evidence for generational changes among students /trainees and made recommendations for teaching based on these changes. Generational changes are rooted in shifts in culture, and are reflections of changes in society and educational systems. People born in the 80's and 90's score progressively higher on assertiveness, self-liking /entitlement, high expectations, and some measures of stress/ anxiety – and lower on self-reliance. These findings represent average changes and exceptions certainly occur, but they have implications for education.

Twenge goes on to say that these characteristics suggest younger trainees (brought up in the west) benefit from a more structured but also more interactive learning experience, and that their overconfidence may sometimes need to be tempered. Educators should give very specific instructions, frequent feedback, and should explain the relevance of material. Instruction may need to be delivered in shorter segments and incorporate interactive elements.

With these two important starting points in mind, let us examine the nature of *professional* education.

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Professional education and the acquisition of expertise has been extensively studied

When the Foundation Programme Curriculum was revised in 2007, it emphasised that doctors learn from practice in a clinical environment, rather than the classroom.³ It also stressed the concept of expertise, which is something different to competence, and is the goal of professional education.

It is worth pausing here to clarify some definitions. 'Competency' refers to the ability to perform a certain skill, e.g. insert an intravenous cannula. Acquiring a set of competencies does not mean that a doctor is competent, e.g. at managing an acutely ill patient. 'Competence' refers to being *adequately* qualified. Expertise refers to skill, plus (in medicine) several invisible attributes, such as judgement, reasoning and expert intuition.⁴

There are four key ingredients to becoming an expert. Medical educators can help by making these explicit, and facilitating and coaching trainees in them:

- Experience
- Feedback
- Deliberate practice
- Reflection

Research shows that for professional practice, it takes around 10 years of intensive involvement in a discipline to become an expert, whether it is a concert pianist, professional sports player or physician.⁵ This is something I use to remind trainees when they are downcast over getting a diagnosis wrong. Even then – learning never stops!

However, all the experience in the world does not matter if it is the *wrong* experience. Without an expert to give feedback on your performance, you cannot improve, as 'you don't know what you don't know'. I experienced this when I learned how to perform a lumbar puncture as a medical house officer, and later spent some time in anaesthesia! Studies show that trainees want and welcome feedback, but say they do not experience it very often.⁶

Deliberate practice involves effort. It refers to time spent on a specific activity designed to improve performance in a particular aspect of practice. This is not the same as simply going on a course, e.g. Advanced Life Support. Experience and continued training have been shown to improve performance whereas continuing experience alone just leads to a progressive decline in performance.⁵

Reflection is a vital aspect of developing expert professional practice. Simply put, reflective practice is when we view our practice from different perspectives: our own experiences; our colleagues' and patients' experiences and perceptions; and the literature. Reflection can be written, verbal or simply thinking. It can happen in the middle of an event, afterwards, even beforehand. It can happen in your study or in the pub.

If you think carefully about these four key ingredients, you will probably realise that the best doctors do this already without realising.

Models of opportunistic teaching

Starting with a shared understanding of what teaching and learning on the AMU is all about, and that learning is a process, there are various models to help you facilitate learning at the same time as seeing patients. Some of them are very simple indeed.

• *Thinking aloud* – as experts, some of our clinical judgements appear to be intuitive and therefore unteachable, but with shorter, more focussed postgraduate training, there is a need to make explicit things that were previously 'gained by osmosis' over time. Speak out loud the steps you took to get you to a particular decision.

• *Demonstrations* – the key thing is to remember to announce you are demonstrating something beforehand, so people can pay attention. 'Watch how I take this history / perform this manoeuvre – we're going to talk about it in a minute.'

• *Observing trainees* – often we assume that a trainee who performs well in one area also performs well in another. If you try observing once in a while, you will experience what Norcini – who researched many of our work-based assessments – calls, 'Oh my God!' moments.⁷ Try swapping roles with your registrar for part of the ward round. Registrars are meant to be observed doing the post-take ward round; very few are on a regular basis.

• *Teaching in chunks*⁸ – using models such as the 'one minute preceptor' or 'SNAPPS' model – see Box 1.

Putting these in to practice literally takes some practice! For example, I have found that it is important to let people know that I am thinking aloud, otherwise my thoughts get incorporated in to the documents management plan before I realise it! In a ward round of mixed abilities, getting trainees to teach others or demonstrate things serves two purposes: it helps you focus on thinking about the patient, and allows you to evaluate your trainee at the same time.

Registrars in Acute Medicine usually prefer the variety of going off to see patients themselves and then discuss the

a. One-Minute Preceptor Model

Trainee presents a case, then the teacher:

- Gets an idea about what the trainee thinks the problem is
- Probes their reasoning and alternative explanations
- Teaches one or two general principles
- Feeds back about what the trainee did well
- Corrects one or two errors in reasoning

The One-Minute Preceptor is a good model for ward rounds, and does not take any more time.

b. SNAPPS Model (developed originally for out patients)

The trainee:

- Summarises
- Narrows down
- Analyses the differentials
- Probes the teacher about uncertainties
- Plans the patient management
- Selects a topic for self-directed learning

Box 1. Teaching in chunks.⁸

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plan afterwards. It is important to ensure that the subsequent discussion is worthwhile, and that you go together to see any 'tricky' patients afterwards as well, if they are to get the most out of this. Trainees often find being watched a little unnerving. I spent an entire year doing a weekly post-take ward round as the 'consultant' with the actual consultant being the 'registrar' and writing in the notes. I soon became comfortable with this arrangement, and learned far more about decision making than I would have otherwise.

Like most AMU ward rounds, we start off with the night team at 8am and have an hour or so seeing patients they have managed over night. If you are often task focussed, rather than people focussed it is important to smile and ask how the night shift went to start with, because every educationalist knows that *learning environments* have a powerful impact on learning. The one-minute preceptor model (Box 1) is most useful for post-take ward rounds. Many trainees are hesitant to commit to what they actually think is going on. Especially after nights, it is important to feed back what was done well, and to focus on only one or two errors in *reasoning* – often with a recommendation of some brief reading later in the week.

For the day shift, an additional useful trick is to summarise at the end of a ward round: 'What three things did you learn this morning?' This encourages reflection, often leads to a learning goal, for example some reading or deliberate practice, and makes it clear that learning was indeed taking place.

Effective feedback has certain characteristics

Like many things in medical education, feedback has been thoroughly studied. Feedback can positively change clinical performance when it is systematically delivered from credible sources. For feedback to be effective its content should be

clear and delivered in a timely, interactive, face-to-face and non-judgemental environment.

Holmboe et al proposed a useful model for feedback in postgraduate medical education.⁹ Effective feedback:

- Is interactive
- Encourages self-assessment
- Involves an explicit action plan

There is a good reason why feedback should start with the question, 'How do you think that went?' Exploring a trainee's insight in to problem areas is a vital aspect of giving 'negative' feedback. Feedback should focus on one or two areas for improvement. Starting with things that went well shows you were paying attention. Focussing on only one or two areas for improvement helps in the development of an achievable action plan. Learning is a process.

Conclusions – food for thought

Education is a medical specialty just like paediatrics or orthopaedics. Good educational practice is not necessarily a matter of just 'common sense'. Reading about education and understanding some important principles and models like the ones above will help you improve your own educational practice.

I encourage readers to experiment with some of the ideas here. Some of them take a little while to get used to. Particularly for Registrars in Acute Medicine, it is important that trainees are neither *passive* observers of consultant practice, nor off on their own making decisions about patient care without the benefit of clinical conversations with experts. When I look back at the consultants who I learned most from, they were the ones who employed the techniques above (probably without realising) and were also excellent physicians themselves. Food for thought?

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Further reading

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