Supporting Excellence in Medical Education

NACT UK 2011

Maintaining Training in a Changing World

Wise doctors are fundamental to safe patient care: their education requires *the invisibles*

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Agenda

- What are we trying to achieve in PGME?
- What do we use currently?
- Introducing The Invisibles
  - Making more from less
  - Clinical Reflective Writing (CRW)
  - The process of *CBD Plus©*
- What does it place on record about the learner and their development?
- A take home message

What are we trying to achieve in PGME?

It must have a clear ***educational*** aim

The aim of PGME is about:

Developing Wise Doctors

is about preparing them to care for patients
safely and appropriately in the uncertain and messy environment of clinical practice

is not about producing technicians, protocol followers and unthinking professionals -
because this is unsafe for patients

Being a wise doctor means:

- Understanding the values that drive your practice

  (as distinct from just doing a job)

- Understanding the importance of context

  (because everything is context specific)

- Being able to articulate the thinking that underpins your decision making

  (not just following protocols)

- Being able to make your own wise professional judgements

  (not just doing what the boss wants!)

- Being able to create a therapeutic relationship with a patient

  (going beyond safe patient care to caring about the patient)

- Having self knowledge

  (not just being skilled)

Developing wise doctors requires the prioritisation of:

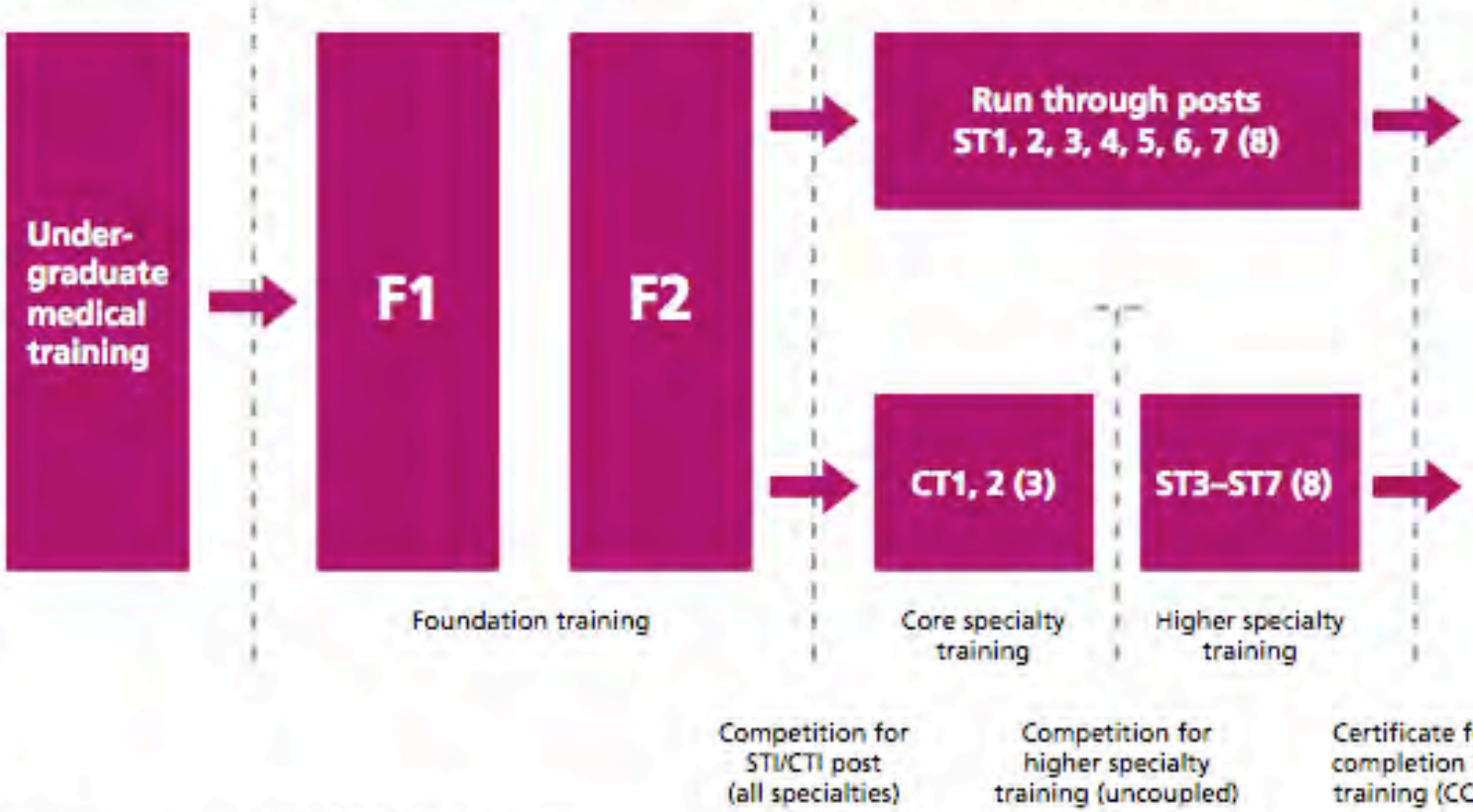
- Sound teaching
  (teaching medical educators to use for themselves and then to teach the invisibles)
- Space for learning
  (making more of less within and around the edges of clinical practice)
- Drawing on multi-disciplinary T&L
  (engaging the team with the Invisibles)
- Meaningful and fair assessment
  (Using Clinical Reflective Writing)

Developing new vision in medical education

Current systems and processes

Career structure for foundation and specialty training

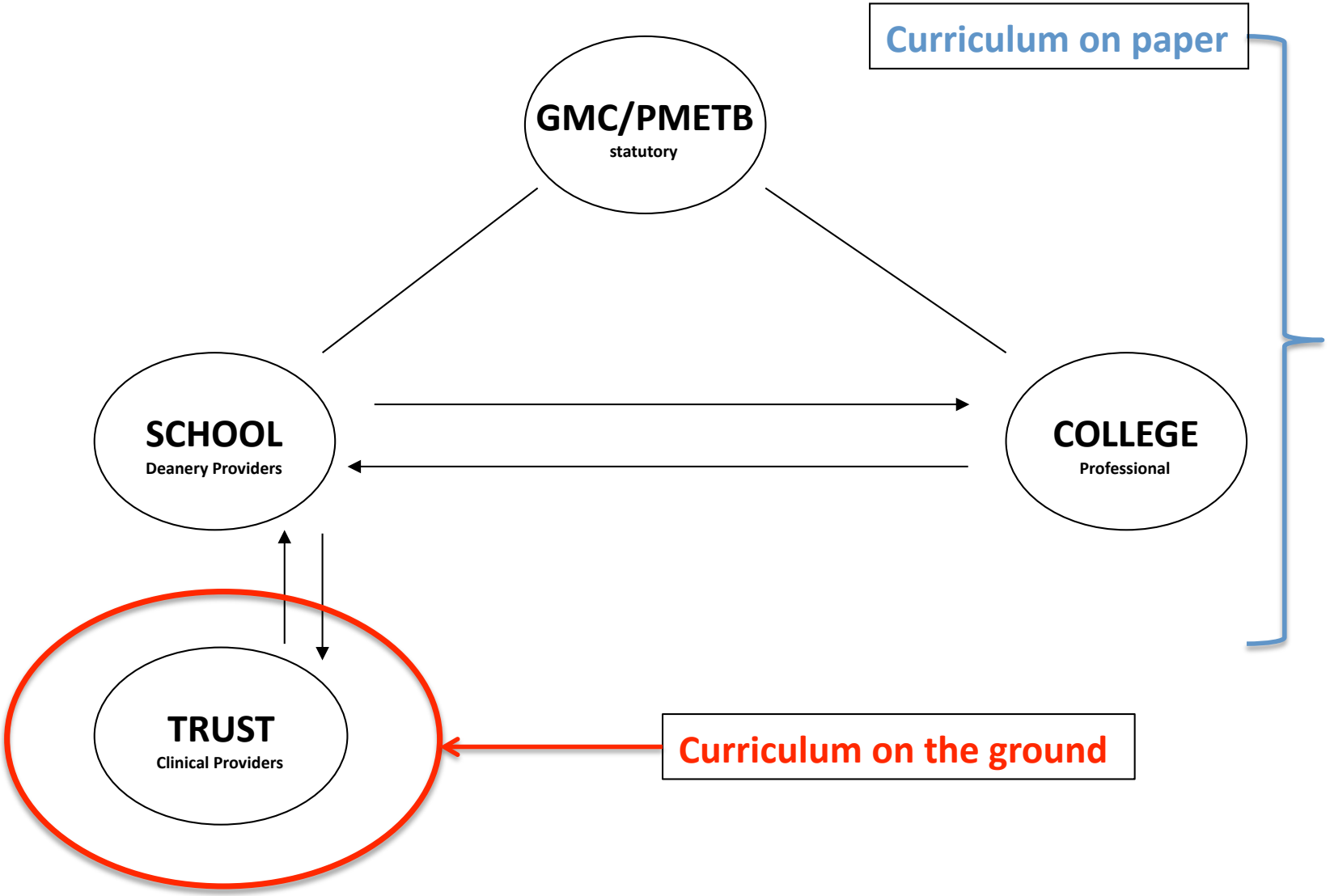
The flowchart below outlines the career structure for foundation and specialty training. This is an overview only. There may be other points of entry which aren't shown here, depending on which vacancies are available at different stages of training.



(Diagram adapted from image by David Rice, KSS Deanery, 2008)

WISE DOCTORS

Educational Systems and Governance



Fish and Coles 2005

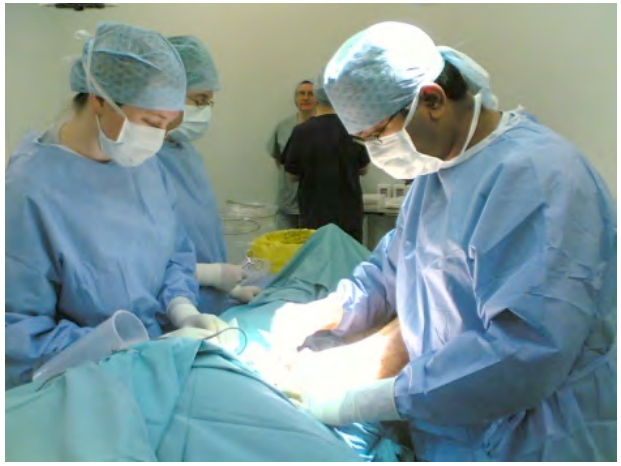
Tools of the Trade

Understanding how doctors think

Observable

explicit

What you see and its limitations



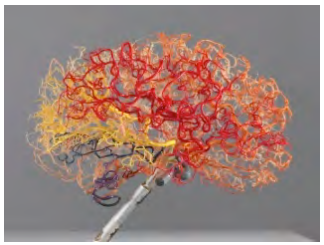
Implicit

inferable

Tacit

unpackable

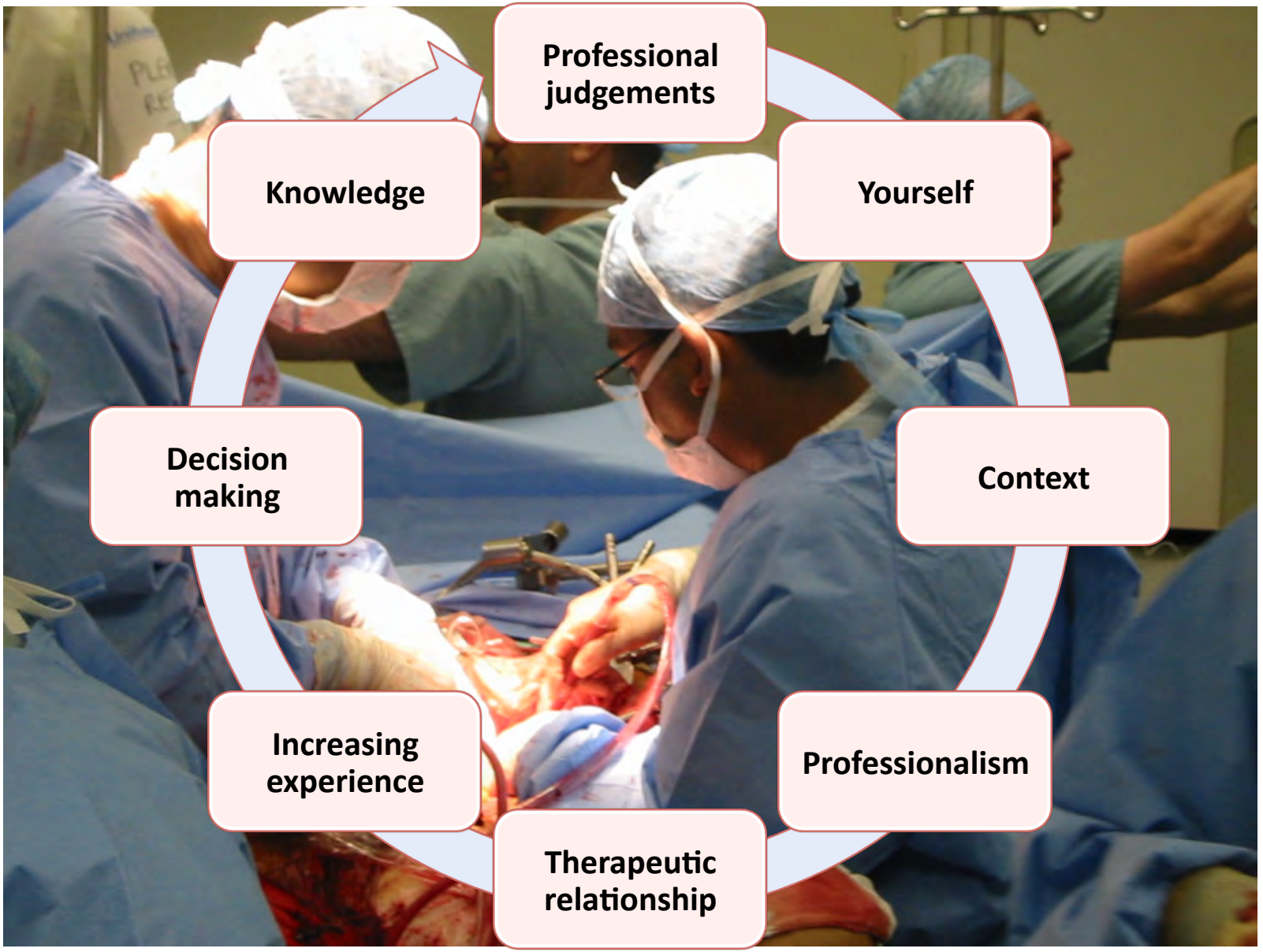
ineffable



We offer *the Invisibles as* an enhancement to *Tools of the Trade.*

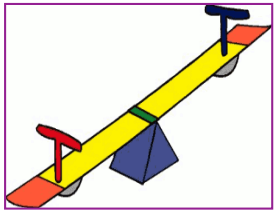
They are not a replacement for them.

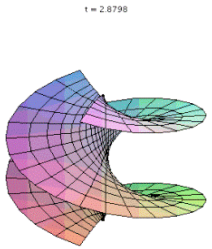
***The Invisibles* explore the implicit and the tacit which *Tools of the Trade* do not.**


Professional judgements
Yourself
Context
Professionalism
Therapeutic relationship
Increasing experience
Decision making
Knowledge

Resources

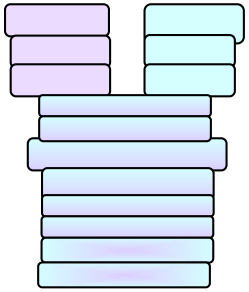
Professional judgement





Clinical thinking

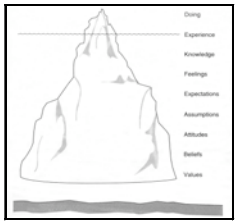
Forms of Knowledge



Context of the case

The Invisibles

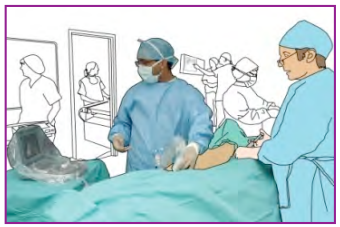
To be used with an individual case/ event/procedure



Person you are

Values

Therapeutic Relationship



Extended view of Clinical practice

Kind of professional

The context

What details can you provide
about the context
of what is happening in this picture?

About the people?

The environment?

The likely history?

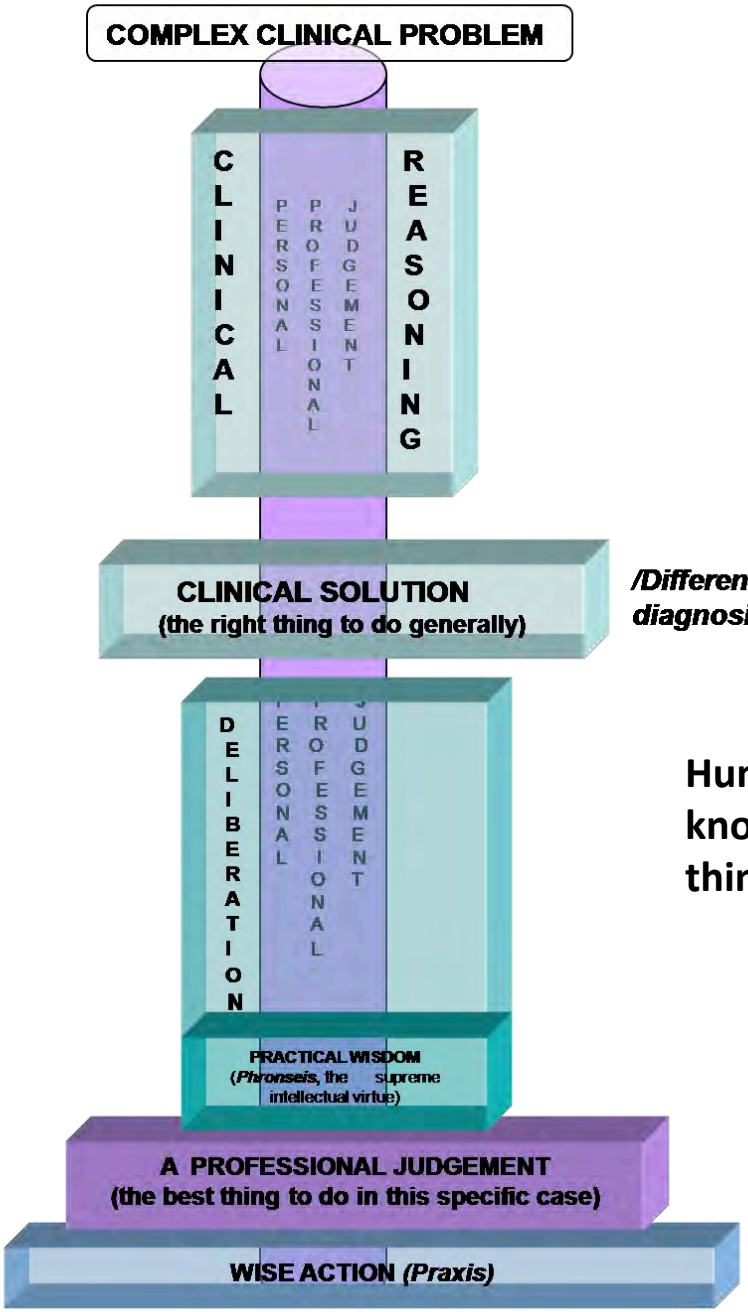
About what **you** bring to it?

About the position it
puts **you** in?

How does your previous experience of this type of
event affect your interpretation of it?

Clinical decision making and Professional Judgement

The Clinical Thinking Pathway

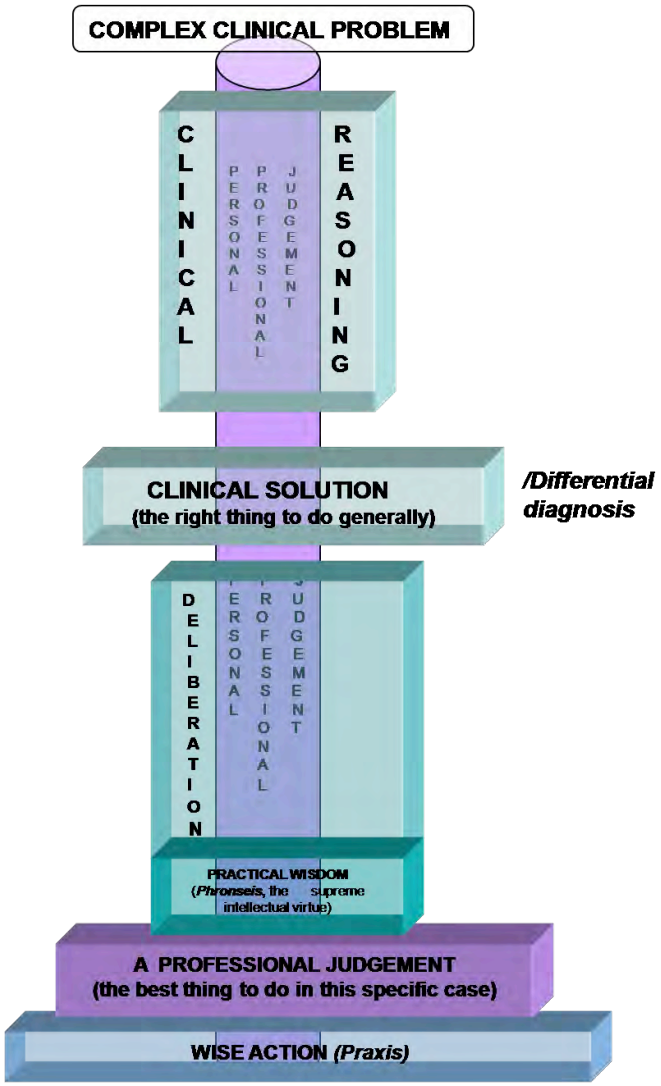


/Differential diagnosis

Scientific knowledge & thinking

Humanities-based knowledge & thinking

The Clinical Thinking Pathway



General procedures for a particular case

- The reliability of information provided
- Extracting the salient features of the case
- When to stop ordering more tests
- Recognising which test results are relevant

Specifics to this individual patient

- Prioritising
- Choosing between competing demands
- Discounting own interests
- Intuition
- Reconsidering plans

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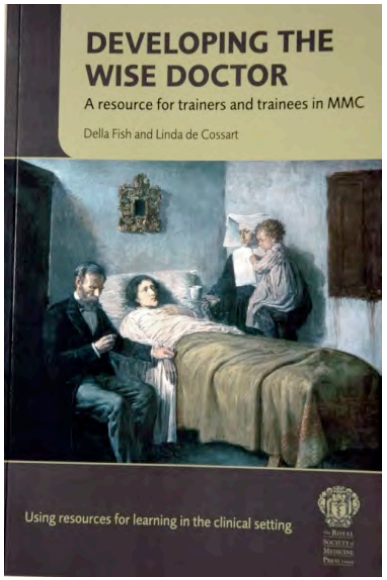
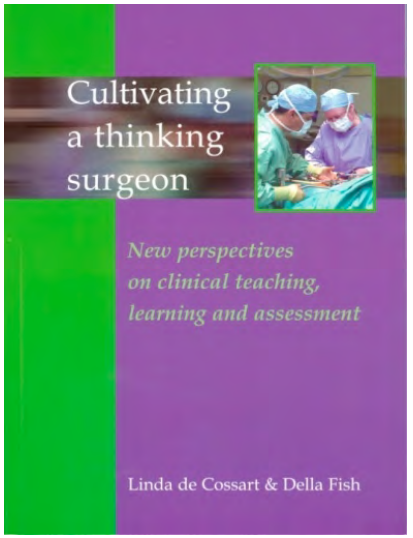
This talk is based on ideas developed by Linda de Cossart and Della Fish between 2002 and 2010 and continuing





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Processes for using the Invisibles

Making more from less

Clinical Reflective Writing (CRW)

The process of *CBD Plus©*

More from less

Making more out of less

Enhancing a learner's clinical experience

Old medicine

New medicine
Advanced teaching

Oral debrief/ reflection on THE PARTICULAR case

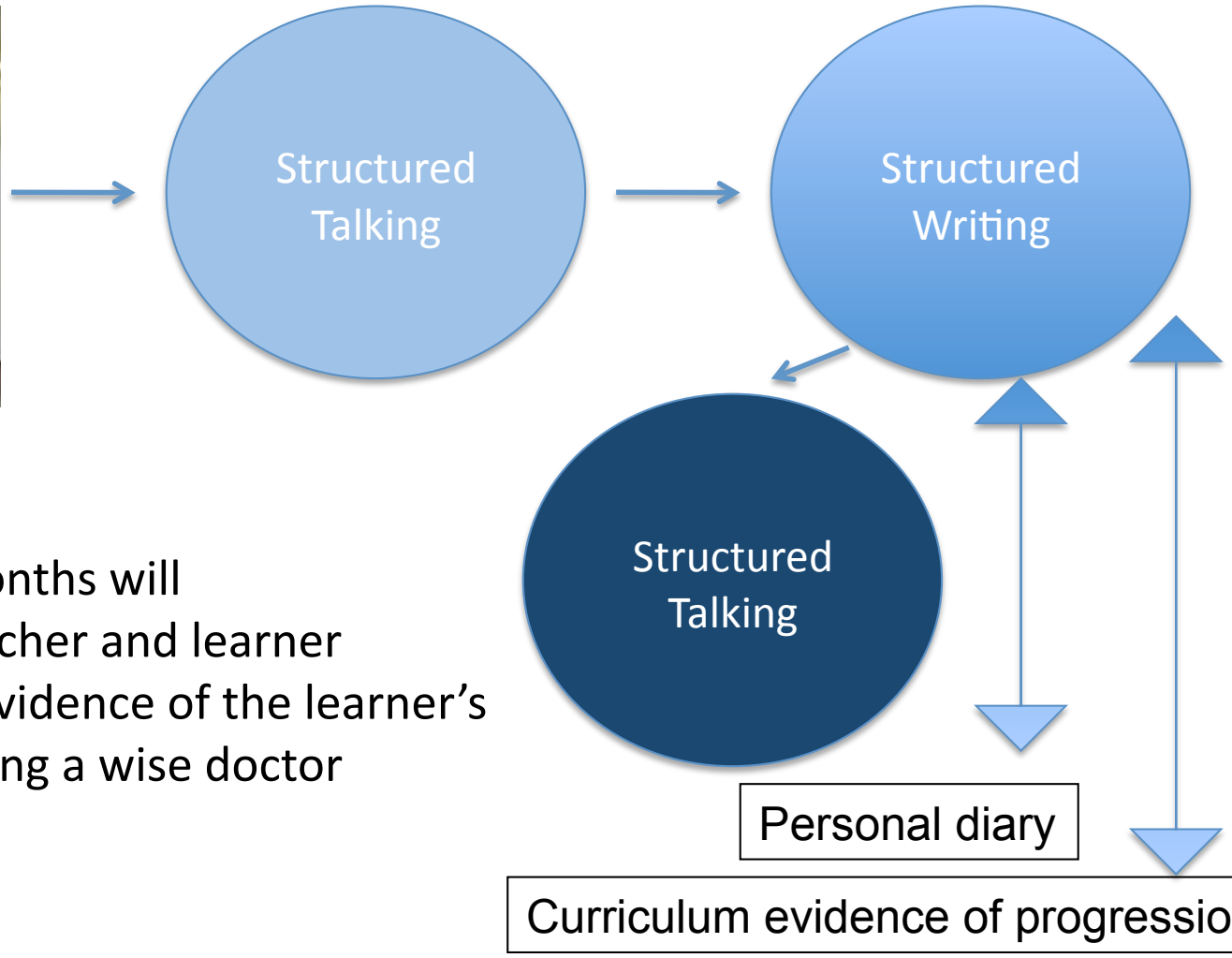
Agree CRW

RESPOND to CRW then agree new learning focus

DISCUSS next CRW then agree further learning focus

And so on……

Clinical Reflective Writing (CRW)



5/6 writings over six months will
be very revealing to teacher and learner
and will have accrued evidence of the learner's development in becoming a wise doctor

The key characteristics of successful reflective writing

- is about **concrete situations**
- uses the **first person singular** — is autobiographical
- seeks to **understand an action** / event which has been personally experienced
- is '**in the moment**'
- attends in **detail to the context of the action** / event being reflected on
- seeks to study an event / action more deeply and to **unpack the thinking** and knowing beneath its surface
- **describes wholes** rather than parts
- is **narrative** in style
- shows **evidence of learning** (deepening understanding)
- sometimes uses **figurative language** (rich descriptions based on, for example, comparisons as in similes and metaphors)
- demonstrates **commitment to professional ideals** and uses these as a touchstone to critique practice
- takes account of **the views and perspectives of others** involved in the action or event
- identifies **factors contributing to the situation** which may be historical, political, economic, social, ethical, autobiographical, psychological
- draws **attention to what may previously have been taken for granted**, rendering the familiar strange
- enriches experience by the acquisition of **new perspectives**
- seeks **relationships to wider theory and general principle.**

The Process of *CBD Plus©*

- **Pre-requisites**

  Teachers and learners become comfortable with The Invisibles and CRW

- **Before the CBD meeting**

  Learner to create 8 to 10 bullet points about the case and bring two copies

- **At the meeting**

  Structured talking extending the bullet points of the case using the language of *the Invisibles*

- **After the meeting**

  Structured Clinical Reflective Writing expanding on the bullet points

  Teacher's response to CRW

- **Further meetings**

- Taking points identified in the case to elaborate on

See ED4MEDPRAC.co.uk for further elaboration

Occasions for using the Invisibles and Clinical Reflective Writing to enlighten *YOUR* practice

- Case Based Discussion (CBD)
- MiniCex
- DOPs, PBAs and other technical skills/ procedures
- Significant clinical events in your practice

  eg breaking bad news, taking consent, talking to relatives
- Simulation learning
- Reflecting on personal clinical practice
- Serious untoward incidents in your practice (SUIs)

What does CRW look like?

A *Rainbow* Draft

Standard presentation

Context of the case

Forms of knowledge

Professionalism	**Green**
CTP	**Purple**
PJ	**Brown**
Seeing wider	**Grey**
TR	**Turquoise**

I had seen an 11yr old girl with her mother in surgery. The appointment was scheduled late in the afternoon and the girl was still in her school uniform having just finished at school. She was seen at the GP surgery during one of my routine booked clinics. She had persisting symptoms of tiredness over the last month. She had prior to this episode been very well. There were no other physical features or symptoms of note. On examination she appeared well and I could ascertain no abnormal findings. I had discussed my findings and my conclusions from both the history and examination with mother and child. Propositonal knowledge – causes of tiredness in a child. Also through my previous paediatric work – experiential knowledge (likely causes of symptoms including sinister as well as psychological causes). Intuitive knowledge – issues at school and whether she had changed school recently. This had not been the case. Sensory knowledge – through examination. The mother however remained concerned as her symptoms had lasted so long and felt there was something more serious going on. The mother had been doing most of the talking and although the child did contribute and speak for herself at times. In my previous role as a paediatrician, I had spent a fair amount of time working in paediatric oncology. I had therefore come across cases of non-specific symptoms which were subsequently found to be due to a more sinister cause. I was therefore influenced by the mother's concerns despite my initial reassurances. Intuitive knowledge – from my previous experience in paediatrics. I had suggested checking some routine blood tests including one for glandular fever which I explained was possible but, even if positive, would not affect our management. Procedural knowledge – the logistics of getting blood tests done and how this may be different for children. Also, the effect on management on doing such tests. The mother was happy with this and the blood tests were performed. These had all come back as negative – including the test for glandular fever – so I had felt the mother would be reassured that the cause was most likely viral and, therefore, self-limiting. Pathology results come through to us electronically at the surgery. We tag results according to any action needed and ask patients to contact the surgery a week after any investigations. As many are usually normal and do not require any further action, these are dealt routinely by admininstrative staff to help save time for us. As these results were normal, I did not contact the patient directly and had assumed the symptoms had settled having heard nothing back for a few weeks.

A few weeks later mother and patient attended again in surgery with the same symptoms. On this occasion, I believe it was during school holiday time and the appointment was earlier in the day than before. Nothing had changed since I had last seen them. Examination was again normal and I had spoken about the blood test results which had come back as normal. Sensory knowledge and propositional knowledge. As the child appeared well we had agreed to monitor symptoms and I review if there were no changes.

What does it place on record about the learner and their development?

A *Rainbow* Draft

Standard presentation

Context of the case

Forms of knowledge

I had seen an 11yr old girl with her mother in surgery. The appointment was scheduled late in the afternoon and the girl was still in her school uniform having just finished at school. She was seen at the GP surgery during one of my routine booked clinics. She had persisting symptoms of tiredness over the last month. She had prior to this episode been very well. There were no other physical features or symptoms of note. On examination she appeared well and I could ascertain no abnormal findings. I had discussed my findings and my conclusions from both the history and examination with mother and child. Propositonal knowledge – causes of tiredness in a child. Also through my previous paediatric work – experiential knowledge (likely causes of symptoms including sinister as well as psychological causes). Intuitive knowledge – issues at school and whether she had changed school recently. This had not been the case. Sensory knowledge – through examination. The mother however remained concerned as her symptoms had lasted so long and felt there was something more serious going on. The mother had been doing most of the talking and although the child did contribute and speak for herself at times. In my previous role as a paediatrician, I had spent a fair amount of time working in paediatric oncology. I had therefore come across cases of non-specific symptoms which were subsequently found to be due to a more sinister cause. I was therefore influenced by the mother's concerns despite my initial reassurances. Intuitive knowledge – from my previous experience in paediatrics. I had suggested checking some routine blood tests including one for glandular fever which I explained was possible but, even if positive, would not affect our management. Procedural knowledge – the logistics of getting blood tests done and how this may be different for children. Also, the effect on management on doing such tests. The mother was happy with this and the blood tests were performed. These had all come back as negative – including the test for glandular fever – so I had felt the mother would be reassured that the cause was most likely viral and, therefore, self-limiting. Pathology results come through to us electronically at the surgery. We tag results according to any action needed and ask patients to contact the surgery a week after any investigations. As many are usually normal and do not require any further action, these are dealt routinely by admininstrative staff to help save time for us. As these results were normal, I did not contact the patient directly and had assumed the symptoms had settled having heard nothing back for a few weeks.

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Supervisor's response to CRW for a CBD

I am really pleased with how this writing is progressing.

You have explored the context very well and in considerable depth.

You still need to think more carefully about how you tailored the top end of the CTP to your particualr patient.

Please look at the comments that I have written in the margin above.

Take home message

- It is feasible as others have already shown
- It is fun
- **YOU can do it!**
- Medical Education Leadership needs to take this forward
- Learn more about Clinical Reflective Writing and The Invisibles by visiting our web site

www.ED4MEDPRAC.co.uk