

Clinical teaching in a busy emergency department: strategies for success

Rick Penciner, MD*

ABSTRACT

Clinical teaching is an integral part of emergency medical practice. With the growing number of medical students and residents in the emergency department there are increasing expectations for clinicians to teach. But there are many challenges and obstacles to overcome when teaching in a busy department. By incorporating diverse strategies and techniques, we can become more effective and efficient emergency medicine teachers.

Key words: clinical teaching, effective teaching, trainees, students, education

RÉSUMÉ

L'enseignement clinique est une partie intégrante de la pratique de la médecine d'urgence. Avec le nombre grandissant d'étudiants en médecine et de résidents au département d'urgence, le besoin de cliniciens enseignants se fait de plus en plus grand. En intégrant diverses stratégies et techniques, nous pourrions devenir des professeurs de médecine d'urgence plus efficaces et efficaces.

Introduction

Emergency physicians teach residents and medical students for many reasons. Some teach because they gain knowledge and skills through these interactions. Others believe it is their professional responsibility to train a new generation of physicians. For some, teaching is a condition of employment — a requirement to maintain hospital privileges.

As the popularity of emergency medicine rotations increases, so have the number of trainees in the emergency department (ED). The ED is recognized as great training ground not only for family medicine and emergency medicine residents, but for most other specialties also. As a result, more trainees are being placed in “teaching hospitals” and in busy community hospitals for their emergency medicine rotations. More emergency physicians are sharing teaching responsibilities.

Physicians face unique challenges and obstacles when teaching in busy EDs. Patients often have serious illnesses requiring immediate expert care, and emergency physicians must maintain patient flow, care quality and patient satisfaction while teaching. Physicians may feel uncertain about their ambiguous role with the trainee. Are they a supervisor, mentor, teacher or evaluator? And clinical teachers face challenges involving trainees at different levels, trainees from different specialties, and “difficult” trainees. To complicate matters, few physicians are trained as teachers and even fewer are paid to teach.

Although there is a fair body of medical literature on how to teach in the ambulatory setting and on the wards,^{1,2-5} there is essentially no guide on how to teach in the ED. How can emergency physicians become more effective and efficient clinical teachers? This article outlines strategies that will help create a more effective and efficient teacher in a busy ED.

From the Department of Emergency Medicine, North York General Hospital, Toronto, Ont.

*Assistant Professor, Department of Family and Community Medicine, University of Toronto

Received: Mar. 7, 2002; final submission: May 5, 2002; accepted: May 7, 2002

This paper is based on a presentation made at Mount Sinai Hospital, Toronto, Ont., Nov. 28, 2001, as part of a faculty development workshop on teaching in the emergency department.

This article has been peer reviewed.

Strategies for success

Researchers have identified the most common characteristics of an effective clinical teacher in medicine and ambulatory care medicine,^{1,6} as perceived by medical students, residents and faculty. The best clinical teachers are described as being enthusiastic, clear and well organized, and adept at interacting with students and residents. They are actively involved with the learner, promote learner autonomy and demonstrate patient care skills.

To succeed in the ED, physicians need to be effective, efficient teachers. The emergency physician should develop and use various strategies when teaching. A good

Researchers have found that ... teachers wait less than 1 second for students to respond. By prolonging this wait time to at least 3 seconds, students' responses become 3 to 7 times longer and contain more logical arguments and speculative thinking.

strategy for organizing ED teaching is to think in terms of "How will I teach?" and "What will I teach?". The former refers to teaching style, and the latter to learning domain (knowledge, skills, attitudes).² The following strategies are based on published literature, feedback from colleagues and trainees, and personal observations.

Get to know the trainee and plan the shift together

At the beginning of the rotation or shift, get to know the trainees. Address them by name. Enquire about their program, level of training, objectives for the rotation and their emergency medicine experience. Communicate your objectives, expectations and evaluation criteria for the trainee.³ Decide together whether this shift will have a particular emphasis. One shift might focus on treatment plans, another on procedures. Encourage more efficient and less frustrating interactions with the trainees by telling them how you want them to present their cases. Provide guidelines to make the presentations more concise, complete and thoughtful.⁴

Listen more and talk less

William Osler was a remarkable teacher, known for clarity,

precision and economy of words.⁵ Teaching style may include *telling* (didactic), *asking* and *showing*.⁷ Didactic teaching is an inefficient and passive way to learn. *Asking* questions can be done using the Socratic Method, where the trainee is gently led to the answer, or in a more direct fashion — the latter being more common in medical teaching. When questioning a trainee, be sure to ask questions that are clear, brief, focused, and that have more than one acceptable answer. Then allow the trainee time to respond. Researchers have found that, in many cases, teachers wait less than 1 second for students to respond. By prolonging this wait time to at least 3 seconds, students' responses become 3 to 7 times longer and contain more logical arguments and speculative thinking.⁸ Avoid *pimping*. This age-old teaching method occurs when the teacher asks essentially unanswerable questions in rapid succession.⁹ *Showing* the trainees is effective but time consuming. This might include demonstrating procedures or teaching at the bedside.

Encourage trainees to commit themselves and allow them to make mistakes. Have them write down treatment plans and orders, no matter how wrong they may be. Tolerate errors and review their charting regularly. This is a great source of teaching material and it can be done at any time.⁷ The chart can serve as a focal point for case review, to stimulate a teaching point, and to guide further reading or teaching.

Seize the teachable moment and provide early feedback

Every case has a teaching point. The teaching point should be brief; it should not include everything the teacher knows about the subject. It should address the patient's concerns and the learner's needs.⁴ Trainees often complain about the lack of feedback.¹⁰ Feedback should be given frequently and in a timely fashion, either formally or informally. It should be specific and based on first-hand observation.¹¹ Allowing the trainee to self evaluate first will make your role easier. Tell the trainees when you are going to provide feedback and invite similar feedback from them — to improve your teaching performance.^{12,13}

Allow trainees — especially junior trainees — to have successes while working. Set up positive patient interactions and be sure they can answer at least some questions. This builds confidence and enthusiasm for the remainder of the rotation. Encourage self-directed learning by suggesting the trainee seek answers to clinical questions that arise. Excellent teachers stimulate learners' curiosity and engender an excitement for learning.¹³

Finally, try to directly observe the trainee. Although this is time consuming, it will pay off immensely for the

trainee and the teacher. You will have a better assessment of how the trainee actually performs independently.¹³ Direct observation should not be limited to procedures. The ED provides a unique opportunity to observe trainees performing histories and physical examinations of patients.

Expose trainees to good "teaching cases"

Direct them selectively to interesting and appropriate cases for their level of training. Encourage them to do procedures or tasks that might otherwise be delegated to nursing staff. Trainees should give tetanus immunizations, fit patients for crutches and apply slings. Tell trainees about interesting cases that they are not directly involved in. Share educational x-ray, EKG and physical findings with them.

Improve efficiency and maximize your teaching

In a busy ED when time constraints are a reality, physicians must be efficient yet still provide an effective learning environment. Teach more than one trainee at a time when appropriate. Allow senior trainees to teach junior trainees (this creates a valuable learning experience for the seniors). Encourage other ED staff to teach trainees. For

example, a nurse can teach how to start an intravenous, and an orthopedic technician can teach how to apply a cast.

Conclusions


Clinical teaching in a busy ED is both challenging and rewarding. By incorporating multiple and varied strategies we can become more effective and efficient teachers. Because only some of these strategies may work in any given situation, it is important to be flexible and creative. Respect and acknowledge your own teaching ability, knowledge and style.

Competing interests: None declared.

References

1. Irby DM. Clinical teacher effectiveness in medicine. *J Med Ed* 1978;53:808-15.
2. Irby DM, Ramsey PG, Gillmore GM, Schaad D. Characteristics of effective clinical teachers of ambulatory care medicine. *Acad Med* 1991;66:54-5.
3. Chambers R, Wall D. Teaching made easy: a manual for health professionals. Abingdon: Radcliffe Medical Press; 2000. p. 111.
4. Ende J. What if Osler were one of us? Inpatient teaching today. *J Gen Int Med* 1997;12(suppl 2):S41-8.
5. McGee SR, Irby DM. Teaching in the outpatient clinic: practical tips. *J Gen Int Med* 1997;12(suppl 2):S34-S40.
6. Rubenstein W, Talbot Y. Medical teaching in ambulatory care: a practical guide. New York: Springer Publishing Company; 1992. p. 13-29, 60-68.
7. Brancati F. The art of pimping. *JAMA* 1989;262:89-90.
8. Ende J. Feedback in clinical medical education. *JAMA* 1983;250:777-81.
9. Bayley T. Learning principles. In: Bayley T, Drury M editors. Teaching and training techniques for hospital doctors. Abingdon: Radcliffe Medical Press; 1998. p. 1-8.
10. Irby DM. Teaching and learning in ambulatory care settings: a thematic review of the literature. *Acad Med* 1995;70:898-931.
11. Orlander JD, Fincke BG. Soliciting feedback: on becoming an effective clinical teacher. *J Gen Int Med* 1994;9:334-5.
12. Knight JA. Our physician forebear Sir William Osler as teacher to emulate. In: Edwards JC, Marier RL editors. Clinical teaching for medical residents: roles, techniques and programs. New York: Springer Publishing Company; 1988. p. 35-49.
13. Rowe MB. Wait time: slowing down may be a way of speeding up. *J Teacher Ed* 1986;37:43-50.

Your host...


**Detroit Receiving Hospital
 and University Health Center**
 Detroit Medical Center / Wayne State University

presents

**Detroit
 TRAUMA
 SYMPOSIUM**

November 14 & 15, 2002
 at the Detroit Marriott Renaissance Center

Speakers for the Detroit Trauma Symposium

Barbara Barlow, M.D.	Charles E. Lucas, M.D.
Margaret Campbell, R.N.	Fred Luchette, M.D.
Lawrence N. Diebel, M.D.	J. Wayne Meredith, M.D.
Scott A. Dulchavsky, M.D., Ph.D.	Daniel Michael, M.D., Ph.D.
Sr. Janet Hudspeth	Andrew Pietzman, M.D.
M. Margaret Knudson, M.D.	David C. Viano, Ph.D.
Anna Ledgerwood, M.D.	Stewart C. Wang, M.D.

**Sign up for e-mail updates! Visit www.dmc.org,
 and click on Detroit Trauma Symposium.
 For more information, please call (313) 577-5005.**

Correspondence to: Dr. Rick Penciner, North York General Hospital, 4001 Leslie St., North York ON M2K 1E1; rick.penciner@utoronto.ca