Division of General Internal Medicine

THE CLINICAL LEARNING ENVIRONMENT: STRIVING FOR EXCELLENCE

McGill General Internal Medicine Retreat
2 November 2019
Manoir Saint-Sauveur, Saint-Sauveur, QC

PROCEEDINGS REPORT

Submitted by V. Tagalakis

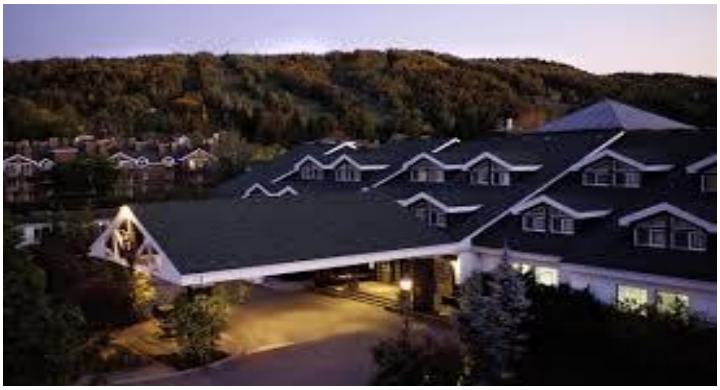
McGill GIM Division Director

December 12, 2019

Division of General Internal Medicine

PREFACE

The McGill Division of General Internal Medicine held a retreat on the **The Clinical Learning Environment: Striving for Excellence** on Saturday November 2nd, 2019 at the Manoir St Sauveur. This report describes the retreat's proceedings. This year's retreat provided a forum to discuss the clinical learning environment anchored on issues most relevant to the GIM context. The program included presentations from division members as well as the Associated Deans of Faculty Development and Post-graduate Medication Education. The focus was on defining the components of the clinical learning environment, aligning faculty-trainee expectations, learning of best practices for giving feedback, and understanding the process and approach to a learner in difficulty. In addition, attendees discussed the challenges to balancing clinical and teaching obligations, obstacles to a healthy work environment specifically high clinical acuity settings, and suggested possible solutions. Included in this report are key take home messages from the sessions, the speakers' power point slides, and the compiled program evaluations. Many thanks to the 2019 GIM Retreat planning committee members and invited presenters. They did an outstanding job of sharing their expertise and engaging honest and collegial discussion. Special thanks to Antoinette Sevensma for managing and coordinating the planning process and the retreat events, activities and logistics.



A Retreat of McGill's Division of General Internal Medicine

THE CLINICAL LEARNING ENVIRONMENT: STRIVING FOR EXCELLENCE

DATE: SATURDAY NOVEMBER 2nd, 2019

TIME: 8:00-17:00

PLACE: MANOIR SAINT-SAUVEUR

PURPOSE

At the end of this retreat participants will be able to:

• Explain practical steps a clinical supervisor can take to create and maintain a safe learning environment

• Apply an evidence-based model for sharing feedback in clinical educational settings

• Assess trainees in a way that aligns institutional, supervisor and learner expectations

• Apply a practical approach to the learner in difficulty using the perspectives of the Clinical Supervisor, Program Director and Undergrad or Postgrad Dean

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Retreat Agenda

FRIDAY November 1	
16:00	**Hotel check in**
19:00 **19:30**	**Doctor's social: sharing conversation** **Cocktails** **Dinner** *La Tablée Restaurant*
SATURDAY November 2	
7:00 **8:00**	**Breakfast Buffet** *La Tablée Restaurant* **Registration** *Whistler Room*
8:30	**Welcome and introduction** *Whistler Room* *V. Tagalakis*
8:35	**The clinical learning environment - overview** *Whistler Room* *L. Snell*
9:00	**Bridging supervisor and learner expectations** *Whistler Room* *M. Boillat*
10:15	**Break** *Whistler Room*
10:30	**Evidence-based feedback** *Whistler Room* *J. Wiseman* **Healthy clinical work environment for all** *Vail Room* *M. Koolian and E. McDonald*
12:45	**Lunch Buffet and Wellness Walk** *Buffet Lunch: Served in La Tablée with seating in M Steak*

13:45	**Practical approach to the learner in difficulty** *Whistler Room* *E. Constantin*
15:15	**Break** *Whistler Room*
15:30	**Peer coaching for excellence** *Whistler Room* *M. Elizov*
16:45	**Key points and next steps** *Whistler Room* *M. Koolian, E. McDonald and J. Wiseman* *V. Tagalakis* *L. Snell* *J. Wiseman*
17:00	**Closing**

FACULTY

Linda Snell, MD MHPE FACP FRCPC FRCP (London) FCAHS
Professor of Medicine, McGill University

Miriam Boillat, MD CCFP FCFP
Associate Dean, Faculty Development
Associate Professor of Family Medicine, McGill University

Jeff Wiseman, MDCM MEd FRCPC
Assistant Professor of Medicine, McGill University

Evelyn Constantin, MDCM MSc(Epi) FRCPC
Assistant Dean, Postgraduate Medical Education
Associate Professor of Pediatrics, McGill University

SMALL GROUP FACILITATORS

Maral Koolian, MD FRCPC
Emily McDonald, MD FRCPC

ATTENDEES

Kaberi Dasgupta
Ken Flegel
Gail Goldman
Susan Kahn
Maral Koolian
Khue Ly
Samuel Mamane
Thomas Maniatis
Emily McDonald
Joyce Pickering
Louise Pilote
Linda Snell
Vicky Tagalakis
Patrick Willemot
Jeff Wiseman

INTRODUCTION

The day began with a welcome from Dr. Vicky Tagalakis who thanked the attendees for coming and reviewed the program agenda. She noted that the retreat's overall aim was to address the clinical learning environment. In response to an unfavorable RCPSC and CanERA accreditation review in March 2019 of the core internal medicine residency program with a final recommendation of intent to withdraw, the Department of Medicine held its own retreat on the clinical learning environment in September 2019, calling on all Divisions to address the clinical learning environment within their context and emphasizing attention to trainee feedback, summative evaluation and clinical supervision. The Division considers trainee learning a high priority, and that high quality teaching leads to high quality patient care. Our clinical work environment is increasingly complex, stressful, and taxing for both learners and teachers especially on the CTUs and emergency medicine department. She hoped that by the end of the retreat, knowledge gained and solutions proposed would guide meaningful action to optimize the clinical learning environment within the GIM context so that trainees can learn safely and members can teach safely while striving for excellence in patient care.

1. CONCEPTS AND CONTEXT OF THE LEARNING ENVIRONMENTNT – OVERVIEW
L. Snell
Power point presentation: Appendix page 18

1.1. Key messages from presentation and small group discussion

- There was a new RCPSC-CanERA accreditation process in 2019
- Accreditation report: the clinical learning environment was highlighted as being suboptimal and problematic
- Need to address aligning teacher – learner expectations
    - Routine orientation of new faculty regarding teaching expectations
    - Routine orientation of trainees at the start of a rotation
- Clinical environment – case / mix has changed; more acute patients; high stakes medicine
    - How to reconcile time for learning and teaching
    - Expectations need to be explicit
- Direct observation and feedback is important to learning
- Need to be aware of hidden curriculum
- Excellence in patient care ↔ excellence in learning
- Clinical learning environment is complex and multifactorial – Requires LEADERSHIP from all key stakeholders
    - Clear and defined roles
    - TEAM concept

2. BRIDGING SUPERVISOR AND LEARNER EXPECTATIONS

M. Boillat

Power point presentation: Appendix page 23

2.1 Key messages from presentation and large group discussion

- Difficulty of meeting or connecting to all team members – must do it even if very brief
- Millennial behaviors:
  - Finish what you start
  - Impatience; instantaneous→ receiving feedback timely and frequently?
  - fast and explicit communication (e.g., messaging forums; tech savvy)
- Structure team beforehand: set expectations and roles
- Need to make time available for teaching, label it, can be brief
  - Quality of teaching = Quality of care
- Faculty staff orientation to best practices regarding teaching
- Ambiguity of feedback: Formative vs. Summative
- Orientation to expectations of both Teacher and Learner
- Patient safety vs. Leaner experience / skill
- Dealing with less continuity and increase in patient complexity
- New clinical context vs. old expectations
- "System" influences relationships
- CQI vs. intermittent evaluation
- Orientation / expectation on day 1
- Tension between patient safety - # of trainees
- Educational models have not adapted to the clinical environment
- Faculty of Med CQI – ongoing evaluation
- Words matter
- Make expectations obvious and explicit
- Acknowledge the differences
- CTU / ER directors – best practices
- Ask day 1 of rotation if trainee oriented
- Ask trainee for feedback

2.2. Small group discussion: learner vs. supervisor needs and expectations

SHARED MENTAL MODEL	LEARNER NEEDS AND EXPECTATIONS	SUPERVISOR NEEDS AND EXPECTATIONS
EDUCATION	• Basic medical management of internal medicine problems • Comfort of managing patients • Teacher will be responsive to my requests for teaching • Different from a classroom setting	• To trust resident • Asks for help when needed • I will organize the teaching • I will expect residents to participate • Residents will come on time for teaching

	• Patient care part of equation • Types of learning are multifaceted • Am I being constantly evaluated? • Level – setting – communication by staff of their goals? • Teaching / learning feedback • Didactic teaching • Reviewing • Group vs individual • Regular teaching every day • Predictable teaching • Orientation • Clear expectations in advance orientation • Orientation / role definition • Clear instruction / framework on how to complete consult	• Wants to master • May differ involving "soft" aspects • Have I completed evaluation? • Self-directedness of leaners look for learning opportunity • Teaching tailored to level of learners • NTTT teaching outside expertise – role modeling • Timing • Learning from residents (up to date literature) • Resident teaching • Need fewer complex patients if # /skills of trainees don't match the CLE • Language for communication of expectations • Appropriate # / types / skills of trainees • Co-teaching / supervision • Teaching team rounds
SAFETY OF: **PATIENT** **LEARNER** **SUPERVISOR**	• Ability to ask questions, not know without being • I can say I'm out of my depth without being made to feel incompetent • Learner free to ask for help "out of depth" safety • Formative vs summative • Conversation • Learn from patient by doing • No mistreatment • Mental and physical • Group think / expectation • When should trainee ask for help? • Who should they ask for help? • Orientation • Setting Expectations	• *trust of resident • Learners will tell me if they are out of depth • Expect that learners will tell when out of depth • Formative vs. summative • Conversation • Patient care – efficiency • Time - burnout • Feedback • Patient care • Comprehensive discharge summary • Patient safety is paramount (tension with safe leaner environment) • "strength" of learners • "junior heavy" team • absenteeism • safety – patient – appropriate #/types/skills of trainees to assure safe patient care • orientation / expectations • Patient flow • Discharge checking • co-teaching • adequate supervision • Patient flow / safe discharge

3. EVIDENCE-BASED FEEDBACK

J. Wiseman

Power point presentation: Appendix page 29

3.1. Key messages from large group discussion

- Ensure that **verbal** feedback matches **written** feedback
- Make time for feedback; quiet space; one-on-one
- Clearer expectations for faculty and residents regarding the process of feedback; core PD and RTC need to communicate and be more present on the units, especially with learners in difficulty, what are the standards?
- Trainees need to recognize difference between mistreatment and negative feedback
- Trainee orientation to feedback; do they see it as an opportunity?
- Relationship building important to giving feedback
- In the moment feedback or direct observation feedback is challenging; do we have time?
- New GIM faculty should receive face to face & written orientation for busy clinical services such as CTU and GIMCS in ED as to best practices to giving feedback in these units
- Start of rotation orientation meeting with learners
- For faculty on giving feedback: online / flipped modules on clinical education skills with face to face chat = most important component
- Teaching workshop expected within ± years for new faculty
- Lessons learned from the recent accreditation experience
- Think tank for clinical environment
- What will be the approaches used by the Dean for the accreditation office and PGME office?
- Written summary of our retreat actions and proposed directions to date
- What do the residents need to know about mistreatment and roles of PGME and clinical educators?
- Teach residents about their roles and responsibilities
- Feedback Officer: We need to know what is wrong and what we can do about vague non-actionable feedback messages given at the last minute
- Need to change how we do or are forced to do GIMCS + ICU
- Improving communication among:
    - Front-line clinician educators
    - DPS Office
    - PGME coordinators and leaders
    - Residents
- Who are the faces, representatives / team to get this done?
- How to repair broken trust between educators and leaners?
- Involve hospital leadership re clinical practice environment
- Silence is hurting us
- How to prioritize what are the high-impact actions to take?
- How to create fair, congruent, compounded assessment narratives from different preceptors?
    - Rotation assessment coordinator?
- How to communicate action plans with GIM colleagues who did not attend the retreat?

4. HEALTHY CLINICAL ENVIRONMENT FOR ALL

This session consisted of two small group discussions moderated by Drs. Maral Koolian and Emily McDonald. The groups discussed obstacles to an optimal clinical work environment and proposed solutions for trainees and faculty.

4.1. Overall challenges and obstacles to a healthy clinical environment

TRAINEES		
-Distractions/spectra-link burnout -Time -Roles on team	-Different staff expectations -Expectations and alignment -Prior conceptions labeling -Career effects -Time to teach	**T**
		R
ATTENDINGS		
-Work-life balance -Multitasking -Distraction/interruptions -Role of coach / assessor	-Our safety -Career effects -Time to teach	**U**
PATIENT SAFETY		**S**
-Time: limits, pressure, performance metric		
-Acuity, undifferentiated patients		
-Long patient lists in ED; pressure to admit		
		T
PROFESSIONALISM		
-Role modeling- “being perfect” -Feeling “unsafe” -Hungry, thirsty, tired -Inter-professional relationships	“I don’t get no respect”	
PHYSICAL ENVIRONMENT		
-Distraction -Learning new systems -Lack of private space		
SYSTEM		
-Goals not aligned		
-Institutional factors – talking to each other		

4.2 Solutions to optimizing the clinical environment

TRAINEES	
• Rotate spectra link phone daily • Do like orthopaedics and let locating know that during morning review and afternoon sign-out internal med in the ED is not available • Turn the phone off during sign in /sign out (protected time for sign in/sign out); advise ER docs/nurses that phones are off during this time. • Page overhead if emergency	• Team based admitting • Designate teaching and feedback explicitly (e.g. case review vs. didactic vs. bedside) • Set teaching expectations at start of rotation and restate during rotation • Set a specific time at beside for teaching (Early in AM is best) • Residency program leadership present on teaching units
ATTENDINGS	
• Set time for physical wellness • Practice mindfulness • Set admin/secretary expectations (e.g. unavailable to answer urgent emails) • Define time to start and to end workday (there will be unfinished work) • Clear schedule of all other non-essential responsibilities during a service well • Create and make use of backup system (formal and informal) including colleagues and other staff (e.g. NP) • Split work weeks and overnight call	• Know trainees • Know trainee work agenda and trainee expectations on day 1 • Outline expectations (e.g. how long to complete consult; time allocated for case presentation) • Inform residents of time to consult expectations in the ED as per gov't rules • Be present; cancel clinics • Seek feedback • Seek backup from colleague to do teaching
PATIENT SAFETY	
• Daily "mini pause" debrief • Sicker patients to more senior trainees • Protect sign out	
PROFESSIONALISM	
• Seek help from colleagues • Workload sharing • Back-up schedule • Strengthen relationship with ED	• Avoid confrontation in front of trainees • "Neutral" email asking for help-sent by division director to all members when critical number reached in ED for example
PHYSICAL ENVIRONMENT	
• Privacy for feedback • Reserved space for team meetings/sign in/sign out •	
SYSTEM	
• Regular interaction with leadership re issues (CTU head, ER head, DOM Chief). • Perhaps an end-of-rotation debriefing re systems issues (residents + staff)	• Pressure to DOM to have extra support in CLE (back-up, NP support, increase HHR, etc.)

4.3. Challenges and solutions specific to GIM ED consult service

4.3.1 Safe/ healthy learning environment for trainees

a. Challenge: the spectra link!
   - Do like orthopaedics and let locating know that during morning review and afternoon sign-out internal medicine in the ED is not available
   - Turn the phone off during sign in /sign out if you are in an easy to access part of the ED (protected time for sign in/sign out); also relates to patient safety. Advise ER docs/nurses that phones are off during this time.

b. Challenge: lengthy morning sign-over
   - Prioritize reviewing new consults then addressing quickly whether any issues or not on other patients on list.
   - Minimize interruptions as above, ensure overnight resident not carrying phone, go to the bedside of "sicker" patients only to minimize travelling
   - Distribute and delegate any pending tasks to other team members/yourself

c. Challenge: time for teaching/availability
   - Set clear times
   - Orientation on day 1 with expectations made explicit
   - Designate all teaching and feedback activities as such explicitly (e.g.: case review vs didactic vs. bedside vs. role modeling)
   - Set teaching expectations at outset of rotation and restate during rotation
   - Set a specific time at bedside (e.g.: start at 8am and end when time for Multi rounds - can integrate into case review/EPA

4.3.2 Safe/ healthy working environment for staff physicians

a. Challenge: maintaining a healthy work-life balance while being on call 24/7 for several days in a row
   - Ask a colleague to cover pages for a short period of time to "unplug" one evening
   - Schedule regular exercise even if just 30 minutes a day
   - Schedule an outing with partner/friends
   - Wellness activities

4.3.3 Matters related to patient safety

a. Challenge: multiple complex patients that you may not know very well who are acutely ill and may be managed by junior trainees
   - Make a plan with the senior resident and divide up the tasks; make sure sicker patients have a buddy system (example pair a medical student with a junior resident in medicine)
   - Identify and clearly label the sickest patients and make sure the senior members on the team all know a bit about them

b. Challenge: timely bed assignments/discharges from ER requiring rapid reassessments when large number of patients on list
   - Identify bed assignments evening prior/ask overnight (if not overwhelmed) to r/a "stable" patients with bed assignments
   - Identify "back-up" colleague that can focus on reviewing new consults while you do reassessments to allocate more time to each patient

c. Challenge: direct supervision/being available
   - Set a schedule day 1 of the rotation for "appointments" having to do with EPAs

d. Challenge: long list / sick patients with beds to fill
   - Fill beds first--> start with reviewing "longer" hours yourself
   - Set realistic goals with bed flow coordinators (e.g.: set "call-back" time)
   - Set expectations with ED docs re "consult turnaround" time
   - Ask ED docs to consult for cases that NEED admission unequivocally
   - Call in back-up to do teaching/split service**
   - Increase HHR (e.g.: nurse practitioner)

**discussion regarding splitting service and possible disincentive to teach/back-up given discrepancies in remuneration: consider pooling ERC earnings

4.3.4 Professionalism

a. Challenge: disagreement between admitting services/ER physician regarding most appropriate patient pathway
   - Avoid engaging in front of trainees. Discuss with colleague privately
   - Invoke DPS/medecin coordonateur to help resolve conflict
   - Build a stronger alliance with ED
   - Refer to admitting algorithm
   - "Phone a friend"-medecin coordinateur, DPS, colleague for advice
   - Turn off the "I'm losing" mindset/attitude

4.3.5 Physical layout of the teaching and learning environment

a. Challenge: very visible to ER physicians/nurses/subspecialists during sign-in/teaching leading to frequent interruptions
   - Move rounds to a more private setting

4.4. Key priority immediate action items

- Pressure to DOM to have extra support in CLE (back-up, NP support, increase HHR, etc.)
- Set aside time for physical wellness
- Shrink down work week
- "Neutral" email asking for help-sent by division director to all members when critical number reached
- Designate finite time work period (e.g.: leave at 6pm, teaching/rounding from 9am-10)

- "Neutral" email asking for help-sent by division director to all members when critical number reached
- Stating clear expectations related to teaching/workflow at beginning of rotation
- Restructure trainee teams across teaching units

5. PRACTICAL APPROACH TO THE LEARNER IN DIFFICULTY

E. Constantin

Power point presentation: Appendix page 33

5.1. Key messages from presentation and large group discussion

- Importance of direct observation and feedback to the learner in difficulty
- S.O.A.P acronym: from symptoms to an educational diagnosis to determining intervention plan that may include small educational strategies to a more involved remediation plan (FLEX: focused learning experience)
- The McGill PGME FLEX stats were presented; less than 10% of all PGME trainees on FLEX
- Importance of documenting
- Importance of **not** feeding forward; high risk for trainee successfully appealing evaluation
- Importance of a summary evaluation; consider assigning one person to complete a summary trainee evaluation at the end of the rotation for rotations where there are many evaluators (e.g. GIMCS; CTU) and that the role be rotated among faculty every few months.

CanMEDS Role Most affected	Educational Diagnosis	Educational Strategies	Evaluation Strategies
Med. Expert Communication Manager	Lack of exposure Poor knowledge Wellness Knowledge gps Clinical judgment Difficulty expressing Time mgmt. / priorities Knowledge gap - clinical judgment Can't write / can't synthesize Time management	Reading Reading plan with simulated cases Change rotations Reading plan: test reading with real –life simulation	Guided reading Simulated cases/real cases Review consults Real life reviews Real cases Real-life simulation Assessment tools

CONCLUSION

The day ended with a wrap-up session moderated by Drs Snell, Wiseman and Tagalakis. Dr Elizov was unable to attend so it was decided that her session on Peer Coaching for Excellence would be re-scheduled as a divisional session in the near future.

During the wrap-up discussions, members expressed that it is important, and would be extremely helpful, for the Faculty of Medicine-Deanery and/or Department of Medicine to communicate with its teaching faculty the findings of the accreditation final report and what the Deanery considered most problematic with the core program and the clinical learning environment, and to provide ongoing communication regarding the next steps, with a proposed timeline for prioritized deliverables. Some members hoped that all Divisions – not just GIM – were addressing the clinical learning environment. All members of the Department of Medicine need to be engaged to resolve these issues in the core program. It was emphasized that, at the Department of Medicine retreat in September, there was a call for all Divisions to address the clinical learning environment. The next step for the GIM Division is to circulate this report of the GIM retreat's proceedings to all GIM Division members and to the Department of Medicine, the office of the DPS, and the Postgraduate Medicine office. Thereafter, Division members and key stakeholders on the clinical learning environment will be invited to a working group that will review the report and provide recommendations in the development, implementation and sustainability of prioritized strategies to improve the environment for trainee learning, faculty teaching and well-being, and promotion of best patient-care practices.