Resigned Professionalism? Non-Acute Inpatients and Resident Education

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Non-Acute Patients

- Those perceived to have needs which could be met in a non-acute setting
- Awaiting transfer
- Most common presenting diagnoses: COPD, CHF, UTI, dementia, stroke

CIHI, 2009; Costa & Hirdes, 2010
Context: Non-Acute Patients

- Significant part of the acute care population:
  - 13% of hospital days each year
  - 5% of all hospital beds

- This will only continue to increase:
  - Aging population
  - ↑ life expectancy

CIHI, 2009; 2010; 2011
Non-Acute Patients Influence on Resident Education

• What is that influence?
• What are residents learning (according to residents)?
• What are residents learning (according to attending physicians)?

Do Non-Acute patients provide learning opportunities around CanMeds roles of Advocacy? Communication?
Methods

- Constructivist Grounded Theory
- Homogeneous focus groups + interviews until theoretical saturation
- Semi-structured interview guide tested and refined.
  - Questions asked broadly about learning experiences and impact of non-acute patients

Charmaz, 2006
Homogeneous Focus Groups + Interviews

Faculty

- Internal Medicine 4
- Internal Medicine 6
- Mixed: IM (3) + Neuro (1)
- Neurology 5

Residents

- Internal Medicine 5
- Neurology 3
- Internal Medicine 2
- 1
Findings

1. Tone of Resigned Professionalism
2. Identification of Learning Opportunities
Findings

1. Typically: tone of “Resigned Professionalism”
   • N-A pts not interesting, not educational, don’t require medical expertise

   BUT
   • Commitment to meeting the standard of care
   • Diligent disinterest
I think the main reason it [N-A patients] is frustrating is because we enjoy the medical side of our practice, this is where we learn. When we start doing other stuff like arranging nursing homes, family meetings, arranging with ... [trails off] We are not getting any information from that, we are just doing social services.

IM Resident
These patients are busy work. Busy work that nobody wants to do. Most staff people are not interested in doing the busy work and so any way we can avoid doing the busy work - that’s the message we give. We don’t value the work that they [residents] do, it’s just added work.

Internist
We don’t have learning objectives for these patients. If you said ‘this is going to be your opportunity to have interaction with family about level of care’, if it was a stated thing you had to get checked off on your score card, they might see a value to it.

Neurologist
Findings

2. Divide in identification of learning opportunities:
   • Residents: only very basic learning
   • (Some) Attendings: more complex learning
Learning Opportunities Identified by Residents

There is only so much you can learn about treating a urinary tract infection.

Neurology Resident
Learning Opportunities Identified by Some Attendings

- Non-Acute patients are a chance to learn:
  - Symptom management
  - About the progression or cycle of an illness
  - How to transition patients and families
  - How to provide psychosocial care
  - To treat the whole person, not just the episode
  - How to work with a patient group who will be a significant part of independent practice
Discussion

Results show residents engaging with non-acute patients as *professionals*, but not as *learners*.

- Why might this be?
Limitations of Focus Groups

- Social desirability bias may suppress discrepant opinions in focus groups.
  - Tone of Resigned Professionalism
  - Absence of ‘disavowed’ opinions

Elmes & Gemmill, 1990; Kitzinger 1995; Ginsburg et al 2003
Billett’s Workplace Affordance Theory

- Sociocultural approach to learning through participation.

- Learning requires both:
  - Workplace affordances
  - Engagement with those affordances

Workplace Affordances:

- The degree to which individuals are granted access to opportunities for learning and participation at work (formal and informal).
Engagement

- Requires agency-individual’s choice to engage.

- Choice to engage related to understanding of role, workplace, requirements of occupation + applicability of affordances.
• Billett: learning cannot occur if learners choose not to engage with affordances.
  • Even if non-acute patients afford the opportunity to learn and practice advocacy, communication, symptom management etc., learners must choose to engage

• What factors may affect the decision of whether or not to engage?
Cultural Influences on Individual Engagement

- Individuals engaged simultaneously with multiple cultures.
  - E.g. institution-specific, professional, societal.

- Cultures signal to an individual what is interesting, important, necessary, appropriate etc.
Why aren’t residents engaging as learners?

- Cultural Influences Suggested by Results:
  - Institutional level affordances around time, balance between teaching/learning/care
  - Learning values espoused by formal curricula (internal and external)
  - Professional culture emphasis on “Expert” role eclipses other types of learning
  - Clear distinction between jurisdiction of different HCP
If we want residents to engage as learners...

- Creating a culture in the learning environment which encourages individual engagement:
  - Re-constructing role of physician in relation to N-A patient care.
  - Re-constructing N-A patient needs in terms of what specialty can provide.
  - Value expertise in this area as much as expertise in other areas.
Conclusion

- Attention to the cultural influences of the learning environment may assist residents to recognize and take advantage of learning opportunities.
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