

ARTICLES

Ten-minute snapshots – a team approach to teaching postgraduates about professional dilemmas

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Abstract

As medical professionals, most of us face professional dilemmas that catch us unawares and are not discussed in medical training. One often learns about these dilemmas on one's own and deals with them with a common sense approach, rather than reflection. The professional dilemmas may concern receiving gifts from patients, handling issues of confidentiality or dealing with personal questions. There is seldom any formal instruction in competencies related to professionalism, especially in India. We adopted a team approach to provide training in these issues to postgraduate trainees in mental health and to engage them in discussion, using team feedback on snapshots of real-life professional situations, which were simulated through role play. We found that the trainees felt that these methods were acceptable and to their liking. However, a more formal method of assessing how this approach actually influences day-to-day practice must be evolved.

Introduction

Who among us has not accepted a box of sweets or a pen from a patient with reluctance, not knowing how to refuse without hurting the patient's feelings? Dilemmas, ranging from the simple such as this one, to the more serious, such as those related to confidentiality, are professional potholes that we all learn to anticipate and in most cases, circumvent with experience.

However, one often learns on one's own, without guidance or teaching. The barriers to learning how to handle professional dilemmas are many. They include the fact that such situations occur infrequently, they catch one unawares, one's peers and teachers do not talk about them and one often tends to brush

them under the carpet. The main barrier, of course, is that there is seldom any formal instruction in competencies related to professionalism, especially in India (1).

The Working Party on Medical Professionalism of the Royal College of Physicians of London has defined medical professionalism as a set of values, behaviours and relationships that underpin the trust of the public in doctors. The values identified as being of particular importance are integrity, compassion, altruism, continuous improvement, excellence and working in partnership with other members of the healthcare team. The working party suggests that these values should form the basis for a new moral contract between the profession and society (2). In its Graduate Medical Regulations, the Medical Council of India says, "Medical graduates should have personal characteristics and attitudes required for professional life such as personal integrity, sense of responsibility and dependability and ability to relate to or show concern for other individuals. "Traditionally, professionalism was learnt through role modelling and an institutional culture. However, in recent years, there has been a call for teaching professionalism as part of competency training, in a way that is experiential and involves reflection (4–6).

Postgraduate trainees are at the threshold of a career as consultants and may become teachers and future role models. It is hence imperative that their training should include instruction in the quality of altruism, the need to respect the patient's dignity and confidentiality, the need to be aware of boundaries and the importance of working as a team.

Experiential learning involves real-life or simulated situations that challenge one's concepts, make one question one's inner feelings, motives and thoughts, and lead to a deeper understanding. Clinical experience is, of course, the most powerful teacher because it is real and has immediate relevance. However, this may not be feasible in all situations. For example, some situations occur rarely in a professional's life but may be of paramount importance in a doctor–patient relationship. Simulated situations are thus an important way of learning (7).

Most experts view reflection as a key component of the process of developing professionalism. Reflection has been described as "those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation" (8,9).

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In addition to being a powerful learning tool, reflection in practice is regarded as an essential element of professional competence and, therefore, must be addressed in postgraduate training (7).

Reflective learning involves learning through questioning, investigating, evaluating, analysing, seeking feedback, and incorporating the ideas and viewpoints of team members (1,9). While ideally, this should happen during ward rounds, outpatient discussions and case conferences, often the preoccupation in these situations is with diagnosis and treatment, and little time is spent on encouraging reflective practice.

Therefore, it is necessary to fix a scheduled time for teaching professionalism, an activity that should take place in a safe and nurturing environment. Changes in the way medicine is practised in most situations add a new dimension to this issue. While there are still a few doctors who have a private practice, the majority work with nurses, social workers, technicians and other support staff. It is hence important for each team member to understand and participate in the reflective exercise.

When professional competencies are accompanied by reflection in a safe and nurturing atmosphere within a multidisciplinary team, a culture of group learning is fostered. The trainee then explores the several hues and dimensions of a problem, thus creating a repertoire of views and ideas that nurture reflective learning further.

The ability to reflect can be learnt with practice, and is effective when learnt in the presence of one's peers and in small groups. Reflective thinking is promoted when teachers and mentors share their own experiences with a group (8).

It is important to learn to manage professionally challenging situations in most branches of medicine, but it is particularly important in the case of mental health and psychiatry. This is because patients may develop transference towards the therapist that might take the form of giving gifts or attempting to get to know the doctor personally. Transference is a process in which individuals displace patterns of behaviour that originated during their interaction with significant figures in childhood onto other persons in their present lives, and is known to be a powerful determinant of their behaviour in medical encounters (10). Patients may reveal extremely personal or intimate details, and the doctor must make sure that he/she maintains their confidentiality. Patients should be guaranteed privacy and given uninterrupted time to speak. However, most of the situations described below are common to all medical practice.

Our methodology for teaching professional skills was developed on the basis of our past experience in teaching communication and patient educational skills, using an Objective Structured Clinical Assessment and Feedback (OSCAF) format (11). The OSCAF format is adapted from the *objective structured clinical examination (OSCE)*, but instead

of assessment, it is used for training, with feedback on brief, simulated case scenarios enacted by trainees.

We adapted this method to make it less structured and even more brief. The method involves simulated scenarios using role play, multidisciplinary team feedback, reflection by the team and those playing roles, and experiential disclosure by teachers. This is done through "ten-minute snapshots" of day-to-day events in the professional life of a trainee in an outpatient or inpatient setting.

Selecting common professional potholes

Initially, a team of trainees had a brainstorming session on the common scenarios they found difficult to handle. Important scenarios were selected from among these. They included common professional challenges that trainees might face in their day-to-day practice, such as those involving confidentiality, being presented with gifts, boundary violations by patients or their relatives in the form of personal questions, patients' attempts to develop a personal relationship with the health professional, managing interruptions in the clinic and violations of privacy. Some of the other scenarios pertained to explaining medical errors and handling bullying by a senior when it happens in front of patients.

The following are a few examples of simulated situations and the instructions given to the trainees.

1. *Handling interruptions and intrusions when talking to a patient*

Instructions to the trainee – You are in a busy outpatient clinic with your patient, who is disclosing a very personal matter and is quite emotional. Please handle the situation.

Instructions to the trainee playing the patient's role – You are a newly married young man and have found that you have a sexual dysfunction. You are upset about this and embarrassed as well. With great difficulty, you manage to open up to the junior doctor before you. You appear anxious and worried.

Instructions to the trainee playing the colleague's role – Your colleague, a junior resident, is talking to a patient in the outpatient department. You need the investigations of another patient urgently. You enter the room without knocking and start talking to your colleague about it, oblivious to the situation.

2. *Confidentiality*

Task for the trainee – You are in the outpatient clinic when a young man tells you that he wants to talk to you. He says he is the fiancé of your patient, who suffers from bipolar disorder.

Instructions to the trainee playing the fiancée's role – You are a 29-year-old man who plans to marry a woman who has told you that she has bipolar disorder. You want to know about her illness in greater detail before getting married to her. You have come to the outpatient clinic alone, without

the knowledge of your fiancée, to talk to her doctor and get more information on her mental health problem.

The following are some other scenarios that can be converted to the teaching format.

3. Personal questions

Task for the trainee – You are in the outpatient clinic when a patient of yours starts asking you personal questions.

Instructions to the trainee playing the patient's role – You are a 30-year-old man under the treatment of a woman health professional. She speaks your language and you know she is a trainee. You want to get to know her as a person and maybe even take the relationship further. Just before leaving the room after a follow-up visit, you ask her whether she is married, where her home town is and if you can meet her as a patient even after she finishes her course.

4. Being given gifts

Task for the trainee – You meet your patient and her husband during a follow-up visit after she has been discharged from the hospital. They are very satisfied with your care and thank you.

Instructions to the trainee playing the patient's role – You are a young woman. Following your discharge from hospital, your husband and you, who are very satisfied with the care you received from the health professional, have brought her some gifts. You really like the doctor, and have seen her Facebook page and discovered that she likes dark chocolate. During the follow-up visit, you take a pack of imported chocolates for her. You insist that she take it, otherwise your feelings will be hurt. When she refuses, you feel upset and leave the chocolates on her table before saying goodbye.

5. Bullying within the team in front of a patient

Task for the trainees – You are a group of trainees who are taking rounds with your senior resident. One of your colleagues is being reprimanded for not performing a task properly.

Instructions to the trainee playing the senior resident's role – You are a senior resident taking rounds with a multidisciplinary team and come across a patient and his family. You are in a bad mood and start questioning the junior resident in a rude manner. When she is unable to answer your questions, you make sarcastic comments about her gender and intellect. She feels these questions were inappropriate to the context, and feels bullied in front of the team and her patient.

This snapshot focuses on the response of the other team members when a colleague is being bullied and how the trainee herself handles the bullying.

6. Invitation to a party by a patient

Task for the trainee – A patient who has been under your treatment for many years is hosting a party.

Instructions to the trainee playing the patient's role – This doctor has treated you for a chronic condition for many years. You are having a dinner party for all your well-wishers and you feel that this doctor is one of the most important persons in your life. You request her to attend the dinner, which will be held at a beautiful venue known for its ambience. In a casual conversation during an earlier visit, the doctor had mentioned that she had not visited this resort, but would love to.

7. Explaining a medical error to the patient or relative

Task for the trainee – Your patient complains that he has developed a severe skin rash after your last prescription. You check his last outpatient prescription, which has been written and signed by you, and find that you have made a mistake. Talk to the patient about the situation.

Instructions to the trainee playing the patient's role – You were supposed to be prescribed Tab Chlorpromazine 200 mg for your illness. However, after your last visit to the doctor last week, you developed a severe skin rash and allergy, for which you were almost hospitalised. You still have a rash. After reading the prescription, the junior doctor tells you that he prescribed Tab Carbamazepine by mistake, using the wrong abbreviation (CBZ instead of CPZ).

Procedure of the session

The trainee who plays the role of the patient/relative is given a standard brief about the situation. The vignettes for each snapshot are standard and provided in a written format. The trainee playing the role of the doctor/professional, however, is given basic information on the patient and told only what is necessary, such as, "A patient named Ms S or Mr R has come to see you for follow-up." This is done to simulate the situation in such a way that the event takes place out of the blue, catching the healthcare professional unawares. The idea is to ensure that the snapshots simulate real-life situations that the trainee may face.

The team has 10–12 members, and includes members from psychiatry, clinical psychology, psychiatric social work and often, a psychiatric nurse. Both trainees and consultants participate, with the trainees being given more time to reflect and discuss their thoughts. A senior resident moderates the discussion. Each role play takes no more than 8–10 minutes as it is meant to provide only a snapshot of the challenging professional situation. The role play is followed by a discussion lasting nearly 20 minutes. All the trainees are requested to share their feelings and briefly describe any similar experience they have had. At the end of the trainees' reflections, two consultants discuss the matter further and also share any past experience they may have had of a similar situation. The trainees who participate in these sessions are posted to our clinical unit for an average period of three months, within which time they are able to cover at least 10 such snapshots.

Following the simulation of a situation, the facilitator asks all the trainees in the group to answer questions such as: what

the challenge was, why it was a dilemma, how it was handled, what else could have been done, how they would have handled it, and how difficult it is to handle this situation. The group is encouraged to reflect on the grey areas.

For example, in the case of being offered gifts, some of the trainees' comments were: "What if you hurt the patient?" and "I felt very proud when my patient gave me a gift—it was important for my self-worth – so I would accept it." One trainee even said that he had seen a consultant displaying the gifts that patients had given him, and that this had made him think of it as a way of validating a doctor.

After the team has finished commenting and reflecting, the role player who portrayed the patient/relative is asked to discuss how he/she felt and finally, the trainee who played the doctor is encouraged to talk about his/her dilemma, the feelings that went through his/her mind and what he/she had learnt. Finally, the teachers give a feedback that is often related to their own experiences. They speak about the impact of the professional's behaviour and attitude in these situations on subsequent doctor–patient relationships. The discussion also focuses on how the trainees can generalise what they have learnt and whether the type of practice (institutional or private) makes a difference.

One session is held once a week, at the end of teaching hours, with the aim of covering at least eight scenarios during a clinical posting.

Lessons learnt from "Ten-minute snapshots in a team" methodology and suggestions for further use

An important aspect of this methodology is that the trainees should feel safe so that they can discuss their deepest concerns and be honest about how they feel. The group should provide a safe and non-judgmental space which encourages better reflection, sharing and learning from peers.

Getting feedback from a multidisciplinary team brings different perspectives into play and underscores the fact that not just the doctor, but the whole team must take professionalism seriously. For example, different aspects of the same situation are brought out in a snapshot in which a prospective spouse seeks information on his fiancée's mental health condition without her explicit consent, with the psychiatrist focusing more on how disclosure or non-disclosure could affect the patient's adherence to treatment; the social worker discussing the social and legal impact of disclosing the information, and the possibility of the engagement being broken; and the clinical psychologist focusing on the patient's emotions and thoughts when her fiancé brings up these issues during a consultation. Thus, the trainees become aware of more than one perspective. Feedback from the trainee who plays the patient's role gives the trainees a more subjective perspective as well.

Each trainee must be given a chance to speak and also, encouraged to share any similar experience he/she has been

through during training. This helps in analysing the thoughts and feelings behind their actions (even if they were not the most appropriate). The trainees must feel free to talk without fear of censure.

The role of the facilitator is important. He/she should avoid asking leading questions, as Socratic questioning works better. For example, he/she could ask questions such as, "What would happen if you did take the gift?"; "What are the implications for your future contact with the patient?"; and, "What message does it send out to other patients?"

We have been using this method for three years, during which we have conducted about 80–90 sessions. We have found that this interactive teaching method is acceptable and is a quick way of getting trainees to reflect on important areas that they might face in their day-to-day practice. The sessions are light, though they often deal with serious issues. They also help to dispel misconceptions in a way that is more palatable than receiving instruction which is didactic or patronising. Moreover, the scenarios are culture-specific in that they account for the nuances of the social contract between the health professional and patient in the Indian context. Thus, factors such as limited time, crowded outpatient clinics and the perception of the doctor as a guide in many aspects of life are kept in mind.

Even though teaching of professionalism is extremely important, it has not kept pace with other pedagogical advances. The literature in this area, which is sparse, includes examples from communication skills in oncology and boundary issues in psychiatry (12–14). Several other methods have used an OSCE format and more recently, virtual platforms have been used to simulate encounters with patients (15,16). However, all these are for medical undergraduates and there is no research or literature on the training of postgraduates in professionalism or on the use of multidisciplinary approaches. Though our experience has been limited to postgraduate mental health trainees, the methodology can be adapted to any other postgraduate specialty.

While the experience of using the snapshot format has been helpful and acceptable to trainees and trainers, we recommend that this exercise be followed by discussions on professionalism at any given opportunity. These could take place on rounds, in outpatient settings, or during any other encounter with patients. Previous research in the area has found that there is often a disconnect between what is taught and what trainees see around themselves. Faculty members need to be role models and also, have the ability to raise these issues with students if they find something amiss (17). For this, it is important to train the faculty in flagging professional issues and giving useful feedback. Finally, while academic prowess is associated with incentives in the form of marks and medals, there are no prizes for professionalism. It has been recommended that ethical conduct and professionalism be evaluated and become a part of the 360 degree evaluation of students.

Conclusion

Instruction in professionalism is an important part of training in medicine. Professionalism is mostly learnt from role models or with experience, but it is necessary to evolve and assess formal teaching methods that are context - and culture-specific. The importance of cultural factors in training in professionalism has been emphasised (6).

We have described one method that uses role play, followed by feedback from peers and supervisors who are a part of a multidisciplinary team. There is a need to assess how this method compares with other ways of teaching similar professional skills. Among the other methods that have been used are clinical contact, including feedback from tutors; bedside teaching; educational portfolios; videotaped consultation analysis; significant event analysis; humanities writing and reading poetry related to doctors and patients; and mentoring programmes. A systematic review of the topic did not find any differences in the way these programmes enhanced professional skills, mainly due to the paucity of adequate assessment methods (18). We are also not sure whether what the trainee learns in the sessions actually translates into practice. Any evaluation will have to rely only on subjective reports or simulated situations. This training methodology can be evaluated in two ways. One is by assessing the extent to which the perceptiveness of the trainees and the discussions among them become more mature over several sessions. The second is by asking the trainees for written feedback on what they have learnt and how they would handle a similar situation. Finally, the best but most difficult method of evaluation is to see if the trainees handle their day-to-day dilemmas more professionally and ethically in the future. This is possible only through direct observation and by obtaining feedback from patients.

Undoubtedly, there has to be a professional way of dealing with professional dilemmas and the snapshot method is one step towards achieving this goal.

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