Teaching and learning in the clinical workplace

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ABSTRACT

Participation in clinical practice is key to the development of clinical skills, and so the goal of clinical work is both to deliver healthcare and facilitate learning. Four factors shape learning in the workplace: safe access to practical experience; the role of talk in the workplace; teaching opportunities; and the learning climate. The challenge is to structure and carry out work so that support for learning is built into normal work routines.

Key words: clinical workplace, learning, teaching, education

INTRODUCTION

Healthcare professionals learn and refine their practice in the clinical workplace. This means that the goal of clinical work is both to deliver healthcare and to facilitate learning. 'Learners' may be students, present in the workplace for a limited time, or qualified clinicians, with a job to do but with much still to learn. This article discusses how to optimise learning within the workplace, whilst meeting the demands of clinical care.

INTEGRATING WORK AND LEARNING

In classroom teaching, the focus is entirely on learning. In the workplace, the focus is on clinical care. Yet because clinical care provides the basis for learning, the needs of patients and of learners must both be accommodated. It is important

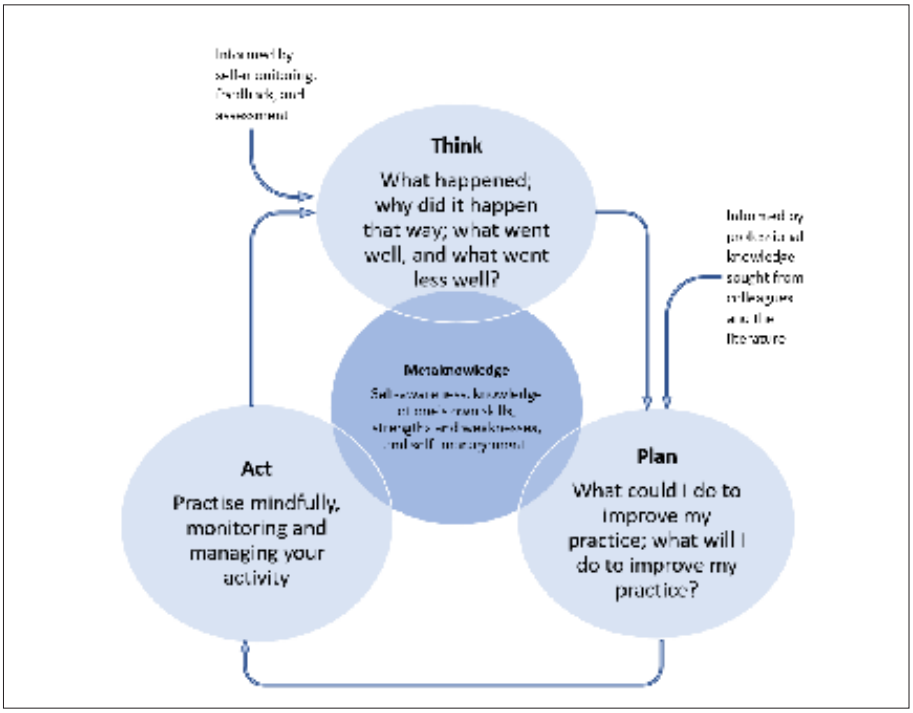

Figure 1. A process of learning from experience

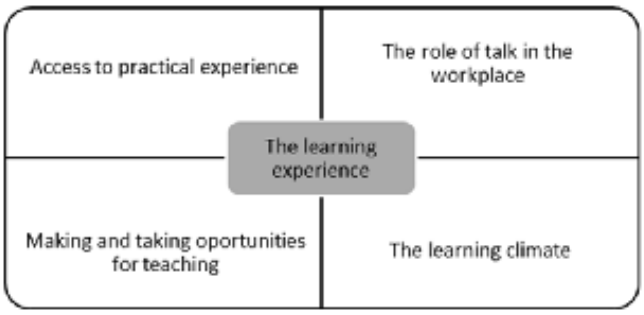

Figure 2. Four factors shaping learning in the workplace

that learners are accepted as learners, as well as part of the clinical team. Their role is to work and to learn, and so they should approach work as active participants in a process of learning from experience (Figure 1).

The challenge for the wider clinical team is to structure and carry out work in a way that supports this learning process, so that support for learning is built into normal work routines. Figure 2 identifies four inter-related factors that shape learning in the workplace.

ACCESS TO PRACTICAL EXPERIENCE

By expanding their participation in clinical work, learners develop their ability across the eight trajectories[1] shown in Figure 3. How work is allocated and supervised is key to supporting their learning through safe participation in clinical practice. It is important that supervisors know where the boundaries lie for each learner, between needing and not needing help.

A learner may be allocated work that they can do without help. This is productive, and it releases senior staff to their own tasks. It offers the learner some limited autonomy to exercise their clinical skills, but is unlikely to support development beyond their current competence. To develop further requires them to take on more challenging tasks, which require help, provided by supervision and other forms of 'scaffolding'.[2]

Scaffolding enables safe working. It includes, for example, placing limits on what a learner can do, giving instruction on when and how to ask for help, providing advice, showing how, or ensuring the presence of a more knowledgeable colleague. When allocating work, then, the supervisor has to know the learner's ability, their learning needs, and the availability of appropriate scaffolding.

Learners may need close supervision: the 'hands-on' presence of a more experienced clinician, working directly with the learner. On other occasions supervision may be required in a more general role of checking and advising, or it may mean being available to the learner if they need to call for help. This last option requires the supervisor to be confident that the learner will recognise when they need help. Asking for help requires learners to exercise 'metaknowledge', situational awareness and knowledge of their own abilities (see Figure 1). Learners' must also trust that a call for help will be dealt with constructively. Their previous experience of asking for help may affect their willingness to ask in the future.

THE ROLE OF TALK IN THE WORKPLACE

Routine talk between team members in the workplace has several functions, including a social function, a team management function, and a performance function.[3] Each is significant to the development of the 'community of practice' [4], within which learning takes place.

Including learners in social talk helps confirm their acceptance within the community. Excluding them from social talk can isolate learners from the team and affect how they participate in the work of the team.

The team management function concerns organising the team to get the job done. It includes what tasks need be done, their allocation, and the provision of supervision. This is central to shaping the learner's clinical experience: their participation in clinical work, their understanding of their job role, and their place in the team.

Performance talk concerns standards of work and how they can be improved. At its simplest, performance talk offers 'normative' feedback[5] to the learner: on the spot, task-based feedback about how things ought to be, what is OK and what is not OK. Performance talk also allows opportunities for questions, sharing experiences, perspectives and clinical reasoning. Talk of 'How?' and 'Why?' brings us close to the point of teaching: the point where we intentionally invest time and effort in the learner as a learner, rather than as a worker. It may lead to extended feedback, teaching that goes beyond the task in hand, and the identification of learning objectives.

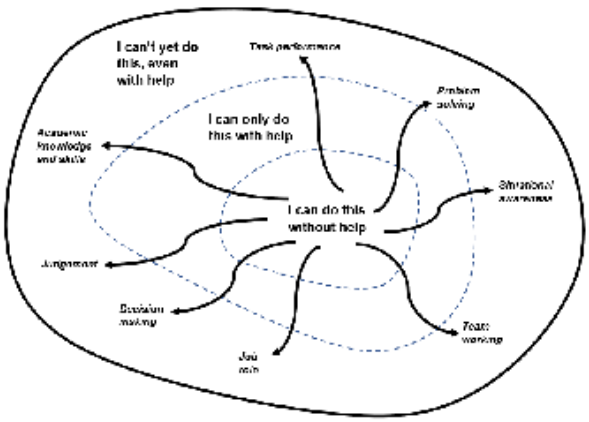

Figure 3. Developing clinical ability

Extended feedback

Extended feedback is a conversation with the learner that describes, explains, and evaluates performance, identifying learning needs and how to meet them. It is intended to inform, motivate and direct improvement. Its routine use demonstrates and reinforces the habit of learning from experience.

The normal courtesies and expectations of communication are culturally shaped, and so the various models developed in, say, European contexts may need to be adapted to different cultures. However, it seems important to be specific, rational, to focus on observable elements of practice and their consequences, to acknowledge effective as well as less effective performance, and to maintain the motivation and self-esteem of the learner. A basic model of feedback, known as 'Pendleton's Rules'[6] is summarised here:

1. Ask the learner what they did well
2. Discuss what went well, adding your own observations
3. Ask the learner to say what went less well and what they would do differently next time
4. Discuss what went less well, adding your own observations and recommendations for improvement

MAKING AND TAKING OPPORTUNITIES FOR TEACHING

Workplace conversations that offer feedback, information and advice, and lead to improvement plans, are indistinguishable from teaching. Variables include the breadth and depth of the conversation, and whether the focus remains specific to the case-in-hand, or builds upon the case to teach more general principles.

Workplace teaching opportunities may be planned or unplanned. They may arise in ward rounds, at or near the bedside, and from case briefings/debriefings, which can be extended to case-based small-group teaching sessions. Time is a determining factor, and this is acknowledged in the following three approaches, summarised from Chacko et al,[7] each of which describes a model of workplace teaching. All three approaches have their place in the clinical teacher's toolbox, to be used according to circumstances.

The Traditional Model

The traditional model[7] is a patient centred approach, in which the learner presents the case, and is then questioned in order to clarify the presentation and establish diagnosis and treatment. This may be followed by brief teaching concerning the case-at-hand. It is an efficient way of making clinical decisions, with the participants maintaining their respective roles of novice and expert. It does not prioritise the learner's wider learning needs, offer extended feedback, or explore clinical reasoning in any depth, and so is time-efficient, but this limits its value for learning.

The 'One Minute' Model

The 'One Minute' model[7] entails feedback, teaching, and the identification of improvement objectives. Following the learner's examination of a patient, discussion is based on the case and the learner's knowledge, and so involves the clinical supervisor in thinking about both the patient and the learner:

1. Ask the learner what they think is going on.
2. Ask for their reasons, alternatives, and next steps.
3. Use the case, and what you know about the learner's understanding, to teach a general rule relevant to the case.
4. Acknowledge what the learner did well
5. Correct any errors and make a recommendation for improvement.

The SNAPPS Model

The 'SNAPPS' model[7] is a learner led discussion. The supervisor contributes expertise, building upon and validating the learner's analysis of the clinical case, agreeing a management plan, and advising on a learning goal. This takes more time than the previous models, and is appropriate for more advanced learners:

1. The learner summarises the history and findings.
2. The learner narrows the differential to two or three possibilities, and explains their reasoning.
3. The learner asks the supervisor specific questions to aid their reasoning.
4. The learner offers a management plan, which the supervisor discusses, builds upon, and informs.
5. The learner identifies an issue for their further, self-directed learning, and the supervisor offers guidance.

THE LEARNING CLIMATE

The idea of a 'learning climate' refers to aspects of the workplace that contribute to the learners' feelings of belonging, safety, and support for learning. It is important because it shapes learners' willingness to participate in challenging work, and engage in learning activity.

In the clinical workplace, the over-riding concern is for

Table 1. Applying these ideas to your practice

The aim is to structure and carry out work so that support for learning is built into normal work routines. How will you:

- support learners to be active participants in their own learning (see Fig. 1).
- take account of learning needs when allocating work
- 'scaffold' work to facilitate learners' safe access to clinical practice
- ensure appropriate supervision of learners
- improve your feedback to support learning in the workplace
- make opportunities to use each of the three teaching models described above
- improve learners' feelings of belonging, safety and support, and reduce vulnerability
- become a role model for your junior staff

patients and the task-in-hand. The clinical team will have established ways of doing things, and expectations of their junior staff and students. When a learner joins the clinical team, even for a brief period of time, an early conversation to clarify role expectations, how work is managed, and opportunities and support for learning, can reduce misunderstandings.

Feeling vulnerable in the workplace can affect a learner's 'self efficacy',[8] their confidence to sustain effort and master challenging tasks. Vulnerability can be affected by a range of factors, including workload, the challenge posed by the task, supervision, inter-personal relationships and behaviours, attitudes to learning, and how power is used within the team.

It is unlikely that we can rid the clinical workplace of stress. This is especially true in resource-poor, high workload, and exposed situations. We can, though, support learners by working in ways that reduce their vulnerability in these situations.

Feeling responsible for something beyond your capability is particularly stressful. Isolating learners and exposing them to situations beyond their ability, with insufficient access to support, is a feature of the clinical workplace that we need to work to minimise, and finally eradicate – for the sake of both clinicians and patients.

BECOMING A ROLE MODEL

There is a way in which we can contribute to the learning climate that does not take any additional time. It is by being a role model for clinical practice and continual learning. This is 'teaching by being': by being authentic, by being a capable clinician, by being a learner, and by caring about the learning of team members.

In Table 1, we encourage you to think further about these ideas, discuss them with colleagues, and apply them to your situation as you continue to develop your own teaching repertoire.

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