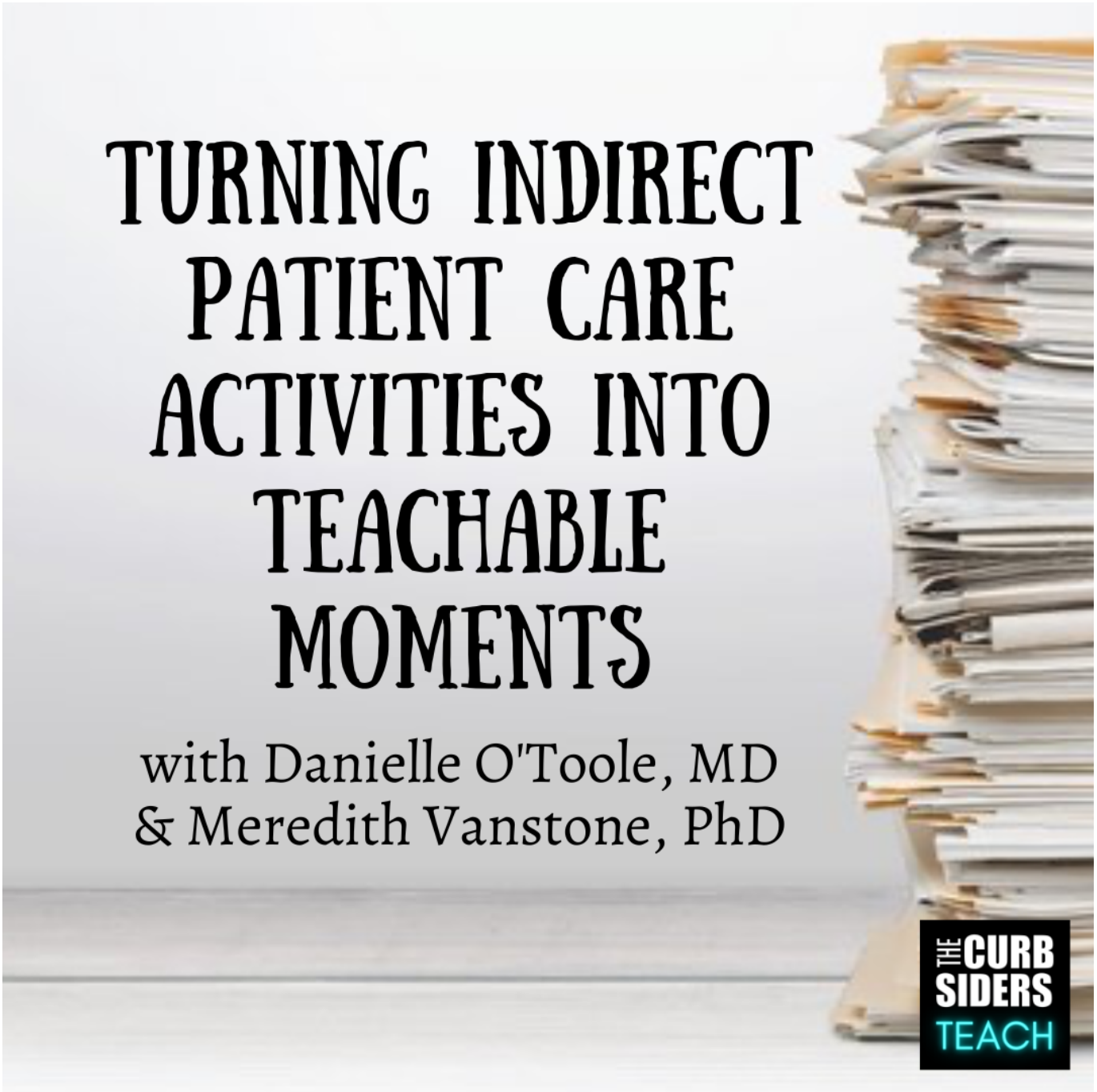
#25 Turning Indirect Patient Care Activities into Teachable Moments



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Molly: Welcome back to The Curbsiders Teach, Season 3, our mini-series on medical education. I'm Dr. Molly Heublein, joined by my cohost, Dr. Era Kryzhanovskaya. And today's episode, we'll discuss best practices for teaching indirect patient care skills with Dr. Meredith Vanstone and Dr. Danielle O'Toole. Before we get started with that, Era, will you remind the audience what we do on our show?

Irina: Sure, Molly. We are *the* Internal Medicine Podcast for all things medical education. We use expert interviews to bring you teaching pearls and practice changing knowledge to inspire the next generation of medical educators. We have an awesome conversation with our guests, Drs. O'Toole and Vanstone tonight. We cover teaching of indirect patient care activities, the implications of how to do that as a practitioner, as an educator, and really just opening our eyes to the value of the IPCAs.

Molly: Meredith Vanstone, PhD, is an associate professor in the Department of Family Medicine at McMaster University in Hamilton, Ontario, Canada. Meredith is a qualitative researcher who is interested in using health policy and health professional education to improve the socially and ethnically challenging aspects of primary care.

Irina: Dr. Danielle O'Toole is an academic family doctor and an assistant professor in the Department of Family Medicine at McMaster University in Hamilton, Ontario, Canada. Dr. O'Toole has a master's in Health Science education and a special interest in medical education, evidence-based medicine, and care of the elderly. This is your reminder that most episodes are available for free CME Credit through VCU Health CE for all health professionals at *curbsiders.vcuhealth.org*. All you have to do is create an account.

Molly: Without further ado,

Irina: Let's get to it.

Molly: Let's get to it. Dr. O'Toole and Dr. Vanstone, thank you so much for joining us. We're really excited to talk to you today. Are you okay with us calling you Danielle and Meredith for this recording?

Danielle: Oh, yeah.

Meredith: Please call.

Molly: Amazing. Well, Danielle, we'll start with you. Could you give us a one liner to describe yourself?

Danielle: Yeah. So, I'm a 37 year old family physician, married for almost 13 years to my high school sweetheart. We've got four little ones and we have found a new addiction to escape rooms in the last couple of months. So, that is what we're spending our spare time doing.

Molly: That sounds amazing. And how about you, Meredith?

Meredith: So, I'm 38 [laughs] if we're sharing our ages. I'm originally from Ottawa, which is the capital of Canada. So, I think that probably your listeners will enjoy listening to our Canadian accents today, for Danielle and I. I always wanted to be a lawyer and then somehow found myself in research, because I just couldn't cope with the idea of precedent and the idea that you might make one decision and that will be the thing that everyone needs to rely on forever. I really love the contextual aspects of thinking through things and the gray areas and navigating that. So, that's, yeah, how I think about things. I don't know. I really wasn't prepared to-- [laughs]

Irina: No, no that was great.

Danielle: Sounds great, yeah.

Irina: I feel like I know you so much more. All right, well, Meredith and Danielle, would you be able to share a book, movie, show, or maybe an album that you have recently enjoyed? Maybe Meredith, do you want to go first?

Meredith: Sure. Yeah. So, I just finished reading Joan Didion's *The Year of Magical Thinking.* This is kind of an older book, but for those who don't know Joan Didion, is a very prolific writer who had a lot of personal tragedy. Her husband died suddenly at the same time as her daughter was in the ICU. And so, she wrote this book about navigating a year of grief and trouble. But it's just so poetic and reflective and I think offers a lot of insights on the human condition and how we cope with struggle.

Molly: That is a really beautiful book. I read it when I was in med school. So, it's been quite a while. But, yeah, a very good one.

Irina: Danielle?

Danielle: I wish I had something as beautiful as that. So, with the four little ones at home, I have to say, most of my books and movies and TV shows are all cartoons. So, this past weekend we saw *Puss in Boots.* It feels like we have *Honey, I Shrunk the Kids* and *Home Alone* nonstop at my house. Most of the reading I've been doing, actually, lately though is around travel stuff, because I have a sabbatical coming up this July, so hoping to do a couple of big trips. So, mostly just figuring out where we want to go.

Irina: Are we able to know where you're going or is it still like one of those, if you tell us you have to kill us things?

Danielle: No. Yeah, so, we're hoping to do two trips, maybe, one to New Zealand, Australia, and the other, we're hoping Japan, maybe. We'll go see some Pokémon stuff.

Molly: [laughs]

Danielle: My kids are really excited about those pieces. So, yeah, we'll see.

Irina: Oh, it's exciting.

Molly: Wonderful. Well, in the interest of time, let's hop right into our topic today. This episode is going to be a little different than our usual Curbsiders Teach episodes, because we're going to be talking about your recent publication from August 2022 in medical education optimizing the educational value of indirect patient care. So, to start us off, I'm curious what led you to explore this topic of indirect patient care and how it relates to medical education.

Danielle: Well, in general, no one really gets into medicine to do paperwork. On top of it, we found that it's a bit of a hidden part of the job. People don't go in anticipating the workload that it's there. So, once they get into the system, it's a bit of a shock to see how much time and how many hours are spent doing this type of work. And so, the indirect patient care activities can really be a significant source of burnout for practicing physicians and residents. We were starting to hear that from our residents. So, not only during accreditation eight years ago did we hear feedback that indirect patient care activities were quite a burden, but on an ongoing basis informally and both formally at some of the tables that we sit at. So, it was something that our residents were actually bringing forward to us.

Molly: Absolutely. Well, when I saw your publication, it really resonated with me because I work with our residents and I'm absolutely hearing the same thing, and also just in my own life, it's a lot. It's a burden.

Meredith: That's what we heard from reviewers too. Our reviewers all identified themselves as physicians who experienced this around their own life and we were really like, "It's not just family medicine, pay attention to our indirect burden too." So, I think it's ubiquitous in the field.

Irina: Totally. And also, a way to take something that's like a pain point and look into it and study it further so we can learn from it, because I feel like that's the way to make those pain points slightly or maybe hopefully a lot less painful. Just to take us back one extra layer, can you define indirect patient care activities or how you all define them in this particular piece?

Danielle: So, usually, when we think about patient care, we think about where we picture a doctor sitting right in front of a patient, face to face, taking a history, doing a physical, discussing management plans. That's often what our med students are envisioning when they join this as a career. But a significant amount of work is actually done outside of the examination room. So, indirect patient care, so patient care that's not directly in front of the patient includes things like documentations, dictations, billing, filling out requisitions, consults, and family medicine-prevention reminders, updating the chart, filling out forms, managing the investigations that were ordered, or filling prescriptions. So, all the components are required to provide patient care, but without that patient directly in front of you.

Molly: What's the history surrounding indirect patient care activities and why do you think we're starting to talk more about this now?

Danielle: So, there's always been some form of indirect patient care in medicine. But unfortunately, that workload really seems to be increasing exponentially in the last decade or so. When we were doing a bit of a literature dive, we found three components that are really exacerbating the volume of indirect patient care. So, the first was the adoption of the electronic medical record. So, we know that the electronic medical record provides rapid access to information.

The reason we use it is that we're hoping that it's going to improve quality of care and safety. But we do know it can alter the interactions that we have with patients and it redistributes the clerical work to the physician that wasn't there before. In some situations, it actually creates new tasks or new data entry pieces that we need to do. It's caused a bit of a cultural shift to looking at quality indicators and patient satisfaction, which also causes more data input or structured data input.

The second piece is a little bit more around what we're using our charts for. It used to be used as a form of communication between clinicians. But now, it's leaning more towards a

legal document as well as we use it for education and we use it for remuneration, so what are you allowed to bill. It's shifted from what was done to what was documented. This has led to defensive medicine or what I like to call note bloat, where we fill our notes with these details just in case there's a concern or a complaint, not because we necessarily think that information is relevant or makes a difference to our clinical decision.

The last piece is just technology in general. So, we know technology has improved communication between clinicians and medical sites, but this actually comes with increasing paperwork. So, every time someone in our hospital presses save on a record, I as a family doctor, get virtual paperwork in my medical inbox. Pharmacies now have automatic refills for prescriptions. And so, I get requests for prescriptions even if the patient isn't actually out of it, just because the pharmacy thinks that they should be due soon. So, to put this in perspective, my inbox in November 2017 had about 600 items. I ran the numbers this past November. So, just five years later and it had 1,100 items. My practice size is the exact same, I practice the exact same, but this increased amount of volume of work is coming because a lot of this technology. In my practice, that equates to about an extra 16 hours of work a month just dealing with the inbox.

Molly: Wow, I feel so sane, Danielle, that was incredible and also, just like the trickle-down effects of the EMR relative to our lives on a daily basis. I wonder what you all think in terms of some of the mention of burnout earlier. I think there's been a lot of reports of primary care, generalist, physicians leaving practice and people choosing not to go into primary care. That means that patients can't find a doctor, can't find a physician to be their primary provider. Do you think that the indirect patient care activities fit into this phenomenon that we're seeing or is it something that's independent of that?

Meredith: From my perspective as a health systems researcher and an education scientist, I think that people who are attracted to different types of medicine, just as Danielle outlined, they have an idea in their head about what they're going to be doing. It's usually about the meaningful work, and the patient interaction, and probably not about the paperwork, and all of the little bits that you need to get that done. So, I think that what's happening around burnout is people are spending less time doing the thing that lights their fire, that speaks to their vocation, that is meaningful to them, and more time doing the other work. When the other work is not remunerated very well, I think that that's a real recipe for people being unhappy in practice.

Whether that turns into burnout or whether it's just about professional fulfillment and professional quality of life, I think we see all kinds of physicians making decisions to structure their clinical practice in a way that feels more meaningful and balances better with the other ways that they want to spend their time, which these days, at least in Canada, tends to mean spending less time doing comprehensive generalist primary care.

Danielle: Yeah, I think you hit it right on the head. We're finding a lot of med students and residents describing almost this hidden curriculum. They got into this without appreciating what the other pieces of this workload is. Unfortunately, it's often because that indirect patient care activity is stuff we do on our own time outside of clinics. So, we go home and we chart or we fill out forms or those are things that we do on the weekends or early in the morning before the day even starts, and so, our learners don't see it and don't recognize it as part of the job that they're signing up for. Then they get this big shock when they come in that this isn't what they had planned and that really can lead to satisfaction.

Irina: Danielle, I'm glad you shifted it toward the medical education side of things, because I am excited to talk about that aspect of it. Are we starting to see more training explicitly around this now for our learners or is it still something that's really that hidden curriculum?

Danielle: Yeah, so this is definitely a newer topic. And so, whether or not we're already seeing that shift in explicit teaching IPCAs or indirect patient care activities is yet to be seen. But I think our study highlighted that our learners do actually really want that. They do want that explicit teaching. I think it comes down for me to educational value. So, when I think about this workload, this hidden paper workload taking up about 50% of physicians time. But as an educator, if I spend 100% of my time only teaching around direct patient care, I'm really setting up this hidden curriculum where I'm indirectly telling learners that there's no education in this part of the work, that it's just scutwork, menial administrative work, just needs to get done. There's nothing for me to teach you there.

In medical education, there's a saying I really like that says, "They respect what you inspect." I think that really applies here. So, by telling a learner what I want to provide them feedback on as part of their patient care and by incorporating it into our entrustable professional activities, and our assessments, and formally setting aside time to provide education, I'm actually indirectly telling the learner that there is value in this work. So, whether or not we're there yet with the explicit teaching, I think it's an important piece for us to start considering, because that explicit teaching actually will lend itself to labeling this as valuable work to be done.

Meredith: If we can get a bit theoretical here, one of theories that we were working with in the study was Stephen Billett's workplace learning theory. Within this, Billet talks about affordances for learning and what affordances are opportunities. But they require the learner to recognize that that is an opportunity and to choose or to value that opportunity in order to take advantage, in order to realize the learning potential. So, regardless of what the learning potential of these indirect activities are, if they're not recognized and they're not chosen, then they're never going to be realized.

So, I think that part of what we entered into this project was was sort of an assumption that this could be done better, that there probably are some learning opportunities here, but that maybe folks aren't recognizing them because we haven't really thought maybe very much about what the extent of the learning opportunities are or what precisely they are, how they could be taught better, how they could be scaffolded or approached in a graduated way.

So, what the Billet theory really helped us, sort of focus on in our data collection and in our data analysis was the question of what are people recognizing as valuable opportunities for learning and what are the signals of what those valuable opportunities are? So, just as Danielle said, "What you inspect, they respect." We were really alert to what are people paying attention for and how are they talking about these activities in our accreditation process and in the feedback from learners. I heard from my physician colleagues that learners really didn't see these as learning opportunities. They saw it as scout work. They saw it as a burden. They saw it as something they were doing to help their preceptor out.

But what they weren't seeing was, one day, I'm going to be an independent practice, and I'm going to need to manage this all on my own, and I'm going to need to do that efficiently and strategically and in a sustainable way in order to have a decent quality of professional life.

Irina: I guess, as we move into the paper and talking about the question and the methods and you already mentioned Meredith, the workplace learning theory, I saw that there was also another constructivist grounded theory approach. I was wondering if you could give a little bit more detail about that separate from the workplace learning theory.

Meredith: Sure. So, grounded theory is a qualitative methodology that is very useful when you don't have a lot of current knowledge about the phenomenon that you're studying. It's useful for studying social processes and particularly when you take a constructivist approach to grounded theory, you're really thinking about how people experience the social world, how they make meaning from that social world, and how they choose to navigate through that social world.

So, applied to this topic, what we're interested in is understanding how learners make sense of the indirect patient care activities that they encounter during their residency training and what the different pieces of information or signals or structures are that they're encountering to help them make sense of those indirect care activities. So, for example, Danielle just mentioned that sometimes preceptors will be doing this work at home or early in the morning, a time that's not visible to the learners. And so, from a constructivist perspective, understanding that sometimes this work is invisible is helpful for us to understand why learners may or may not value it, how they might think about how much work there should be or how I might structure my time to do this. They need to be aware of it or to see it in order to think about it.

Molly: Can you talk us through the basics of the method and design of your study?

Meredith: So, we started with current residents because those were the folks who were raising this as an issue to their education leaders. But from Danielle's experience as a family physician and from our other collaborators who are also family docs from their experience, what they thought about indirect patient care activities while they were in residency was really different than how they thought or how they experienced them when they were out in practice.

So, we also wanted to make sure that we're collecting data from folks who were in their first five years of family medicine practice, who had gone through that transition of learning about indirect patient care activities in some way during residency, but then striking out on their own and having to deal with them in real life when they didn't have a preceptor as their safety net, when they weren't given academic half days, and these other opportunities that learners are to figure this stuff out when it was just them and their patients and their electronic medical record out in the wilderness on their own. So, we also included this group in our practice.

Then finally, we had a group of educators, people who had been around for a while, who had seen the crest of indirect patient care activities that we're currently riding right now and could have a longitudinal perspective on what it's like to teach and to practice as a family physician and how indirect care activities interface with that.

So, once we recognized that we wanted to collect data from these groups, we had to make the decision about what kind of data we wanted to collect. And so, constructivist grounded theory is a flexible methodology in that respect. We could have chosen to do interviews or focus groups. We might have chosen to incorporate some observation of how people were working in the clinic.

What we decided to do was focus groups because we thought this topic is not something that's intensely personal and sensitive. We weren't really worried that people wouldn't want to talk about it in front of their peers. We thought that it would be useful to have folks in a group, so that they could build off of the ideas that each other was sharing and also maybe have a chance to talk to other folks who were working with different preceptors or who were working in clinics that had different setups in terms of other staff members that you might be able to delegate tasks to or different patient populations. Because what our collaborators

were hearing from their own residents was a lot of really individually focused like, "My preceptor gives me too much of this activity," or "My preceptor has unrealistic expectations about what I might do here."

So, we thought that setting up our data collection where they would have an opportunity to compare those individual experiences and listen and learn and build upon each other's experience would yield a richer perspective on what this phenomenon looks like across the spectrum of our residency program.

Irina: We'll get into the implications of your results and maybe more deeply into the results. But just the top of your heads, Meredith and Danielle, I wonder what was the most surprising result to you of these focus groups and the data that you collected?

Danielle: Well, I have to say, for me, the most surprising component was the idea that this job, like, this component of the job ,like paperwork could actually have such a huge impact on a physician's career path. And so, we touched upon this already. But we really heard from our recent graduates that the reason they opted not to participate in comprehensive family practice was because of indirect patient care activities that everyone recognized that there's ways that we can adjust or impact the volume of this work either by doing smaller practice sizes or changing some techniques. We call it the choosing wisely. So, do you need to order that test? But in reality, the best way to change it was actually just to step away from involvement in traditional primary care or traditional family medicine and move towards subspecialties like hospitalist or emergency.

So, it amazed me to think that something like this, a component of indirect patient care activities, could actually change on a broad spectrum the way our public healthcare system is set up and how people choose their career and what that means for our patients.

Meredith: I think I was surprised by that but also by something different. So, as a medical education researcher who's not a physician, I have an outsider perspective and often find myself surprised by things that may be taken for granted or assumed by people who are more embedded in the context. I was shocked that the residents didn't recognize that this was going to be the bread and butter of their professional lives and how angry they were about being asked to do these tasks while they were learners.

I'm not trying to blame physicians or to say that there's something unique about this. I think that all kinds of people in professional training programs focus on one aspect and maybe don't think about the other less exciting, less glamorous, less fun bits, and then maybe get into practice, do a PhD. You focus on the methods, you focus on the theories, you focus on the content, and then, all of a sudden, you need to manage a project and budget and personnel. It's like a similar analogy. But I couldn't understand why there was so little interest in learning how to do this, and learning efficient ways of doing this, and learning how one might structure the direct patient care, or how your appointments are set up, or the ways that your patients are coming in order to maximize the efficiency of your patient care later on. And that this learning opportunity, which seemed so obvious to those who were further on in practice, went completely unnoticed by so many residents.

I think in our data set, we only had a couple of residents who said, "Yeah, this is a great opportunity for me to learn out how to fill out these disability forms, so that they don't keep coming back to me and my patient gets what they need when they submit it to the government." Really, very few had that perspective, which was so widely held by our more experienced participants, like, the physicians in their first five years. The more senior educators were just like, "Oh, thank goodness I had the opportunity to learn how to structure

my patient visits, so that I don't get all these prescription refills before the patient needs to come back."

Now that I know how to set my practice up like this, it saves me so much time. This was like a real gem that my preceptor taught me back when I was in residency. Although some of them were a bit reflective on maybe that they didn't recognize those opportunities while they were residents as well that it took hitting the field to figure out like, "Oh, that was like a real service that my preceptor did when they had me go through this process."

Molly: I feel like what you just said, Meredith, the pop culture analogy for me is like, Meghan Markle not knowing that she had to bow to the Queen, because the Queen was her relative. I feel like it's that shock or that moment where you're like, "Oh, my gosh, I had no idea that this was part of the job of being in royalty." Or, in this case, it's like, "I had no idea that IPCAs were part of my job as being a physician." The moment of opportunity, like you said, to learn that skill and then also trickle it down, have other trainees under you or learners working with you seeing that you can role model this educational value as well.

Yeah, I'm glad you pivoted it to the positive error, because I was very much imagining myself in these focus groups. What you said really resonated. I feel angry about the amount of work that we have, and I'm hopeful that we can make some changes to improve that. I know here at UCSF, we have seen a shift that very few internal medicine residents want to go into primary care. I love primary care and I want to encourage them to do. And so, hopefully, there are some ways that we can shift this culture and make it easier for all of us.

Meredith: So, I think that it's really important for us to mention that we absolutely understand that and have this insight too that this is not a problem that can be solved through individuals working more efficiently and more effectively. We did this as an education study, we wrote it up for medical education, but I'm also a policy researcher and I think that there's so much policy work that can be done here to minimize the duplication and the redundancy in this documentation work. And so, I think that that could be a whole other follow up study. We probably have lots of stuff, even in the same data set. Because it was an education study, we did take more of an education focus, but I want the listeners to understand that that's not the only or even necessarily the best way to look at this problem.

Irina: I love it. The systems piece is huge in this. The other thing that I think y'all already highlighted for us was the kind of IPCAs as noneducational extra work impeding the ability for learners to actually learn from the tasks. I wonder if maybe there are particular kind of quotes or other themes that you want to highlight relative to this, but also the next step of, "Well, how do we shift this perception? How do we take what your study found out and then lean into it and maybe shift the fact that actually this is a growth opportunity and a learning opportunity and needs to be part of the overt curriculum?"

Danielle: I think the educational value is less obvious in the IPCAs. I think that's a bit of a barrier like we were talking about before in engaging with it as an opportunity for learning. I think there's a lot of different reasons for this. So, we know that by educators themselves investing less time into teaching. We talked a little bit about how that indirectly tells the learner that there is less value in it as well. But I also think a hard part about it is that a significant portion of the education is actually the logistics of the task itself and less about medical knowledge.

So, there's really an art to being able to effectively and efficiently document encounters that balance detail while avoiding that note bloat. There are ways to manage the inbox efficiently while still ensuring that you've updated the record accurately, and put reminders in the right places, and followed up on the lab work, and all those other components. Like Meredith was

talking about with disability forms, there's really an art to filling them out in order to advocate the best way for your patients using the right language and summarizing patient context. These are not the classic skills we think of for medical expert that we're teaching, but they fall into the other roles that we see in medicine, like, manager or leader.

The hard part is residents don't often see this as meaningful, because it's not going to help them pass their exam. They're often still identifying them as themselves as a learner, "What do I need to know to pass my exam to be done schooling?" But they're not seeing it as the opportunity to look at their career in a sustainable way. In the end, actually doing these things properly helps provide quality care, and advocacy, and patient safety, and all those other important pieces. So, if we want residents to be able to see that educational value in these tasks, I think as educators, we need to actually identify the value and explicitly label it. We need to teach it, we need to provide feedback, we need to formally assess it. We need to bring it into the light, so that they can become more aware of it and so that the residents can recognize the value and hopefully engage in a meaningful way.

Meredith: I want to pick up one aspect that Danielle just said and put it in a theoretical framing. So, Danielle is talking about the transition in professional identity from learner to practitioner. I think that this is really key in these indirect activities. So, just as she said, the learners, many of them, are focused on the exam, "What do I need to pass my exam? What do I need to get a good evaluation? What do I need to move forward?" Residency is also a time that they're moving, they're developing their identity into more of a practitioner. And so, the indirect patient care work could provide an opportunity to help your learners start to think about how am I going to advocate for my patients? How am I going to set up my practice in a way that works for me, but also works for my patients and works in the remuneration model that I'm in and really help them move along that trajectory from learner to practitioner, where all of a sudden, it's not about passing the exam, it's not about your experience as a learner and the opportunities that you can avail yourself of or not. It's about preparing yourself for practice. It's about getting ready to be a doctor, not getting ready to be the best learner that you can be.

Danielle: Yeah, and I think Meredith like that point of it. You and I have talked about this a lot that we saw hints of that within the data collection that learners that approach this work as a student approached it very different than learners that approached it as an apprentice. When they started to think of their work as their career instead of as passing the exam, they started seeing some of those opportunities. I think as an educator, there's something there that we can grab hold of. So, if we can help them develop their professional identity, "Congratulations, you're in residency. You're no longer a student. You are an apprentice. This is your career path. Let's learn all the different ways that you can make this business sustainable." Then, all of a sudden, that reframing opens up these opportunities as something worth learning.

Irina: Have you made some changes, Danielle, in how you precept or in the medical education curriculum that you share with your learners?

Danielle: Yeah, so, this is like a new data that we have coming out. We haven't had a ton of time [giggles] to make big changes yet. I do have a colleague that I've been working with, Dr. Amy Davis. And so, when our data started coming out early last winter, we decided to put together a meeting that we called the Think Tank. So, it had a bunch of stakeholders from our local area. So, it had residents and educators, it had representatives from the program and clinic management from the different sites. In that meeting, I presented our findings and we defined what IPCAs look like for us and our sites.

Then we highlighted what we have as the entrustable professional activities, or EPAs, or the things we want people to be able to do by the time they're graduating, showing competency in. We highlighted which ones were linked to the IPCAs. We actually took time to benchmark them. So, we took time as a group to decide when we would expect a resident to be able to achieve the EPA as a competency during their residency. Then we actually took time to brainstorm what tools we already have in place, what clinical exposures we expect the resident to learn the skill set in and observable behaviors and take all that and put it together into a nice 5, 10-page document that we later circulated to our 40 faculty and our 100 residents at our site to make sure it was reasonable and acceptable and felt like it fit. We made a couple of tweaks based on that feedback and launched it this past July.

So, starting this past July, our incoming PGY1s, our incoming residents actually have a bit of an indirect patient care curriculum. So, it outlines which things that they would be learning indirect patient care, when throughout their residency we expect them to become capable from it, what teaching tools are available, and what observable behaviors we have. So, it's just at our local site. We haven't put it program wide yet, but we're hoping to do that and hopefully in the next couple of months.

Irina: Danielle, that's incredible. I feel like you put everything that you just told us about labeling, giving feedback, assessing kind of that frame shift of harnessing the professional identity that residents have into practice in your clinic. If we could be, like, a tiny bit more explicit, is there a didactic that you shared in order for these EPAs to happen or to be met, or is there more of an experiential learning process? I was just wondering if you could maybe share a bit about those strategies.

Danielle: Yeah, so, I'm lucky that I had some of these resources in my back pocket. One of the roles I have in the program is Director of Resident Learning and Remediation. So, I work within that role with learners that need enhanced education plans or remediation plans, filling in gaps, doing tutoring. Over the last 10 years, I have actually developed some resources because surprisingly, things like charting, documentation come up when you have a learner that needs some additional support. So, I had some great one-on-one resources. With some tweaks, we're able to adjust them to be presented in a bigger platform. So, as of July 1st, all of our residents had a bit of an orientation rollout where each week they had a new topic that was done in a bit of a small group setting, so about 20-ish learners and we did a session on professional communication, which included documentation and case reviews.

We talked about the medical legal component, and we talked about how to avoid note bloat, and we talked about how to do it efficiently, and we talked about resources depending on your style whether you like templates or dictation and those components. We did one on billing and now they also get quarterly reports with their billing numbers. The point of those is to identify learning gaps. So, if you're not using a specific code for a specific population, is that because you're not seeing them and therefore, how do we get the exposure, or is it because you're not billing them and how do we educate you about the billing? We did one on inbox, again, looking at the medical legal requirements and how to do it in a sustainable way. Then we topped it off with a wellness one. So, how do we balance this workload, how do we make sure we're setting boundaries, keeping mindful of ourselves, and what do we do when we make mistakes, because we all are going to run into those situations?

So, hopefully, this is something we pilot, but we'll be able to expand it a little bit further and we're looking at building onto it. We're looking at doing a second-year resident or PGY2 reorientation. So, a refresher on these things with a step up, so now that you've learned the basics, how do we do that next step?

Irina: When is that curriculum going to be available for the rest of us and the rest of the world? Is that coming to-- [crosstalk]

Danielle: Spread a-- [crosstalk]

Irina: Yeah, exactly. Is that Meta Portal available or is that just emailing, Danielle?

Danielle: Yeah, always. Feel free. Just send out an email. [laughs]

Molly: Amazing. So, you highlighted that you created these EPAs and expectations of when residents would be able to meet them based on their time and training. And your paper highlighted that a gradual introduction to the IPCAs was suggested. How do you put that into practice?

Danielle: Yeah, so, I was fortunate when we put together the paper with Dr. Davis working on benchmarking. As part of it, we actually included some of the tools that I've been using and that she's been using in order to do that gradual introduction. So, in it was a bit of a framework of how that might look. Some of the feedback we got from our residents was how important it is for them when they're just starting out just to focus on direct patient care, which we understand. They're still finding out where the printer is, and how do you make their ID badge work, and how to take a history. It's too much to tack on all those other components as well.

So, the layout that we have for them gives an example for their preceptor to use that might show-- In the first couple of months, really focusing just on charting and direct patient care. And in the next couple of months, incorporating something like prescription refills, and doing some didactic teaching, and how long that should take for them. Then as they get in closer to their second year, maybe they start incorporating things like consult notes or investigations. And so, we've given them a bit of a stepwise approach of what that could look like using that benchmarking as a bit of a frame of reference.

Then we've also been able to incorporate, our group does what we call portfolio reviews. So, each resident sits down with their primary preceptor three times a year to look over their entire educational file. We now have something in there landmarked for IPCAs. So, what is it you're engaging in and what is it you're hoping to learn more about in the next couple of months for your next portfolio review? So, bringing in some of those benchmarking landmarks, but also getting the resident to start to reflect on what other skills they're hoping to learn.

Irina: Meredith taught us more about the workplace learning theory. So, I just wonder, Meredith and Danielle, how do you all teach, we'll say, faculty or more experienced practitioners to really highlight those moments, those opportunities for the learning, for the value of the IPCAs? How do you teach faculty to do that in practice? Because I can imagine maybe there's a best practice towards IPCAs being incorporated, or being highlighted, or maybe within the didactic sessions Danielle that you just talked about. There are little quick bits for the faculty who's just trying to survive during a precepting session, but still wants to highlight that opportunity for their learners. So, just wondering if you have any tips for the faculty, the teachers out there trying to incorporate this work.

Danielle: I don't think there's any explicit best guidelines yet for IPCAs it being a bit of a newer concept. But the way that I've been doing, so I can share my educational expertise. I use a bit of a framework when it comes to addressing educational gaps. So, that's the framework I'm coming from. This isn't anywhere out in the literature. So, this is 100% like an

adult Danielle O'Toole approach. But I use something I call the five Es. So, educate, exemplify, exercise, encourage, and evaluate.

By educate, I mean, I want to provide the learner with a specific teaching on a topic. So, for example, what is the ideal SOAP note? How do we balance making it concise, but with sufficient details? What are the medical legal requirements? How do we demonstrate our clinical reasoning process within our note? So, having a specific teachable within that task. The next step would be Exemplify, so I want to be able to demonstrate it myself. For charting that one's easy. So, people can just read over the notes but thinking about something a little bit more abstract. So, filling a prescription, what would that look like? So, I would actually walk the resident through my thought process when I'm filling vaccine or prescription. Looking at the date, are they too early or too late, and does that mean that there're issues with adherence to the medication? Are there other medications that are due at the same time? So, let's take some of my workload off by filling them all at once. Are there new contraindications? Do I need the patient to come in for reassessment for some way? So, I would actually demonstrate to the learner what my process is instead of just asking them to fill the prescription.

The next step would be Exercise. That we want to use deliberate practice and that is in the medical education literature. So, deliberate practice requires three steps. A specific learning goal, which we talked about, repetition, so you want them to do the same task or the same part of the task over and over, and the third is immediate and frequent feedback. You want to be providing them that feedback on a regular basis. The fourth E is Encourage. So, you want to make sure that you're giving guidance and regular check ins and that feedback component. Then the fifth part is Evaluate. So, providing them field notes or evaluations or [unintelligible [00:44:33]. So, taking all of those five Es and putting it together to actually structure something and it can be teachable in moments.

The hard part about indirect patient care activities though is how to explicitly articulate the learning goal. Because like we talked about, the learning goals for IPCAs are a little bit more abstract. They're not the medical expert goals. So, thinking about what that looks like for IPCAs. So, for documentation often we'll start off just with medical expert. Are you managing it accurately? Are you documenting it properly? Do you have appropriate communication? But maybe then your learning goal moves towards patient centeredness. Does your documentation include patient context? Did you consider access and funding when thinking about the length of the prescription you're filling? Have you thought about a patient centered way to communicate inbox results?

Then maybe your goal moves towards collaboration. So, are you making sure the team is updated in an appropriate way or maybe manager? Are you doing this in an efficient effective way? So, you can teach each of those learning goals, but just break it down into those five Es, the educate, exemplify, exercise, encourage, and evaluate.

Meredith: If you all and the listeners as well are thinking like, "Wow, Danielle really has a great system here. This is something I need to adopt. It's so organized, it's so thoughtful."

Danielle: Yes.

Meredith: We heard that in our data too. None of the physician collaborators were ever involved in conducting the focus group or that kind of thing. We kept it to the nonphysicians. But we could always tell when we had one of Danielle's trainees in the focus group, [Danielle laughs] because they'd be like, "Oh, my preceptor had a whole system. She would show me this, and then that, and then we graduated to here, and then we did this?" The other residents would be, they would just turn and look and be like, "That didn't happen for me."

Then sure enough, I would sometimes look it up later and it got to be a game between me and the other, we'd be like, "Let's see if this was one of the Danielle's." We'd be like, "Oh, yes it was."

[laughter]

Irina: That's amazing.

Danielle: Yeah. If it's one thing I've learned over working my remediation role is it's how often that we do things just automatically and forget to articulate it. And so, that's one thing that I've learned over the years is that I need to articulate what's going on in my head, because that's where so much of the learning actually is, like, where did I come up with this approach and why am I doing it? So, that's why I have the frameworks.

Molly: You also need to brand the five Es, Danielle, I think it's time.

Danielle: Exactly.

Molly: We will spread the word.

Danielle: There we go.

Molly: Amazing. Well, this has been such a great conversation and I feel like just yeah, so great to talk to you guys. Are there any other main points that you feel like we need touch on in terms of your results or things that we haven't really covered that you feel are valuable?

Danielle: I think the only other piece that might be worthwhile thinking about for listeners is, on top of learning how to do this work in a sustainable way, I think it's a bit of a two way street. So, making sure we also talk to our learners about the fact that it's okay to set boundaries for themselves and their patients. So, it's okay to tell a patient that it's going to take time to fill out a form, and it's okay to tell a patient that I'm not filling prescriptions within hours of you sending them in. So, setting those boundaries for our workload, I think is a reasonable task to do, but to set them early on in practice.

So, I know my own family physician. When he found out I was in med school, gave me some really good advice, and it stuck with me ever since. So, he said, "The practice you have in five years is the practice you deserve." So, setting those boundaries early and sticking to them is going to be really important, because if you let your patients no show, come in late, have a million forms, fax in all their prescriptions without setting the boundaries, then that's the workload you're going to pay for later. So, it's okay to set your limits. I think if we do that as a professional community and back each other in those pieces, I think it'll help make those things a little bit more sustainable for all of us.

Meredith: I love that. We need more encouragements to make things sustainable, because I think sometimes, we least have these messages for my charts from patients. They're like, "Your response will happen within two to three business days." But I think some patients may think that days is replaced by hours. And so, I try to emphasize like, "No, we'll get back to you within two to three business days." I would say it's just the last couple of years has been more of my practice to actually set those boundaries. Whereas before, early junior faculty or first year faculty, I was like, "Yeah, send those messages. I'll get back to them instantly." You set yourself up for not success in that situation.

Danielle: Yeah, exactly.

Irina: Anything else Meredith or Danielle that you would like to mention or maybe main take-home points for both of you for our listeners? Maybe Meredith we'll start with you.

Meredith: Sure. Main take-home points? Nobody likes this work. It's not going away, but you can learn to do it better, and more efficiently, and in a more balanced and sustainable way. But everything else that's worth doing. That's going to take effort and it's going to take some time and take some thoughtfulness. And so, it's probably worth doing and focusing frustration and anger on, "Why do I have to do this work? Could maybe be redirected to some health systems advocacy?" Because I think it's not an unreasonable question, like, "Why is there this volume of work that you need to do and what's really necessary and what could be improved?"

I think we've got lots of great scientists, not just in Canada, all over the place, thinking about how electronic medical records could be restructured to serve the patient better rather than the insurance company or the billing provider. That work probably needs to continue. This isn't going to be a problem that can be solved through education.

Molly: Totally.

Meredith: But it could be improved through education. I don't want to say there's no-- [crosstalk]

Irina: [laughs] I was going to say, I'm going to-- [crosstalk]

Meredith: There's certainly an educational role. Yeah.

Danielle: Yeah, I think the big take home I would have is that the way that you do this work is an art and it's very personalized. Even the way that you do the work will change over your career. So, when I started, I did a lot of this work in the evening, and now with four little ones, I do it first thing in the morning. So, when and how you do it is going to change. So, taking every opportunity to see how everyone else does it, to pick your favorites from everyone else is actually really an awesome opportunity. Because once you get out and practice, you won't have that chance to model it off other people and see what works and it doesn't in a protected, safe space with a safety net. You're going to be doing it on your own and having to use your own creativity to come up with those ideas. So, using the time that you have in residency as that educational opportunity is really a bit of a blessing.

Molly: Thank you. Those were wonderful. Anything else that you'd like to plug? Anything that you are excited to share work that you've done?

Meredith: We just got a new grant together last week.

Molly: Congratulations. Yay.

Meredith: Yeah. Funded by our Canadian version of the National Institutes of Health. So, we call it Canadian Institutes of Health Research. With a couple of other economists, we got a grant to study the pay gap in medicine. So, that work will be starting soon, I think.

Molly: Oh, that's huge. Especially with National Women Physicians Day last week, I think there was a lot of buzz about that. So, excited to hear more.

Meredith: Absolutely.

Molly: That was just such a great conversation with Meredith and Danielle. So, I really want to try to be more explicit about teaching these activities. What they were talking about today really resonated with me in terms of we do a lot of this work at home silently without sharing it with our learners. I think modeling that more for my students and my residents, and to really be explicit about teaching them best practices around indirect patient care activities, because it is something we spend a lot of time doing.

[music]

Irina: I'm totally with you. I'm still shook from the line, "They respect what you inspect." Just being very, like you said, explicit and intentional about saying, "I'm going to highlight for you what was good about this note, what was helpful, effective, and how I would approach it," so just the labeling piece and really-- If we respect the IPCAs and their role making sure that the learners can see that as well. So, I'm still shook from this episode, just because of all the learning and all the implications of their work.

Molly: I want to see the five Es in progress. [giggles]

Irina: I know.

Molly: [laughs] So, this has been another episode of our Curbsiders mini-series, The Curbsiders Teach. Get your show notes at *thecurbsiders.com/teach*. A special thanks to Dr. Matt Watto and Dr. Paul Williams for their support in this project, and to Dr. Stuart Brigham for composing our theme music. Thanks to the team at Pod Paste for helping with our production, and I've been Dr. Molly Heublein.

Irina: We're committed to providing you with high value practice-changing knowledge, but to do that, we need your feedback. So, please subscribe, rate, and review the show on Apple Podcasts or contact us at *thecurbsidersteach@gmail.com*. A reminder that this and most episodes are available for free CME Credit for all health professionals at *curbsiders.vcuhealth.org*. All you have to do is create an account. I'm Dr. Era Kryzhanovskaya. Thank you for joining us today and letting us bring you a little nugget of medical edutainment.

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