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Resigned professionalism? Non-acute inpatients and resident education

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Abstract A growing group of inpatients on acute clinical teaching units have non-acute needs, yet require attention by the team. While anecdotally, these patients have inspired frustration and resource pressures in clinical settings, little is known about the ways in which they influence physician perceptions of the learning environment. This qualitative study explored residents' and attending physicians' perceptions of caring for these patients, including their educational value. Using constructivist grounded theory, we conducted seven homogeneous focus groups and three interviews with residents and attending physicians from neurology and general internal medicine. A constant comparative analytical approach was employed alongside data collection, using theoretical sampling to explore emergent themes. Residents consistently described non-acute patients as non-educational, uninteresting, but still in need of care. Some attending physicians echoed this view, while others described multiple learning opportunities presented by non-acute patients. Both groups described residents as engaging with non-acute patients in a professional capacity,

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but not as learners. This engagement in a professional capacity could be considered diligent disinterest, or resigned professionalism. A constructivist understanding of the dynamics which influence learning in the workplace was used to explore the reasons why the residents in our study did not recognize the learning opportunities presented by non-acute patients. Our results resonate with Billett's theory of workplace affordances, which offers an explanation as to why learners may not identify or take advantage of potential learning opportunities. Overall, our study assists our understanding of the sociocultural factors that influence learners' choices to engage with particular clinical learning opportunities.

Keywords Resident education · Non-acute patients · Workplace learning theory · Professionalism · Learning environment · Socio-cultural perspective

Introduction

Increasingly, residents working in acute inpatient settings are being called upon to provide care for patients without acute needs. Patients without acute needs (heretofore "non-acute patients") are those who are perceived to have needs which could be met in a non-acute setting such as a rehabilitation or long term care facility. Non-acute patients are a growing proportion of those receiving services in acute care hospitals all over the developed world. In Canada, where this study took place, non-acute patients occupy 7,550 acute care hospital beds on any given day (5 % of total), accounting for a total of 2.4 million hospital days per year (13 % of total) (Canadian Institute for Health Information 2010). The proportion of non-acute patients is expected to increase in the future (Canadian Institute for Health Information 2011); non-acute patients are older than the average patient (Canadian Institute for Health Information 2008) and as the general population ages (Statistics Canada 2011) and life expectancy continues to increase (Statistics Canada 2010), it is expected that the proportion of non-acute patients will continue to grow (Canadian Institute for Health Information 2008). Indeed, this increase has already been observed. A 2013 study in the Canadian province of Manitoba showed that non-acute patients accounted for nearly 17 % of all days of acute hospital care provided in the province (Fransoo et al. 2013). Non-acute patients receiving care in acute facilities is an international phenomenon, with a similarly high rates of non-acute inpatients reported from Ireland (PA Consulting Group & Balance of Care Group 2007), the Netherlands (Panis et al. 2002), France (d'Alché-Gautier et al. 2004), and Hong Kong (Leung et al. 2011). As the population of non-acute patients continues to grow, this patient group may take up an increasingly significant portion of resident clinical activities. Creating a working environment which encourages learning opportunities to be realized from non-acute patients will therefore become an important part of maintaining a high standard of resident education.

Many have characterized the clinical activities related to non-acute patients as possessing limited educational value, naming these activities "clinical service" or, more pejoratively, "scutwork" (Boex and Leahy 2003; Brasel et al. 2004; Fitzgibbons et al. 2006; Hsu Blatman 2009; Sanfey et al. 2011; Smith et al. 2012; Weinstein 2002). These terms refer to tasks that are necessary for patient care but are not educationally valuable, or are repeated more often than necessary for education purposes. In a published commentary, one internal medicine resident labelled clinical service tasks as "non-educational, non-physician level scut" (Hsu Blatman 2009) (p. 13). Residents spend a significant amount of their time (approximately 25 %) on service activities (Boex and Leahy 2003; Brasel et al. 2004; Gustin et al. 2009; Quinn and Brunett 2009). If these activities are truly non-educational, this is time which may be re-allocated to improve education (Fitzgibbons et al. 2006; Weinstein 2002). However, there is disagreement over whether or not particular tasks have educational value (Sanfey et al. 2011; Smith et al. 2012), with experienced physicians arguing that this service or 'scut' work is essential to developing clinical acumen and practicing the art of healing (Green 2007). For instance, activities such as talking to families, often considered non-educational by residents, provide an opportunity for teaching "patient care, professionalism, and communication skills" (Quinn and Brunett 2009) (p. s17). Disagreements over whether an activity is perceived as educational or non-educational (Sanfey et al. 2011; Smith et al. 2012) suggest that there may be opportunities to realize different types of learning from these tasks, depending on the environment in which they are encountered.

The purpose of this study was to examine resident and attending physician perceptions of the educational impact of non-acute patients on internal medicine and neurology resident education. Internal medicine and neurology were chosen because these specialties address some of the most common initial presenting diagnoses of patients who become non-acute, including chronic obstructive pulmonary disease, congestive heart failure, urinary tract infections, dementia and stroke (Canadian Institute for Health Information 2008; Costa and Hirdes 2010). Our primary research question was: What is the influence of non-acute patients on resident education, from the perspective of residents and attending physicians? This question was inspired by the experiences of the clinical educators on the research team, who noted that while non-acute patients are generally considered to be of low educational value, they may present excellent opportunities for learning and refining a practice of good communication, equitable and efficient management, and strong advocacy. We do not take a position that non-acute patients do or do not present learning opportunities, or whether they should be used more or less frequently in formal and informal teaching. Rather, we seek to understand what learning is currently taking place around the care of this growing group of patients.

Methods

The methodology of constructivist grounded theory was chosen because, while we are at an exploratory stage of developing our understanding of how non-acute patients influence resident education, there is existing, relevant knowledge regarding clinical apprenticeships and workplace learning that we wished to speak to in our interpretation of our study findings. Constructivist grounded theory allows the researcher to balance inductive analysis of emergent themes with existing sensitizing concepts in the literature. Care is taken in this approach, through reflexive memo-writing during analysis, to iterate between inductive and deductive analytical processes, in order to be attuned to emergent patterns in the data while simultaneously building on existing relevant theoretical knowledge in the field. (Charmaz 2004, 2006; Watling and Lingard 2012).

Seven homogeneous focus groups and three interviews were conducted with residents and faculty members from internal medicine and neurology at a single Canadian medical school. Participants included 11 residents ranging from post-graduate years 1–4, specializing in internal medicine [8] and neurology [3] and 20 attending physicians who worked on clinical teaching units in medicine [14] and neurology [6]. Groups were homogeneous in terms of role (resident or attending physician) and specialty (internal medicine and neurology) with one focus group comprised of attending physicians from both internal medicine AND neurology conducted to discuss the similarities between the specialties. After using a convenience sample for the initial three focus groups, theoretical sampling was employed to purposively recruit residents and attending physicians who could illuminate developing categories, leading to four additional focus groups and the three individual interviews. Individuals in certain positions in their programs were invited to participate in individual interviews so that their particular expertise could be queried in a specific and confidential way. Recruitment was complete when theoretical saturation had been achieved; that is, when further data collection elicited no new theoretical insights around key patterns in the data (Charmaz 2006).

A semi-structured interview guide was developed and pilot-tested; data were analyzed alongside collection, in order to refine the interview guide to address topics of interest identified through the analytical process. Questions were structured to ask broadly about learning experiences and the impact of working with this patient population. In the focus groups we did not provide a specific definition of non-acute patients, but introduced the patient group of interest as those who, at this point in their stay, the participant perceived as no longer having acute needs. Participants were not asked specifically about the development of particular curricular goals or competencies, in order to avoid leading responses about this issue. All data were collected by non-physician qualitative researchers MV and LL, and participants were informed that data would be anonymized before being reviewed by physician research team members, who were colleagues or supervisors of some of the participants. The choice of facilitator was prompted by our recognition that data collection is a socially influenced process, and data is produced in the social context created by the interaction of the researcher and participants (Charmaz 2006). We chose to use our non-physician research team members to collect data, so that we were able to take a “naïve” line of questioning, asking participants to explicitly explain many aspects of their comments which may have taken-for-granted understandings by practicing physicians.

Open coding was completed independently by all research team members, who discussed analytical themes to develop a schema for focused coding. Focused coding was completed by MV, who brought coded data and analytical memos back to the entire research team for development of theoretical categories. Constant comparative technique (Strauss and Corbin 1998) was used to test developing categories and to compare categories and data sources. Theoretical categories were further explored with future respondents, ensuring credibility of the findings (Charmaz 2006). Once early inductive theoretical categories were elaborated to the point that all data had been constantly compared numerous times, we considered the relationship between these categories and existing sensitizing concepts in the literature. During this process, Billett’s workplace learning theory (Billett 2001, 2002, 2008, 2011) was identified as strongly resonant with coded patterns in our data; thus, we sought to enrich our interpretation of the grounded theory through consideration of its relation to Billett’s concepts (Charmaz 2006). The study was approved by Western University’s research ethics board.

Results

We started this project anticipating that participants might discuss their practice of advocacy, communication and management when asked about their experiences caring for non-acute patients. These themes were notably absent from resident discussion, and were mentioned only briefly by some attending physicians. Instead, we heard residents describe non-acute patients as requiring care, but uninteresting and devoid of opportunities for learning. Attending physicians were more likely to identify potential learning opportunities presented by this patient group.

Residents consistently described non-acute patients as without educational value, or with educational value better suited to medical students or very junior learners. In these statements about lack of educational value, residents usually referred directly to clinical learning, or medical expertise. For instance, when asked what one learned when caring for non-acute patients, a neurology resident said that they didn't learn very much, because "there's only so much you can learn about treating a urinary tract infection". On the rare occasion that residents mentioned particular learning opportunities, they were often quick to minimize the importance of the opportunity they had just identified: "The only learning involved around somebody like this is how to work with the interdisciplinary team…. But how much medical learning is involved? I would say probably minimal" (IM Resident H).

Some attending physicians echoed the sentiment that there was little "medical" learning involved with non-acute patients, although many attending physicians were adamant that non-acute patients had some educational value. "There are still things that can be learned, whether it's how to manage a difficult social situation or, you know, pain control in a non-operative fracture patient. There are a variety of things they can get out of it" (Internist V).

While residents and some attendings were likely to characterize non-acute patients as uninteresting, without educational value, and more appropriately cared for by other professionals, all participants were careful to emphasize the necessity of providing adequate care for this population, stating their willingness to do the necessary tasks to achieve this goal. Expressions of disinterest in this group of patients were frequently followed by emphatic statements of the importance of meeting the standard of care, leading us to describe this tone of disinterested diligence as "resigned professionalism". A typical resident expression of diligent disinterest pairs a statement of disinterest with an expression of their perception of a duty to care: "we still have to see these patients and dedicate time to following them, even when there is no learning benefit" (IM Resident A).

Resignation and disinterest was expressed indirectly, in terms of what the patient needed, or what time constraints allowed them to do. In a typical example of this type of indirect language, IM Resident D does not explicitly label non-acute patients as "uninteresting", but infers it, with reference to time constraints: "The [non-acute patients] just take up so much of your time that you don't spend as much time as you would ideally want to figuring out the interesting cases" (IM Resident D).

Similarly, expressions of frustration were often linked to a perception that the tasks required by non-acute patients are outside of the role of the physician, and so do not provide relevant learning opportunities:

> I think the main reason why it's frustrating is because we enjoy the medical side of our practice, this is where we learn. When we start to do other stuff like arranging nursing homes, arranging family meetings, arranging with [trails off]… we are not getting any information from that, we are just doing social services. (IM Resident C)

These expressions of frustration about caring for non-acute patients were often couched in language about time and resources: "It's frustrating to me, because instead of that person, there could be somebody else with more complicated issues that we could potentially care for" (IM Resident H).

While residents were careful to couch their complaints in professional language, attending physicians were more explicit when describing their observations of residents working with non-acute patients:

> Internist W: Even the acute, interesting patient in about 3 or 5 days devolves into 'oh yeah, she's got a chest tube, thoracic is dealing with her'. They [residents] would not even want to deal with that. What they want is again focusing on that acute medical presentation and not looking at the entire course of the illness. Very rapidly that patient travels the same common pathway. Everyone eventually needs to walk, eat, and poop to get out of the hospital.
> Internist V: That ain't sexy.
> Internist W: It sure ain't.
> Internist Z: It's not sexy because eventually there is no learning to that. It needs time, the patient needs time, needs physio, needs rehab. From the student's standpoint, there is no learning there (Internist FG 2).

Several attending physicians noted that the lack of interest in non-acute patients was not just a resident issue, and attitudes towards these patients were perpetuated by attending physicians who were similarly disinterested:

> 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. We don't say that this aspect of that is valuable. (Internist E)

We heard many examples of diligent disinterest from attending physicians, who may encourage similar views from their residents: "Regardless of who cares about this patient, they are here under our care and we have to at least spend whatever due diligence we need to do" (Internist O). These perceptions of non-acute patients as uninteresting or uneducational may also be perpetuated by the environment of residency education, including curricular requirements which do not emphasize or place value on the skills or knowledge that could be gained from non-acute patients:

> 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 E)

This sentiment was present throughout the dataset in varying forms; Internist T expressed his perception that certification exams tend to focus on clinical knowledge as embodied by the CanMEDS Medical Expert role, making the conjecture that this may shape residents' judgments of what is educational:

> It's [Communicator role, Health Advocate role] not something they ever get examined on. The Royal College exam is pretty much Expert, Expert, Expert. They [Royal College] don't really walk the walk. They talk that we teach all this stuff, but they don't really set an exam that does that. They are just interested in seeing multiple choice questions and OSCE stations.

Despite this widespread identification of non-acute patients as uninteresting, attendings named a number of learning opportunities that residents could and should realize from working with non-acute patients, some of which were clinical: "The thing that's really important from a learning perspective is symptom management. A lot of what a neurologist does is symptom management and these long term patients have symptoms that need to be managed" (Neurologist D), and some of which related to communication or advocacy type roles: "there's a role for education with the residents to transition patients and their families" (Neurologist C).

Related to our observations of a common tone of resigned professionalism or disinterested diligence, or perhaps in spite of this attitude, several attending physicians expressed that it was extremely important for residents to learn to work well with non-acute patients because these patients will be a large part of their practice: "Is this sexy? No. Is it core medicine that is tested? No. Is it the work we do? Absolutely." (Internist X).

> For the foreseeable future, this type of patient is going to be part of the students' practice, whether we think it is right or not, whether we think it is a good use of physician time or not, it is a use of physician time and it will be as far as the eye can see, unless there are fundamental changes in how healthcare is delivered. Don't we have some responsibility to provide people with experiences in their training that will translate into how they will act as professionals? (Neurologist N)

Discussion

Our study results suggest an intriguing social phenomenon at work in residents' and attendings' perceptions of the learning opportunities associated with non-acute patients. We found that while non-acute patients likely present at least some learning opportunities for residents, those learning opportunities are not widely recognized or embraced. Rather, residents perceived that they engage with non-acute patients as professionals, not as learners. Importantly, this engagement had a particular quality or flavour which our analysis has characterized as 'resigned professionalism' or 'diligent disinterest'. As we worked interpretively to explain the phenomena of resigned professionalism, we applied sensitizing concepts from Billett's workplace learning theory which offers a sociocultural perspective to understanding the ways in which individuals choose to engage with learning opportunities in the workplace (Billett 2002, 2011).

Billett (2011) posits that in order to participate, contribute, and learn in the workplace, two conditions must be met: the workplace must provide opportunities for these activities to take place and the individual learner must choose to engage with these opportunities. Workplace affordances, as articulated by Billett (2002, 2011), are the degree to which individuals are granted access to opportunities for learning and participation at work, including affordances for both formal and informal learning (Billett 2001). Billett (2011) explains that individuals exercise agency when determining how they will understand or engage in work, including deciding whether or not to take advantage of workplace affordances (Billett 2011). According to Billett's theory, workplace affordances and individual choice are relationally interdependent; individuals must choose to take advantage of affordances, but the affordances that exist (or are recognized to exist) affect the decisions made by individuals regarding whether or not to engage. Billett's theory places a strong emphasis on individual choice and agency. While we find this a useful perspective from which to consider our findings, our analysis suggests that the values of the medical learning environment play a strong constructive role in the learning opportunities which are recognized and subsequent choices that are made regarding which learning opportunities to engage with and which to ignore.

Through the lens offered by workplace learning theory, we can examine the influence of non-acute patients on residents' learning. We received contradictory responses regarding the learning affordances offered by non-acute patients. Residents, and a few attending physicians, perceived very few learning affordances, and the learning opportunities they mentioned (as existing or not existing) were usually at the level of the individual patient and generally related to medical expertise. In contrast, most attendings were able to identify distinct affordances offered by these patients. More broadly, in fact, attending physicians were much more likely to recognize that learning affordances may exist in different forms and be offered by different sources. The patient-level affordances mentioned by residents form only part of an array of learning affordances competing for learners' attention and so learners must make decisions about what affordances to recognize and engage with, choices which are made within a particular learning context. For example, the residency program may offer affordances in the form of curricular requirements, time allotted for learning v. clinical service; clinical supervisors may offer affordances in the way that they value or reward particular activities, or in their choices of topics for formal teaching; professional bodies may offer affordances in their curricula, and the content of professional licensure exams. Our results suggest that residents are not currently choosing to engage with learning affordances related to non-acute patients. In the following section we will discuss some socio-cultural factors which may affect these choices, calling upon theories of social construction to draw attention to the ways in which Billett's emphasis on individual recognition, choice, and agency occur within a socially constructed environment (Hacking 1999).

Part of learning through work is the constitution and negotiation of role boundaries; as residents work at being doctors, they are working out what it means to be a doctor, what type of work doctors do, and what type of work doctors don't do, a process of role construction that is navigated by the individual within a complex web of social relations (Apker and Eggly 2004). The way that residents understand the boundaries of their professional role is directly relevant to understanding how and why they construct particular types of learning as valuable and important. This understanding of professional role is continuously negotiated by each individual in their specific work context, a context which is constructed, challenged, and maintained through social relationships and communicative practices (Lingard et al. 2002). Billett proposes that this type of learning through work comprises a relational interdependence between the needs of the social/institutional world and the needs of the individual (Billett 2008). The contribution of the social world to workplace learning may include professional or social norms, values and practices. However, as Billett (Billett 2011) explains, these messages are "never unambiguous, complete or comprehensive enough to secure the unquestioned and unquestionable transfer of knowledge to workers" (p. 61). Instead, the individual must interpret expectations through their own experiences as they engage with different aspects of the workplace. Taking a social constructionist view to this phenomena, we understand the work that each resident does to interpret their experiences and construct an understanding of their role as resident physicians as in negotiation with many messages and signals they receive from their environment, including ideas about the role of physicians, the role of other health professionals, and the parameters of medical work. These constructs are created through a negotiation of messages understood from the social environment as interpreted through the lens of their personal experiences and understanding.

Let us return to our consideration of why residents did not seem to recognize or engage with learning opportunities while working with non-acute patients. Perhaps they failed to perceive the very existence of learning affordances within these experiences. Their remarks about the lack of formal program learning objectives, time constraints, and subtle messages from attending physicians about the learning value of these patients suggest that learning affordances, if present, were often not perceived by learners. Participants' perceptions of the existence of affordances are more important than researcher judgments about the existence of affordances, since individual residents must be able to identify affordances to engage with them in order to meet Billett's two conditions for workplace learning (Billett 2011). Even if the affordances were recognized, however, our results indicate that engagement with these affordances may be restricted by perceptions of limited educational value, personal interest, or competition from affordances perceived as more educationally compelling, such as those offered by acutely ill patients. Furthermore, conflicting messages from the social environment about the scope and definition of medical work may mean that engagement with affordances is limited when those affordances are not easily aligned with the learner's evolving understanding of physician identity.

The existence of affordances and the choice to engage may be inter-related and self-perpetuating. For example, workplace affordances around non-acute patients may be limited in relation to broader institutional and social conceptualizations of the role of physicians in a way that excludes or minimizes care for non-acute patients. If workplace affordances do exist, individual residents may choose not to engage with these opportunities if they engage with the conceptualization of the physician role as something which excludes the types of care required by non-acute patients. In each of these instances, a resident's understanding of the role of the physician acts to limit workplace affordances or individual engagement. This relationship may be bi-directional; for instance, non-acute patients may be considered to be outside of the role of physicians because a lack of workplace affordances and individual engagement conceals the potential utility of physician expertise. Our results suggest that these three factors may be continuously interacting, each compounding the others in their influence on resident learning opportunities. In our setting, this interaction may be leading to a situation where residents perceive the work of caring for non-acute patients to be non-educational clinical service rather than a valuable learning opportunity. While they recognize the need to perform this clinical service as part of their duty to provide adequate patient care, their attitude becomes one of resigned professionalism rather than engagement with educational opportunities.

Limitations

This research was performed at a single centre in one education system which has particular workplace affordances; the findings may not be applicable in other settings. The customary limitations of focus groups also apply, including the social desirability bias that can constrain focus group participants from dissenting from the group's dominant story, potentially suppressing discrepant opinions (Elmes and Gemmill 1990; Kitzinger 1995). This paper does not address the question of whether the affordances offered by non-acute patients are the most effective or appropriate way to learn and practice traits related to the communicator, advocate, or manager roles. That question is outside of the scope of the current study. Future research in this area may conclude that instead of encouraging the learners to work within the existing learning environment, the environment should be changed. For example, further research may suggest removing residents from venues heavily burdened with non-acute patients into settings that are perceived as offering a higher learning yield.

Conclusion

Non-acute patients are a growing population in the acute care health care system, and have broad implications for resident education. The residents in our study were less likely to identify learning opportunities related to non-acute patients than the participating attending physicians, although members of both groups agreed that non-acute patients have limited learning value, especially around clinical expertise topics. The residents in our study were more likely to engage with these patients as resigned professionals, rather than as learners. If these patients are not seen by residents as possessing educational value, residents may miss opportunities to refine their communication, advocacy and management practices. These missed opportunities may indicate more than just the need for different ways of teaching these roles; they may suggest a need for a re-consideration of the institutional messages residents receive about the nature of medical work and the role of the physician. If non-acute patients are medical work, resident education may benefit from increased emphasis on the learning opportunities presented by this patient group and initiatives to encourage individual engagement with these opportunities.

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