Clinical Teaching in the Era of Quality and Patient Safety

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Objectives

At the end of the session, participants will be able to:

• describe the characteristics and skills of an excellent clinical teacher
• explain how to produce an activated learner
• describe teaching strategies to use when time is limited or when teaching about the CanMEDS Intrinsic Roles in the clinical context
• illustrate how to incorporate quality and patient safety into clinical teaching practice
• add a scholarly approach to quality and patient safety teaching
Outline

• What makes an excellent teacher
• Activating the learner
• M&M
• Teaching CanMEDS Intrinsic Roles & Quality & Patient Safety
• Teaching Quality & Patient Safety in the clinical setting
• Exercise: Teaching Scripts
• Instance scripts
We do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization.

Je n’ai aucune affiliation (financière ou autre) avec une entreprise pharmaceutique, un fabricant d’appareils médicaux ou un cabinet de communication.
Introductions
What makes an excellent teacher?
What makes an excellent teacher?

- Enthusiastic/motivated 7
- Responsive/Flexible 9
- Knowledge of area 8
- Organized 13
- Go beyond Med Expert 5
- Interest in the learner 28
- Good role model 0
- Inspiring 0
- Approachable 7
- Good communicator/clarity 30
- Patient 0
- Creative 0

Irby, D. 1973
Wright,S, NEJM
Active Teaching Strategies to use when time is limited

Anna Oswald, MD, MMEd, FRCPC
Clinician Educator, RCPSC
AKA: Teaching on the fly
Objectives

By the end of this segment you will be able to:

• Compare and contrast educational strategies that promote active learning in the classroom setting
• Select and apply appropriate educational strategies
• Outline how these strategies may apply to patient safety and quality
So we know we want to activate our learners...

• But sometimes doing is harder than knowing...

Egyptian Jugglers, circa 1994 BC
(image credit wikipedia)
I am just about to go in and see the next clinic patient.

What would you like me to do?

What teaching method will you use?
Some quick diagnostics

- Name
- Program
- Level
- Goals for the day

- Goals for the rotation
- Goals for career
- How they like to work...etc.
Great clinical learning opportunities can happen almost anywhere!

- Wards
- Clinic
- Emergency Department
But... There is always work to be done too!

• The challenge:
  » Get the work done
  » Maintain a safe high quality patient care environment
  and
  » Convince students and residents that they have “learned something”
What do you mean I didn’t teach!?!?

• Students and residents often think that
  » Learning = being taught
  » Teaching = information transfer (lecture)
Also...Just because you have “taught” it doesn’t mean they have actually “learned” it
Timing is everything

• Think… is **now** the time and place to teach **this** particular thing?

  » Fatigue
  » Stress
  » Setting
  » Available time vs. content
  » Receptivity of the learners
Do NOT try to teach everything

Focus and guide
Think, Pair, Share

• What are some strategies you use in teaching during busy clinical times?
Menu of strategies to try

• Labeling
• Priming
• What if… Questions
• Predicting the Future
• Worst case scenario
• Mini–mini CEX
• Short Simulations
• Role play
• Role Modeling
• Patient Stories
Labeling: What do you mean I didn’t teach!?!?

- “I am going to teach you something...”
- “Today we’ll be teaching on the fly... watch for these strategies...

- Labeling helps to remind them that
  - Learning is what happens in their heads
Priming

• **Prepare the learner** for the encounter and give them a specific task

• Good when you don’t have much time, but want the learner to do something
  
  - “We are seeing this patient for likely missed Tinea incognito. When you discuss this with the patient, I want you to really focus on…”

  - “I’m going to inject this patient’s knee, take note of the features of the procedure that minimize needle stick injuries and we’ll talk about them after... (blunt fill needle, stabilize against the patient, talking through procedure, safety closure needle etc.”
“What if ... ?” Targeted Questions

• Change an important detail – how would it change your differential? Your management plan?
  ▪ Helps hone clinical reasoning skills
  ▪ Distinguishes difference between similar conditions
  ▪ Recognize “key features”
  ▪ What if the patient had a history of chronic renal failure...?
Predicting the future

• How do you expect this patient to respond to your treatment?

• Reinforces “instance scripts” (typical diagnostic features, findings, responses to treatment)
  » Helps them to recognize when a patient isn’t following the script (time to double-check the diagnosis and plan!)
Worst case scenario

• What are you most worried about in this patient or in this care setting?
• How will you deal with it if it happens?
• What are the main complications you are going to be watching for with this therapy?
• If the patient doesn’t respond to therapy, what is your next step?
• Particularly good for rare patient safety events!
Observe and feedback on one item

• A “mini-mini CEX”
• Opportunistic Use vs. Strategic Use

Could also apply to procedures, review of notes, review of presentation

Short Simulations

• Practice hands-on procedural or physical exam skills *before* doing it on a real patient

• *only do the critical or difficult part*
Role Play

• Great for times when system realities prevent learners from participating in aspects of case
  » E.g. disclosing a major medical error

• Point out that role-modeling is teaching
  » “We are going to go tell this patient about the toxicity from her medication. I want you to watch how I do it, and then we will talk about it afterwards.”

• Make your thinking clear – talk about why you approached this a certain way
Patient Stories

• Narrative competence:
  » the ability to absorb, interpret and act on the stories and plights of others
  
  R Charron

• Use stories about patients & about own professional development as a means of learning ...

  “I cared for a patient who had experienced …”
Bottom line: Less is more

• Teaching a little bit is better than teaching nothing

• Teaching a little bit is often better than teaching “too much”

• Think about how to incorporate patient safety and quality into your “on the fly” techniques
Menu of strategies to try

• Labeling
• Priming
• What if… Questions
• Predicting the Future
• Worst case scenario
• Mini–mini CEX
• Short Simulations
• Role play
• Role Modeling
• Patient Stories
Teaching of Quality and Patient Safety: Morbidity and Mortality Rounds

Danny Panisko  MD MPH FRCP©
Department of Medicine, University of Toronto
ICRE, Niagara Falls
September 2016
Morbidity and Mortality Rounds

- The classical “sine qua non” model of teaching around patient safety and quality issues that comes foremost to mind for many people
Morbidity and Mortality Rounds: Definition

Morbidity and mortality (M&M) conferences are traditional, recurring conferences held by medical services at academic medical centers, most large private medical and surgical practices, and other medical centers. They are usually peer reviews of mistakes occurring during the care of patients. The objectives of a well-run M&M conference are to learn from complications and errors, to modify behavior and judgment based on previous experiences, and to prevent repetition of errors leading to complications. They are also important for identifying systems issues (e.g., outdated policies, changes in patient identification procedures, arithmetic errors, etc.) which affect patient care.

Morbidity and Mortality Rounds

• Not perfect:
  – Arose out of a “blame culture”
  – May not have an optimal structure or format that maximizes teaching and education
  – We may not understand the perception of trainees and staff physicians
M and M Rounds
The Medical Education Literature

STAFF PHYSICIANS PERSPECTIVES ON TEACHING:
• Identify and address process and systems
• Taking responsibility for consequences of healthcare decisions
• Tolerance of ambiguity
• Effective communication with patients and families
• Effective case presentation
• Dealing with emotional impact of patient deaths

Kuper et al Med Teach 2010
M and M Rounds
The Medical Education Literature

RESIDENTS PERSPECTIVES ON TEACHING:
- Knowledge about disease, diagnosis, and management
- Processes and systems of care
- Taking responsibility for consequences of medical decisions
- Effective communication with patients and families

Kuper et al Med Teach 2010
RESIDENTS PERSPECTIVES ON WHAT WAS NOT BEING TAUGHT/LEARNED:

- Effective presentations
- Dealing with emotional impact of patient deaths

Kuper et al *Med Teach* 2010
Case Study –
The Ottawa M and M Model

Educational Advance

Enhancing the Quality of Morbidity and Mortality Rounds: The Ottawa M&M Model

Lisa A. Calder, MD, MSc, FRCPC, Edmund S.H. Kwok, MD, MHA, MSc, FRCPC, A. Adam Cwinn, MD, FRCPC, James Worthington, MD, FRCPC, Jean-Denis Yelle, MD, FRCPC, Melissa Waggott, RN, MSN, and Jason R. Frank, MD, MEd, FRCPC

ACADEMIC EMERGENCY MEDICINE 2014; 21:314–321
Case Study –
The Ottawa M and M Model

The Ottawa M&M Model:
A Guide to Enhancing Morbidity and Mortality Rounds Quality

Authors:
Lisa Calder, MD MSc FRCPC
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Adam Cwinn, MD MSc FRCPC
Jason Frank, MD MA(Ed) FRCPC
Jim Worthington, MD FRCPC
Case Study –
The Ottawa M and M Model

Development, implementation, evaluation of an
Educational and administrative intervention
Designed to enhance the quality of
M and M rounds in a large
Academic emergency department and a
Surgical trauma service
Case Study –
The Ottawa M and M Model

DEFINITION: HIGHER QUALITY M and M ROUNDS

• Educational session, interdisciplinary and interprofessional audience
• Discussion of appropriate cases (M&M Facilitator and Presenters)
• Clearly identified cognitive issues
• Clearly identified system issues
• Provide specific recommendations: “M&M Bottom Line”
• Action by administration
Case Study – The Ottawa M and M Model

The Ottawa M&M Model (OM3)

- Appropriate case selection
- Structured case analysis
- Inter-professional and multidisciplinary involvement
- M&M facilitator
- M&M Bottom Line
- Dissemination of M&M Bottom Lines
- Acting on M&M Bottom Lines at quality committee

Enhanced patient safety
Change in practice
Enhanced M&M Rounds
M&M intervention
Current practice
Case Study –
The Ottawa M and M Model

PROCESS:

• Needs Assessment
• Goals and Objectives
• Engagement of Participants
• Training of Facilitators and Presenters
• Implementation
• Dissemination of “M&M Bottom Lines”
• Action by ED Q and Safety Committee and Head of Trauma Services
• Evaluation: Feasibility, Acceptability
Case Study –
The Ottawa M and M Model

LARGE GROUP DISCUSSION:
Now that you have seen the overall schema of the Ottawa M and M model…
Let’s get granular and discuss:
1) Applicability to our own settings
2) Pro’s and Con’s of aspects of the model and implementation plan
Case Study –
The Ottawa M and M Model

DEFINITION: HIGHER QUALITY M and M ROUNDS

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Case Study –
The Ottawa M and M Model

**Tips for your Presentation:**

- Consider the following time outline:
  - 10 minutes for review of the case and state of evidence on current management
  - 10 minutes for case analysis in terms of cognitive and system issues
  - 10 minutes for discussion, identified issues and actions
Case Study –
The Ottawa M and M Model

Remember this is M&M rounds not Grand Rounds!

- Please remember these rounds are confidential and we need to endeavour to protect the privacy of patients. No patient initials, dates, times or names of staff involved should appear in your presentation.
- Think about whether you can make your rounds multi-disciplinary. Email the nurse manager and ask them to invite nurses involved in the case. Would it be helpful to have a pharmacist or social worker present? Are there consultants from other services you could invite? Other allied health members? Pathologist?
- Involving patients and/or their families can be powerful in M&M rounds. If this seems appropriate, speak to the Head of Department first to help you coordinate with Patient Care Relations and ensure it is done in a sensitive manner.
- Consider briefly discussing your selected case one week ahead of time with a colleague to confirm you have identified a clear cognitive or system issue.
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The Ottawa M and M Model

M&M Rounds Process Improvement - Role of the Facilitator

1. Pre-M&M rounds: To touch base with presenters 1 week prior to offer feedback on case selection and slides

2. At M&M Rounds:
   a. Very brief intro mentioning the ongoing study and emphasizing confidentiality
   b. Maintain timeliness – reminder to presenters (ensure presentation starts at on time and ensure enough time for discussion)
   c. Facilitate discussion
      i. Highlight cognitive and system issues
      ii. Seek consensus on bottom line – identify 2-3 key points and emphasize
         1. Remember that these should be blame free
         2. Focus on recommendations that can be actioned
         3. Try and avoid “try harder” type of bottom lines or “more training” but seek out system changes

3. Post-M&M rounds:
   a. Create M&M rounds bottom line using template (remove presenters names) and disseminate to departmental members, RNs, allied health and senior management
Case Study –
The Ottawa M and M Model

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Case Study –
The Ottawa M and M Model

*Cognitive issue*: a specific pitfall in clinical decision making. Can refer to cognitive dispositions to respond (see table 1)

*System issue*: a problem beyond the individual clinician or team which pertains to how an emergency department operates
Case Study – Cognitive Issues
The Ottawa M and M Model

Table 1. Classification Scheme for Cognitive Dispositions to Respond (CDRs)

<table>
<thead>
<tr>
<th>Error of over-attachment to a particular diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Anchoring:</strong> the tendency to perceptually lock on to salient features in the patient’s initial presentation too early in the diagnostic process and failing to adjust this initial impression in the light of later information. This CDR might be severely compounded by the confirmation bias.</td>
</tr>
<tr>
<td>• <strong>Confirmation bias:</strong> the tendency to look for confirming evidence to support a diagnosis rather than look for disconfirming evidence to refute it, despite the latter being more persuasive and definitive.</td>
</tr>
<tr>
<td>• <strong>Premature closure:</strong> a powerful CDR accounting for a high proportion of missed diagnoses. It is the tendency to apply premature closure to the decision making process, accepting a diagnosis before it has been fully verified. The consequences of the bias are reflected in the maxim: “When the diagnosis is made, the thinking stops.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Error due to failure to consider alternative diagnoses</th>
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<tbody>
<tr>
<td>• <strong>Multiple alternatives bias:</strong> a multiplicity of options on a differential diagnosis might lead to significant conflict and uncertainty. The process might be simplified by reverting to a smaller subset with which the physician is familiar, but might result in inadequate consideration of other possibilities. One such strategy is the three diagnosis differential: “it is probably A, but it might be B, or I don’t know (C).” Although this approach has some heuristic value, if the disease falls in the C category and is not pursued adequately, it minimizes the chance that serious diagnoses are made.</td>
</tr>
<tr>
<td>• <strong>Representativeness restraints:</strong> drive the diagnostician toward looking for prototypical manifestations of disease: “if it looks like a duck, walks like a duck, quacks like a duck, then it is a duck.” Yet, restraining decision making along these pattern recognition lines leads to atypical variants being missed.</td>
</tr>
<tr>
<td>• <strong>Search satisfying:</strong> reflects the universal tendency to call off a search once something is found. Co-morbidities, second foreign bodies, other fractures, and co-ingestants in poisoning may all be missed.</td>
</tr>
</tbody>
</table>
Task-based error: failure of routine behaviours such as regular bedside care, attention to vital signs and appropriate monitoring – often reflects work overload

Personal impairment: personal factors that impact job performance e.g. fatigue, illness, emotional distress

Teamwork failure: breakdown in communication between team members, across shifts, between teams, and across specialty boundaries or due to inappropriate assignment of unqualified personnel to a given task – this includes resident and student supervision

Local ED environmental contributors: e.g. appropriate staffing, stocking, functional equipment, sufficient policies & guidelines

Hospital-wide contributors: e.g. access to patient services, consultants, inpatient beds, specialty treatments

Hospital administration contributors: e.g. budgetary constraints, hospital policies & guidelines
Case Study –
The Ottawa M and M Model

DEFINITION: HIGHER QUALITY M and M ROUNDS
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## Case Study –
The Ottawa M and M Model

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Examples of M&amp;M Bottom Lines for the Department of EM and Trauma Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Elderly patients with generalized weakness can be acutely ill—several cognitive biases may lead to undertriaging</td>
<td></td>
</tr>
<tr>
<td>- Be cautious about anchoring on infection as only cause of fever</td>
<td></td>
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<tr>
<td>- Handover can set you up for inheriting someone else’s thinking</td>
<td></td>
</tr>
<tr>
<td>- Find one fracture, look for the next one</td>
<td></td>
</tr>
<tr>
<td>- Actively seek resuscitation status of any arresting patient</td>
<td></td>
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<tr>
<td>- Epidural use in patients with rib fractures can decrease mortality, especially in patients with more than five fractured ribs who are over 65 years of age</td>
<td></td>
</tr>
<tr>
<td>- Consider trauma consults for the elderly and those with comorbidities</td>
<td></td>
</tr>
<tr>
<td>- Consider an ethics consultation when you have discrepant view between family and documented do-not-attempt-resuscitation status</td>
<td></td>
</tr>
</tbody>
</table>
Case Study –
The Ottawa M and M Model

• An excellent Gold Standard
• Idealistic, resource intensive, and not completely practical for implementation by all of us
• Gives us a framework and highlights important issues for consideration
Case Study –
The Ottawa M and M Model

• An excellent Gold Standard
• Idealistic, resource intensive, and not completely practical for implementation by all of us
• Gives us a framework and highlights important issues for consideration

• Comments ??? re:
  – Application to your setting?
  – Application to Bedside Teaching?
Teaching Intrinsic CanMEDS Roles related to Quality & Patient Safety

Anna Oswald, MD, MMEd, FRCPC
Clinician Educator, RCPSC
Objectives

At the end of the session, participants will be able to:

1. Define and describe the CanMEDS framework
2. Identify teachable moments relating CanMEDS Roles to patient safety and quality
3. Discuss the role of teaching scripts for CanMEDS Roles that can be used in clinical teaching regarding patient safety and quality
Do you currently EXPLICITLY teach CanMEDS on a daily basis?

Where do patient safety and quality fit in with this?
Why should we bother?

Isn’t a lecture at academic half day enough?
What We Say Is Important

All = Scholar
     Medical Expert
     Health Advocate
     Leader
     Professional
     Collaborator
     Communicator
What is Often Shown:

Medical Expert

Scholar
Communicator
Collaborator
Professional
Leader
Health Advocate
This is how we create and/or contribute to The Hidden Curriculum
CanMEDS Detour

- Professional
- Communicator
- Scholar
- Collaborator
- Health Advocate
- Leader

Medical Expert
CanMEDS Competencies

- Medical Expert
- Communicator
- Collaborator
- Health Advocate
- Manager
- Scholar
- Professional

What are these roles often called?

Intrinsic Roles

Which CanMEDS 2015 Roles do these key competencies come from?

- Actively contribute, as an individual & as a member of a team providing care, to the **continuous improvement of health care quality and patient safety**
- **Document & share** written & electronic information about medical encounter to optimize clinical decision-making, **patient safety**, confidentiality, & privacy
- **Hand over** the care of a patient to another health care professional to facilitate continuity of safe patient care
- Demonstrate a commitment to patients by applying **best practices** and adhering to **high ethical standards**
- Demonstrate a commitment to **physician health** and well-being to foster optimal patient care
Which CanMEDS 2015 Roles do these key competencies come from?

- Contribute to **improvement of health care delivery in teams**, organizations, & systems
- Engage in **stewardship** of health care resources
- Engage in continuous enhancement of their professional activities through **ongoing learning**
- Integrate best available **evidence** into practice
- Demonstrate a commitment to the profession by **adhering to standards** & participating in physician-led regulation
CanMEDS in practice

• This is part of what you do!
• Trick is identifying integration rather than adding to your day
In-the-Moment Teaching

Following through on content of formal curriculum by identifying and capitalizing on opportunities for BRIEF, EXPLICIT reinforcement of skills in the informal curriculum i.e. The Real World

In order to teach “in-the-moment” you must first identify the TEACHABLE MOMENT

What is a Teachable Moment?
A moment identified by a teacher as opportune for fostering learning both because of the situation at hand and the state of preparedness of the learner.
Teachable moments are the opportunities that arise to reinforce teaching from the formal curriculum in the informal setting.
Think about a day in your professional life . . .

What roles do you exhibit?
A day in the life of Anna . . .

• Sleep well and wake early to get kids to school then to work on time
• Ask nurse to call a patient to have them hold medications and repeat labs in light of elevated liver enzyme result
• Hold a morning clinic
  – Arrange special authorization to fund biologic drug
  – Paged by nurse about a nauseated patient receiving IV Cyclo
  – Discuss implications of a delayed cancer diagnosis with a patient
  – Explained to patient & wife why taking over the counter NSAIDs is contraindicated with his current prescriptions
• Co-present noon M & M rounds
• Meet with resident to review his resident quality improvement project presentation
Task 1
Think about a day in your professional life . . .

- What roles do you exhibit?
- Where does patient safety and quality fit in?
- Write this down on worksheet...
- Highlight any that are Teachable Moments
- Share with your neighbour for to complete Task 2 Table
Teachable Moments for Intrinsic Roles

• Communicator:
  – Describe steps to obtain consent

• Collaborator:
  – Identify how a social worker and occupational therapist might help with planning disposition for complex patient

• Leader:
  – Discuss time management strategies to apply when consults are piling up and you have clinical reports to complete and committee meetings to sit on.

• Scholar:
  – Discuss how clinical observations can inform Quality improvement initiatives and scholarship

• Professional:
  – Discuss the role of the provincial college in licensure and regulation of physicians in your area

• Health Advocate:
  – Describe steps you would take to prioritize two admissions given limited beds
  – Discuss preventative strategies for a given condition (e.g. falls)
  – Discuss how care can be organized to improve access to care for marginalized
PLAN

REVIEW

TEACH

Peets, AD, University of British Columbia
Summary

- Teaching in-the-moment deepens learning
- Reinforces the formal curriculum
- Plan your approach to teachable moments
Acknowledgements

• Slides:
• Drs. Lara Cooke, Sue Dojeiji & Linda Snell
• The Royal College of Physicians and Surgeons of Canada
Questions?
Teaching
“On-the-Fly”
PLAN

REVIEW

TEACH

Peets, AD, University of British Columbia
Teachable Moment

"that moment when a unique, high interest situation arises that lends itself to discussion of a particular topic. It implies "personal engagement" with issues and problems”.

--Lozo, F (2005)
Why Teach in a Clinical Setting?

• “Real-life”
• Identifying and capitalizing on specific skills
• Brief and explicit
• Occurs anywhere
• Component of the informal curriculum
• Reinforces the formal curriculum

What teaching script could you formulate from an instance like this?

Watch the Video!

Worksheet
Guided Reflection
Teaching in the Clinical Setting - Tips
Observe trainees of all levels
Prepare Teaching Scripts
Tag the Moment

“Okay—let’s stop for a moment and discuss what we just saw—this is an important teaching point.”
Rehearse and Review
What teachable moments pertain to Patient Safety or Quality in your field?

Worst Case Scenario

Medical Error

Handover approach or debrief
Task: In pairs, generate/rehearse a Patient Safety or Quality Teaching Script for your discipline
Illness and Instance Scripts: Analogies in the Teaching of Quality and Patient Safety
Danny Panisko MD MPH FRCP(C)
Department of Medicine, University of Toronto
ICRE, Niagara Falls
September 2016
Illness and Instance Scripts

What are they?

Does anyone explicitly focus on them in your clinical teaching currently?
Teaching of Quality and Patient Safety

ILLNESS AND INSTANCE SCRIPTS

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**Educational Strategies to Promote Clinical Diagnostic Reasoning**

Judith L. Bowen, M.D.


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**Figure 2. Example of an Illness Script for Gout.**

- **Predisposing conditions**
  - Age ≥40 yr
  - Male sex
  - Alcohol use
  - Use of diuretics

- **Pathophysiological insult**
  - Abnormal uric acid metabolism
  - Precipitation of crystals in joint
  - Inflammation of the joint

- **Clinical consequences**
  - Acute pain
  - Single joint, usually the first metatarsophalangeal joint
  - Recurrent
Illness Scripts

• After Bowen, 2006
• Illness Scripts are stored pieces of knowledge; as diseases, conditions, or syndromes; that are connected to problem representations by expert clinicians. These representations trigger clinical memory, permitting the related knowledge to become accessible for reasoning. Knowledge recalled as illness scripts has a predictable structure: the predisposing conditions, the pathophysiological insult, and the clinical consequences.
Illness Script for Gout

Gout is a disease that has:

• **Predisposing conditions**
  - Age ≥40 yr
  - Male sex
  - Alcohol
  - Use of diuretics

• **Pathophysiological insult**
  - Abnormal uric acid metabolism
  - Precipitation of crystals in joint
  - Inflammation of the joint

• **Clinical consequences**
  - Acute pain
  - Single joint, usually the first MTP joint
  - Recurrent attacks
Instance Scripts for Gout

• Prevention in a patient with renal failure
• Treatment in a patient with a particular drug allergy
• Management differences for tophaceous gout
Transition to Patient Safety and Quality Teaching

Illness and Instance Scripts…

…lead naturally to Teaching Scripts…

So why not the same for teaching about Patient Safety and Quality???
Illness and Instance Scripts

A QUALITY AND PATIENT SAFETY ANALOGY…

“ILLNESSES”

• Medication order errors
• Disclosure
• Documentation problems
• Failure to follow up
• Transitions in care
• Inappropriate resource use
• Hospital acquired complications
Illness and Instance Scripts

A QUALITY AND PATIENT SAFETY ANALOGY…

“ILLNESSES” “INSTANCES”

• Medication order errors similar med names
• Disclosure thresholds
• Documentation problems under-documentation in notes
• Failure to follow up
• Transitions in care
• Inappropriate resource use
• Hospital acquired complications
Illness and Instance Scripts

A QUALITY AND PATIENT SAFETY ANALOGY…

“ILLNESSES”  “INSTANCES”

- Medication order errors similar med names
- Disclosure thresholds
- Documentation problems under-documentation in notes
- Failure to follow up
- Transitions in care
- Inappropriate resource use
- Hospital acquired complications

… a new concept to many of you … 1) can you think of some examples or 2) how you would link to a real case “in the moment” ?
Wrap up and Conclusions
Help us improve. Your input matters.

- Download the ICRE App,
- Visit the evaluation area in the Main Lobby, near Registration, or
- Go to: http://www.royalcollege.ca/icre-evaluations to complete the session evaluation.

Aidez-nous à nous améliorer. Votre opinion compte!

- Téléchargez l’application de la CIFR
- Visitez la zone d’évaluation dans le hall principal, près du comptoir d’inscription, ou
- Visitez le http://www.collegeroyal.ca/evaluations-cifr afin de remplir une évaluation de la séance.

You could be entered to win 1 of 3 $100 gift cards.
Vous courrez la chance de gagner l’un des trois chèques-cadeaux d’une valeur de 100.