Take 3 – Practical Practice Pointers© September 30, 2019 Edition

The Fall 2019 Teaching Edition:
RIME Developmental Learning, 1 Minute Preceptor, 1 Minute Learner

---

From the Literature and for the Advancement of Effective Teaching

1) Diagnosing the Learner – The RIME Developmental Schema

First published in 1999, the RIME framework emphasizes a developmental approach to learning in medical education and distinguishes between basic and advanced levels of performance. Each step represents a synthesis of skills, knowledge and attitude, creating a common pathway for the development of professional competencies. Here's how the framework looks (SOAP = Subjective, Objective, Assessment, Plan):

R = Reporter: The learner can "tell you" the information;
"What is going on?" = The "S" and "O" of SOAP.
"This patient has low sodium or hyponatremia. The differential diagnosis for hyponatremia is …."

I = Interpreter: The learner can "translate" the information;
"Why is it going on?" = The "A" of SOAP
"The most likely cause of hyponatremia in this particular patient would be …."

M = Manager: Can "do something" with the information;
"How might we manage it?" = The "P" of SOAP
"I recommend the following tests to work this up or the following treatments …."

E = Educator: Can "teach" others along the RIM continuum. This can be with anyone who is at least "one step" behind them on the continuum.

Below is how this looks along the educational continuum from 1st Year Medical Student to Active Practice. This will be different for PA and NP students, and will require more individualization when working with them.

RIME: Developmental Learning

RIME	I	II	III	IV	PGY1	PGY2/3	Practice
REPORTER	I	R	P				M
INTERPRETER		I	R	P			M
MANAGER			I	R	P		M
EDUCATOR	I	R	R	R	R	P	M

I = introduced in the curriculum
R = repetition, practice
P = sufficient proficiency for the next level of independence
M = mastery in practice

Note that different students may be at different places even if they are at the same chronological stage of education, and a learner may be at multiple places along this continuum for different areas/subjects. For example, they might function at a "Reporter" level for a complex or more unusual problem, and at a higher level for problems that they have more frequently encountered or based on the subject matter of a particular rotation they've already completed. Your task for a specific patient/topic is to determine where a learner is on the continuum ("diagnose the learner") and teach from that place toward the next "stretch" place for them. Overall ratings of performance and progress should reflect the level of consistent reliability.

My Comment:
I have found this incredibly helpful in my role as a medical educator, and students appreciate learning about it as well so that they don't feel "unnecessarily inadequate" by feeling they should be more advanced that their educational level would dictate. Keep in mind that all learners appropriately aspire to be "Managers," but many in their early training are really "Reporters of the management plan" rather than true Managers. The distinction is that true Managers will understand and take into account the context for an individual patient and will be able to adapt the plan to the particular circumstance.

Reference:
Pangaro, LN. Evaluating Professional Growth: A New Vocabulary and Other Innovations for Improving the Descriptive Evaluation of Students, Acad. Med., (Nov) 74: 1203-1207, 1999. Article

---

From the Literature and for the Advancement of Effective Teaching

2) Improving Office Precepting: The One-minute Preceptor

The One-Minute Preceptor is model of clinical teaching intended to provide a framework to help shape and guide the learning conversation. First described in 1992, it has stood the test of time and is a very helpful tool for both new and seasoned medical educators (which, if you teach any sort of student in your clinical role, you are!). Below is a brief overview of the steps and some helpful tips on using it in practice.

Step 1: Get a commitment: Ask the learner, "What do think is going on?" or "What do you want to do?" This will encourage them to begin process the information they have gathered rather than just report it to you. The focus and expectations will vary depending on where the learner is in the RIME developmental schema (see Pointer 1).

Step 2: Probe for supporting evidence: Ask the learner, "What factors did you consider in making that decision?" or "Were there other options you considered?" This helps you understand their clinical reasoning and identify gaps in their knowledge or critical thinking skills (processing skills or synthesis skills).

Step 3: Teach general rules: Once you understand more about what the learner does and does not know you can choose one teaching point for the case. This can be as simple as the appropriate medication choice for strep throat or more involved such as dealing with a difficult patient. However, choose only one point to discuss per case so as to not both overwhelm your learner and get behind in clinic. This is a great time to have the learner look up a particular point and teach it to you.

Step 4: Reinforce what was done right: Praise something about the encounter – their thoroughness, rapport, critical thinking skills, or correct diagnosis. Be specific! Don't simply say, "Good job!" or "Correct," rather point out to them what it was that you thought they did well.

Step 5: Correct mistakes: Kindly point out where there is room for improvement. "I agree with your diagnosis of heartburn, but it is important to consider cardiac and other etiologies of chest pain as well. Can you give me 3-5 other potential causes of chest pain we could consider?" If you challenge their knowledge and they are uncertain, then have them look it up.

Once you become facile at using this tool, you will find that your teaching sessions are not only more valuable for the learner, but more fun for you as well. Letting go of the desire to give them all of your knowledge in one half day and instead letting it trickle out in small portions over the course of your time with them will enhance the experience for both of you.

My Comment:
As was done for each of us during our own medical education, I believe it is imperative that each of us serve as teachers for those coming after us. Indeed, the Latin word "docere" from which our English word "doctor" originates, means "to teach." Teaching is our way of "paying it forward," and of course, it is important to remember that those who are training now will eventually become clinicians who will be providing care for our communities, our loved ones, our families, and yes, for us! That certainly provides us some "skin in the game." For those who already teach regularly, my thanks and admiration goes out to you. For those who do not, perhaps this can be something to add as a professional goal for the coming year. Effective teaching is a skill, and we'd love to help you hone that skill.

Reference:
Neher J and Stevens N. The One-minute Preceptor: Shaping the Teaching Conversation. Fam Med 2003; 36(6): 391-3. Article

---

From the Literature and for the Advancement of Effective Teaching

3) The One Minute Learner: Setting Goals and Expectations

This spin on the One Minute Preceptor model is intended to help improve preceptor and learner experience in clinic settings by setting goals and expectations. This is done with a brief "huddle" at the beginning of their rotation with you and prior to any particular session. During that huddle, one or more of the following areas are discussed:

1. **Goals:** What are the learner's goals for the session? What are your goals? Keep in mind their current level of training/experience and RIME developmental stage when goal setting to "keep it real" and "keep it relevant."
2. **Getting Going:** When, how and who should the learner see? Identify patients from your schedule ahead of time with flexibility to modify as the day goes.

3. **How Much and How Long:** Give clear expectations as to how long the learner should spend with a patient and what parts of the visit you want them to do (just history, history and physical, etc.).

4. **Presenting:** Where and how? In your office or in the room? What format do you prefer? This is a good opportunity to reinforce the principles of patient confidentiality/privacy.

5. **Charting:** When and how? What template do you like? When will you review the note with the learner?

6. **Questions:** When is a good time for questions? At the end of each encounter? At the end of the session?

This article includes a handy pocket card for both you and your learner summarizing these points and you may want to print this and give it to them or post it (attached). The "huddle" portion of this should only require 1-2 minutes of time at the beginning of the session, but will set the tone for the time together and help improve the experience for both you and your learner.

My Comment:
The mutual setting and understanding of expectations and goals can help avoid much misunderstanding and can also serve as the foundation for providing feedback for the learner and for receiving feedback on your own teaching effectiveness.

Reference:
Hoffman M and Cohen-Osher M. The One Minute Learner: Evaluation of a New Tool to Promote Discussion of Medical Student Goals in Clinical Learning Environments. Fam Med 2016; 48(3): 222-225. Article

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

Mark

Carilion Clinic **Department of Family and Community Medicine**