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An Interactive Session to Help Faculty Manage Difficult Learner Behaviors in the Didactic Setting

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Abstract

Introduction: The transition to more active learning during residency didactics has made the skill of managing difficult learner behaviors essential: Just one learner exhibiting difficult behavior can derail the educational experience for the room. Many educators feel uncomfortable handling these learners in real time and after the session. **Methods:** We created an interactive session for a mixed group of educators at a medical education boot camp. After learning about a framework for addressing difficult learner behaviors, participants were paired and presented with the case of a withdrawn learner. For each pair, the cause of the behavior was different. With one of the pair role-playing the learner, they were asked to identify the problem and solutions together. Multiple etiologies for the identical behavior reinforced the need to address underlying causes to create an effective plan for behavior change. Strategies to address difficult behaviors in real time were also discussed in large-group format. **Results:** Participants gave the session a mean score of 4.5 out of 5, indicating a high likelihood of changing their teaching practice. Free-response comments remarked on the role-play's educational value and the enjoyability of the session overall. **Discussion:** This session was effective in giving participants a framework for dealing with difficult learner behaviors, as well as hands-on practice with these skills. While this was a short (30-minute), single session, its success with participants with a wide variety of experience levels suggests it would be highly adaptable to other settings and may benefit from future expansion into the clinical setting.

Keywords

Communication, Small Group, Faculty Development, Large Group, Lecture, Role-Playing, Challenging

Appendices

A. Time Lines.docx
B. PowerPoint Slides .pptx
C. Cases.docx
D. Debriefing Guide.docx
E. Handout.docx
F. Quick Reference.docx
G. Evaluation.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this activity, learners will be able to:

1. Describe four challenging learner behaviors in the classroom.
2. Utilize the SOAP (subjective, objective, assessment, plan) process to determine underlying causes of challenging learner behaviors.
3. Demonstrate how to maintain an educational alliance while delivering feedback to learners displaying challenging behaviors.

Introduction

Classroom-based educational sessions are widely utilized in medical education. Some programs have begun to transition from a passive learning environment (e.g., the didactic lecture format) predominantly composed of one-way knowledge transmission from the teacher to the students to a more active learning environment where learners apply their knowledge, solve problems, engage in discussion, and receive feedback.[1] Various types of interactive classrooms have been and are being utilized, including problem-based learning, team-based learning, case-based learning, and the flipped classroom, as well as a variety of other methods employed to increase interactivity and participation.[1-7] To successfully develop and implement a session utilizing active learning principles, learner participation is required. However, the success of these sessions can also be undermined by challenging learner behaviors.

There are many types of learner behaviors that pose a challenge to the successful implementation of an educational session. We have identified four distinct types of behaviors that can be difficult to manage in the classroom setting, including withdrawal and failure to engage meaningfully with the content, the monopolization of conversation, the disruption of an educational session with frequent interruptions or side conversations, and argumentative interjections.[8] Learning a framework to appropriately address these types of learner behaviors and gaining experience with handling these situations can significantly enhance the success of an educational session. While there is one *MedEdPORTAL* resource dedicated to challenges with learners in the clinical environment,[9] to our knowledge, there are no current resources available to teach faculty best practices for dealing with difficult learner behaviors in the classroom setting. We therefore designed an interactive educational session that can be utilized for faculty development on this topic, highlighting both how to manage the various types of difficult learner behaviors in the moment (during the classroom session) and how to address the learner and identify the underlying etiologies of his or her behavior after the session. We incorporated previous techniques for managing difficult learning situations known as SOAP (subjective, objective, assessment, plan), as well as the technique of advocacy-inquiry for the one-on-one conversation with the learner afterwards, to identify the underlying reason for the learner's behavior.[10,11]

Methods

Our activity was implemented at the Society for Academic Emergency Medicine annual national meeting in Indianapolis, Indiana, during the 1-day Medical Education Bootcamp preconference workshop for residents and faculty educators. The session was allotted 30 minutes although it could easily be expanded to a longer session (Appendix A). For participants, there was no specific knowledge or assigned reading required prior to engaging in the exercise. Participants ranged in their level of training from residents to fellows and faculty.

Two facilitators ran the session, although it could be run with one. Facilitators should be experienced in leading interactive educational sessions and ideally have previous experience using the advocacy-inquiry technique and having difficult conversations with learners.

Seventeen participants took part in the exercise (although the session could accommodate more), which included various levels of experience, including residents, fellows, and more experienced faculty. Other Medical Education Bootcamp educators who had no advanced knowledge of the content of this session also participated. Participants were first introduced to the SOAP technique, which asks educators to probe the underlying cause by identifying their subjective experience of the problematic behavior, an objective description of the specific behavior that caused a problem, and a joint assessment between the educator and the learner as to why the behavior occurred, followed by agreeing to a plan to avoid a similar situation again in the future. Participants were also introduced to the techniques of developing an educational alliance and advocacy-inquiry (Appendix B). Participants were divided into small groups of two individuals for a role-playing exercise. One person played the learner, and the other played the faculty educator. All groups received an initial description of a withdrawn learner during a didactic session. However, the underlying etiology for the learner being withdrawn was different for each pair. Six different etiologies were developed for the role-play (Appendix C). This approach was taken (1) to illustrate how different underlying issues can drive the same outward behavior and (2) to demonstrate that only after the true underlying issue is discovered can an appropriate and targeted plan for improvement be cocreated with the learner.

Following the role-play activity, time was allocated for the facilitators to debrief the activity in the large group. During the debriefing, each group was asked how it had approached the conversation with the challenging learner behavior, what had been learned about the underlying issue driving the withdrawn behavior, and for any additional thoughts, comments, or questions. The large group then discussed how to deal with the withdrawn learner in real time (during the educational session).

After this, the facilitators engaged the participants in discussion about other types of challenging learner behaviors they had encountered in the classroom (e.g., the monopolization of conversation, the frequent disruption of the session, or argumentative interjections) and guided a large-group discussion on how to deal with those situations in real time (Appendix D). The session ended with a review of high-yield take-home points, including the SOAP framework. Following the session, a handout with the points from the debriefing guide was also provided to all participants (Appendix E). Additionally, a quick reference guide was created to accompany the handout and allow participants to rapidly access key points during a didactic session, if needed (Appendix F).

After the conclusion of the Medical Education Bootcamp, a postimplementation survey was given to all participants (Appendix G). Each session was evaluated on a 5-point scale (1 = *Not Likely to Change My Teaching Practice,* 5 = *Very Likely to Change My Teaching Practice*). Reactions-level data were determined though the free-text comments provided by participants.

Results

The postimplementation evaluation survey was filled out and returned by 100% (N = 17) of participants. The session received a mean score of 4.5 out of 5 (95% confidence interval, 4.1-4.9), indicating that when participants were asked to self-report expected behavioral changes, they felt that the session was quite likely or very likely to change their teaching practice going forward.

Multiple comments praised the role-playing portion of the session, stating that participants “really liked the practice,” appreciated “actively trying things out,” and felt that “the most beneficial portions were where we were forced to perform” and that the session “greatly contributed to [their] learning.” Overall, participants stated that they “really enjoyed” the session.

Discussion

Learner behaviors that disrupt the educational environment can be challenging and frustrating for both new and experienced faculty members. We have designed this off-the-shelf resource so that it can be used by others for faculty development sessions on this topic. While the session was delivered to emergency medicine educators, it could be easily used in other specialties since the challenging behaviors described are common across all groups of learners. Even though we had a smaller group of participants, the session could be easily scaled up and used with a larger audience. Regardless of the size of the audience, the role-play activity can be employed as long as participants are divided into small groups of two to three persons. Although our groups had only two participants per group, a third person could be added in the role of an observer, who observes verbal and nonverbal communication during the role-play exercise and gives feedback to the individual role-playing the faculty member. The number of role-playing scenarios could also be increased for a larger audience, including role-playing instructions for the other challenging learner behaviors. Additionally, while this session was delivered in 30 minutes as allocated by the conference organizers, we believe it could more successfully be delivered in 60 minutes, with more time dedicated to the role-playing, small-group discussion, and large-group debriefing portions (see Appendix A).

The plan of giving each of our small groups a learner with withdrawn behaviors, with different groups having different etiologies of why their learner was withdrawn, illustrated how many different underlying issues can drive the same outward behavior. The role-playing activity gave participants an opportunity to practice their newly learned techniques and seemed to reinforce the concept that only after the true underlying issue is discovered can one cocreate an appropriate and targeted plan for improvement with the learner. The design of the session, with more than half being interactive, effectively maintained the interest and engagement of the audience. It was interesting that throughout the session, there was some degree of monopolizing of conversation. While we did not call out the behavior during the session itself, we were able to model how to manage this behavior in real time. For this session, it is important that the

educators feel comfortable with the material being taught, given the interactive nature of the session, and be able to utilize the suggested techniques and model these best practices.

Utilizing the SOAP mnemonic for difficult learners seemed to make sense to physicians, who have learned the SOAP mnemonic in the context of patient care previously.[10] Rather than the assessment being the differential diagnosis of the patient, it is the differential diagnosis of the learner in difficulty, including the potential underlying etiologies of why the learner may be demonstrating behaviors that disrupt the learning environment, a vital step in correctly diagnosing the learner.[11-12] Just as with patient care, as more information comes to light (in this case, through discussion with the learner), the rank order of the differential diagnosis changes, as does the plan for improvement going forward.

Advocacy-inquiry has been adapted from the simulation debriefing literature.[13] We have found simulation debriefing strategies such as debriefing with good judgment and advocacy-inquiry to be applicable to clinical feedback situations and other difficult conversations. Advocacy-inquiry seems to be of benefit for this type of difficult conversation as well. Our session also emphasizes creating an alliance with learners, which many educators have identified as essential to behavioral changes.[14]

A limitation of this initial pilot session is the fact that it was delivered to a small group of participants from a national emergency medicine conference. While we believe that the subject matter could be generalized across learners in all medical specialties, the session would need to be delivered specifically to participants in those other specialties to determine generalizability. Additionally, the participants self-selected into participating in this workshop and had some degree of enthusiasm and interest for the topic, which may not be the case for a faculty development program with a more general audience or compulsory participation. Although evaluations were positive and included comments suggesting that the learning objectives of this session were achieved, we did not assess this specifically. Finally, it is possible that a group of more experienced faculty may not find this session as useful as residents and junior faculty. However, anecdotally, faculty of all experience levels report discomfort with difficult learner behaviors in this context, so we would not necessarily expect the session to be inapplicable to experienced faculty.

Next steps for expansion of this difficult learner session would be to create a more comprehensive session, extended to a full 60 minutes, that includes how to deal with difficult learners in the clinical environment. While there is already one *MedEdPORTAL* resource related to difficult learners in the clinical environment, it is limited to cases concerning a learner who is resistant to feedback and a learner who is nervous about approaching a faculty member.[9] There are many additional types of difficult learner behaviors in the clinical environment that would be appropriate for additional training for educators.

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