

**Title**: Resident Experiences of Informal Education: How Often, From Whom, About What and How

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**Summary**:

* Background
	+ Most education that takes places during work activities is informal
	+ Informal learning is unconstrained by time, place, or content
	+ Research Questions:
		- How often are residents taught informally by physicians and by nurses in clinical settings?
		- What competencies are informally taught to residents by physicians and nurses?
		- What teaching techniques are used by physicians and nurses to deliver informal education?
* Methodology
	+ Evaluated informal education in two different settings:
		- 9-bed community-based hospice (nurse led)
		- 167-bed pediatric tertiary care teaching hospital (physician led)
	+ One research assistant trained in ethnography collected 161 hours of observations.
	+ Analysis used data reduction, data display, then conclusion drawing and verification.
* Results
	+ 264 informal learning events: 84.4% physician-led and 15.2% nurse-led
	+ 75.0% inter- and 86.1% intra-professional education happened in palliative setting
	+ CanMEDS Roles most addressed were:
		- Medical Expert (nurses:27.5%; physician: 35.7%)
		- Communicator (nurses: 25.0%; physicians: 22.3%)
	+ Teaching techniques used similar for both inter- and intraprofessional education.
	+ 25.5% of informal interprofessional teaching were modified with indirect manner (non-confrontational).

**Discussion Questions**:

* General Thoughts
	+ Liked the paper and it complements our own work that we are doing in graduate medical education
	+ Mixed reactions to qualitative nature of the study; liked qualitative because it provides a lot of rich context in which to understand the informal learning events.
	+ Interesting that there was not a lot of feedback as a teaching technique; would have assumed feedback is common.
	+ Would be good to replicate this study in other settings and compare the findings.
	+ Study is purely descriptive; it doesn’t provide the reader with implications or thoughts on what to do with the knowledge gained.
	+ Nurses used lots of “hedging” teaching technique; likely because of the hierarchy between doctors and nurses?
	+ Would be interesting to know the years of experience for nurses providing education; a nurse with 15 years of experience may provide more education and/or use different teaching techniques than a new nurse.
	+ 15% of learning was nurse-led; shows that residents still learn from attendings (as is tradition), but this also shows there may be an opportunity for more nurse-led education.
* Potential Limitations
	+ Used one research assistant to collect data: does this introduce bias or reduce problems associated with inter-rater reliability
	+ Does not report anything about quality, value, or length of informal learning events. A slower pace environment such as palliative care may have better quality informal education because there is more time for discussion and reflective learning compared to a larger, faster paced teaching hospital. Perhaps interviews could fill this gap.
	+ Are there any ways to tie in the patient perspective? Would this add value?
	+ Does not address missed learning opportunities.
* Quality of the Paper
	+ Easy to read
	+ Clearly outlined and presented results for four study objectives (who, what, when, how)
	+ Liked the Appendix because it provided important details and concrete examples without disrupting flow of the main results
	+ Liked the study trustworthiness paragraph because it was upfront with the reader about limitations and credibility – this is very different from the engineering/math literature