Precepting during Medical Emergencies

Jimmy: What’s good fam? It’s your host Jimmy Pruitt aka PharmD in the ED and I’m bringing you another episode of the Pharm So hard podcast. Today we have another special episode, and this is gonna be a co-release. I've partnered with Precept Responsibly and we are giving your guys a phenomenal episode.

And I, I wanna say it's one of our, our best works up to date. A few things to shout out before we get into this episode. For one, Happy Pharmacy Week. Uh, this should be dropping in the middle of October, so by the time you guys hear this, it should be Happy Pharmacy Week for you guys. So I'm thankful for not just all the acute care pharmacists but pharmacists everywhere because, uh, we are a community and without all of us doing our job together, we wouldn't necessarily be able to do the things that we do.

So thank you for everyone out there. Another shout out to, Again, this is gonna be our, when you guys hear this is gonna be our third year of being a podcast. We have done some phenomenal things. We've got highly rated and for us to have such a, a unique niche as far as our market, I think we're doing a good job.

So thank you for all you guys who've been listening over the last three years. It's been a, a special time for me, so I really appreciate all what you've guys been doing, and I'm just really thankful for, for, for everything. And lastly, I just wanna say again, if you guys are appreciating all of our stuff, again, always look out for our Pharmacy Friday Pearls with our free blog that gives you some of these bite size information that you need from the acute care ED standpoint.

And check out the PACU. That's gonna be our premium website, and we have a huge project that's gonna drop at the end of the year. So go ahead and get on board with that and check us out. And again, all of that stuff is gonna be in our show notes, so we are very easy to find and always get on our email list.

Uh, stay up to date with the most recent episodes. I'm gonna go ahead and jump into this episode. Again, this is co release with Preset Responsibly, and I thank Jason and, and David for interviewing us on this episode. So thank you guys. Let's get into it.

David: Our, uh, for our episode tonight, uh, we have Jimmy Pruitt from the Medical University of South Carolina MUSC, um, and an interesting conversation, which we hope we'll all find engaging. But as always, as we start the night, uh, we need to tell the listeners. What we're gonna be drinking for tonight's discussion.

And I have, uh, Jason, you're gonna like this. A Titos with Diet Mountain Dew mixed in it. Okay. Um, so I have a Titos and Diet Mountain Dew. Uh, Jason, what you, what are you drinking and uh, then we'll turn it over to Dr. Pruitt

Jason: Dave. He was like, Cannot believe you took Mountain Dew and mixed it with something.

It's not good enough. Straight up.

David: There's always ways to improve. Jason, I tell myself that every day. There's always ways to. Well,

Jason: since we are, uh, rapidly approaching Halloween, I decided to, uh, pop open stone brewings, uh, pump king, nitro stout, uh, out of a can. The, the pop of that nitro sounds really great.

Uh, you know, really getting in that Halloween spirit. So I'm, I'm ready to go. Uh, how about you, Jimmy?

Jimmy: Unfortunately, man, I'm sitting here drinking a water and, uh, BCAs mixing that. So my pre-workout.

Jason: Oh, that's awesome.

David: post workout drink. I love it.

Jason: Absolutely. No judgment over here. Uh, gotta have lots of great vitamins,

David: All right. Let's, let's get into, let's get into the content. Jimmy. Uh, thanks for being here. Can you give us our listeners a sense of your background training, years of precepting? Um, overall, uh, tell us about yourself.

Jimmy: Yep. So originally from Orlando and I was originally a football player and got into pharmacy as a chemistry professor, basically asked me what's my backup plan to the nfl and I went home and watched the episode of House and thought about it a few, and I was like, Okay, I'm gonna be a pharmacist as my backup plan.

And that was my, my, my pass out of class for a week. But, um, went on to Presbyterian College for undergrad, played football there, and went to Presbyterian for pharmacy school as well. And. Then went on to Advent Health Orlando for PGY one until my PGY two at Grady Health System, which was like my, my dream program.

And I always joke around and say I definitely had the best residency year that anyone's ever had. So, uh, went on there, spent some time in Augusta for, for about a year and a half, and been spending the majority of my career at MUSC down here in sunny Charleston, South Carolina and I tell people I really get to lift my dream that I set out at 15.

Just the patient cases, work in ER, all the things. I just really enjoy doing the teaching. Uh, super excited to be energetic about all of this, to be honest.

And I've been precepting now for about four years now.

Really excited. Yeah, super excited for the work you guys been doing and really excited to have this conversation. I got,

David: yeah, Jimmy and I, uh, I gotta set the phone. Big fan of your, your podcast. Pharmacy Pearls. So really happy to have you on today's episode. And although you know the years, uh, you, you have a, a number of years under your belt, I'm, I'm really excited.

You're our first emergency department pharmacist. We've brought on, I think, formally trained, correct me if I'm wrong, Jason. Um, but, uh, today's topic is really gonna focus on teaching during medical emergencies. And, you know, I, I really think it is a challenge and I, I. Really owe a lot of respect to yourself in the emergency department of how you do this.

And I'm hoping to give our listeners a really good, uh, episode on, on how to do this in the emergency department and doing it in a more acute, uh, environment. So, uh, I guess the first question to dive right in, what's your approach to teaching during a medical emergency? Can you, can you walk us through how you do this in the emergency department when, when time is of the essence?

Jimmy: Absolutely. And as you mentioned, this is something that's very challenging and it's a very challenging situation to teach medical emergencies while you're actually in those medical emergencies. But I think one of the things that you can do, and it's something that I've tried to make a cornerstone of my teaching career, is this concept I call teaching out loud.

And I think it's something that really helped me, and it's something that I do with my learners. I create scenarios beforehand and I make sure I try to go through the entire process of what I'm thinking of when the patient comes in with that resident or student. And I try to dive really deep into that.

I, I go into small details like what, where's my equipment? Things like where is the syringe that I'm gonna use? What type of needle will I use? Exactly where are these things, locate. and where's the medications when I go to the Omnicell, what buttons I'm gonna push, what alerts will come up? And I try to go through great detail to think about this because this is where people freak out when it comes to medical emergencies.

These is where it really makes it to where I can see my entire plan and create my whole entire pharmacotherapy plan based on the information that I have out loud. And I noticed twofold, my residents and learners, they understand what I'm gonna do and not be surprised. But I've also found that my physician and nursing colleagues really appreciated as well because they just do things that I ask them to do.

Indirectly, whether it's something as simple as, Hey, I'm gonna use this medication for rsi, or whatever it is, I can go through my entire thought process of how I'm gonna do teaching out loud, and this is one of the ways that I'm able to guide my resident while actually doing things. And I try to balance teaching versus patient care.

Jason: I love the idea of like, using your out loud speak to, um, implant ideas in your team's head without having to physically be like, I'm gonna recommend you do this, this, and this. It's just kinda set out loud, so by somebody. So Jimmy, that's, that's a great, um, that's a great technique for your team, um, but also for your learners.

I, I wonder like, before you even approach this situation, um, do you let learners know like, Hey, when this emergency happens, like. Don't run in like, here's like some expectations for you up front. Uh, I specifically think about like maybe some of our ICU colleagues are floor colleagues, um, that like, it's not as common for us to have that kind of like rapid emergency may happen periodically, but like the, the resident or the student comes in and they're like, Yeah, I, I really wanna be engaged in this.

Do you do some pre-talk to like get them set up for what to expect, et cetera?

Jimmy: Yeah. And what I try to do early on, if I have a learner rotation, Is I, when I make sure, even for on call residents responding to medical emergencies at my shop, I try to let them know that, hey, I'm gonna take the lead on this one.

I'm gonna walk you through this one and I'm gonna be telling you things that I'm thinking out loud. And I try to set this, this precedent's early on that I don't them worrying about doing something. And I found over the years, especially in this early stage of road def rotation and of the residency year, That they get very conscious of the expectations of the team on.

So rapidly I try to disengage this fear and say, Hey, I'm gonna do all of this, but I want you to pay special attention to everything that's happening. And then we're gonna have a very in depth conversation. And this is what I found that really disengaged the fear and opens them up to learning. So ask them.

Trying to open 'em up and, and certain times, certain residents, students want to get involved and they're really, you know, eager and there're simple things for them to do. And I say, Hey, can you go grab this flush? And I, I won't ask 'em for two or three at a time. I ask them to get an individual flush every time that I need one, because that where they're consistently going back and forth and grabbing an IDA and they're like, Oh God, I'm being involved.

Or I, I may do something like, I may prep an epi myself and then have them prep the next. So as certain things I tried to do to disengage them from the overall responsibilities while letting them watch everything and hear my thoughts, so I can notice based off their, their body language, there are certain learners that want to be involved right now and there are certain tasks that I allow 'em to do.

A few ways that I'm able to like disengage 'em initially and let them know I don't want you to do anything outside of learning. And then if they're eager, I throw 'em a bone here and now and then really make it so we can have a conversation later on.

David: Um, I'm almost thinking it's like I'm, I'm hearing like muscle memory, where like, it's like the repetition over and over again.

It's like syringe, syringe, syringe. And then like over time they like automatically know where the syringe is and the next step prepare, prepare, prepare, and then they know to prepare from those chronological steps that it, it's such a, a great idea and um, perspective.

Jason: Jimmy, what do you do to like, work with, um, your residents and, and learners to get from that, like modeling, uh, modeling, direct education stage up to like coaching and facilitating?

How do you, how do you gauge that? Like, this person's ready to go, I think that they're, um, like ready for the next step? Or do you just kinda like pull the rug out and say, Okay, you're doing this next.

Jimmy: All right. So I would say in traditional work volumes and in severities, cuz Covid made things a little bit more unbearable to where we had to divide and conquer early on.

But in traditional environments, what I like to do, especially right after I've done modeling some of these behaviors, is that I have a very in depth conversation and simulations where I say, Okay, we did this particular case, but what if this. And then I ask them certain questions and I drill them. And if they're able to really understand what's going on and engage with me and I can follow their thought pattern, and I would challenge 'em.

Say You want to use Rocky running for these patients? Why? And then challenge them to say, Okay, be able to go through their entire thought process. As if a nurse or a physician was gonna challenge them. And if they can explain this to me and I'm able to find that I can be there for them and walk them through the scenario from the side and they can be affecting the resuscitation, then I switch position and say, Hey, I'm gonna be your runner now.

And I'll be, I can be involved in a slightly different way. So once I switch positions with them and initially, once they're able to show me that they understand a thought process that's needed, I switch place and tell them, Okay, now I want you to think out loud. And that's really been something that's been intriguing for me because I get to assess them prior to the patient getting there to let them know how much work I'm gonna give them.

So for example, we had an EMS report prior to a patient getting there. I say, Okay, rapid fire. What's your thought process? What, what medication do you want to get? What are, what are the things that you're thinking of? What do you need for this case? And always use the phrase with them, What medication will you need for the next 15 minutes right now?

And I caveat with the scenarios that you think, and the ones that you know that I may think to ask you, what medications would you need? Then I caveat it, take over if things get rough and I'm really able to kind of switch roles and let them fly. So if they're prepared at that, .

David: And Jimmy, it seems like in this methodology that, you know, not every resident student learner is gonna get through that same trajectory.

Um, I guess how do you deem success in something where, you know, maybe a resident doesn't, or, or learner doesn't progress up to being, to the level of that final stage of facilitation of an, of a, of a precepting model? Um, do you, can, can you still like, find success in those residents and. Is it okay that you have different levels of, of experiences for the different levels of learners?

Jimmy: Absolutely. I think it's really challenging for those, for those cases, but for those learners that are not able to actually do it. A lot of it, they're just able to talk through certain things and I've had students in particular that just wouldn't get involved. It was just a little bit too much for them.

They were not able to drop medications, they were not able to label, and it was just times where they're just too overwhelmed with the actual resuscitation. But afterwards, I was talking through

certain aspects of the case and I was able to say they understood the Pharm therapy plan. They understood why we did certain things, but.

Because there are just certain moments, you don't have enough volume to show them and get them involved. They just wasn't ready. And when it comes to those moments, they're just a little kind of out of the blue and a little green. So what I do for when they're not ready, I try to change up where I get them involved.

I like to really get them involved in these subacute emergencies where there are certain traumas that are not involved. You know, you have someone that has failed and they're okay. These are the patients where they would get some fentanyl, some tetanus, some antibiotics. Again, not overly acute in nature, but I get them involved in, in those cases where get a lot of fighting with those.

And for those patients that don't progress, I really like to get them Just some easy, some easy, some pa easy passes. I like to say some easy ways to get them involved early on.

Jason: Jimmy, you um, When you're done with these and you do that like in depth discussion with your residents, do you do any other clinical debriefs with team members, with, uh, your, um, learners, et cetera?

Or is it just that piece with the learners and.

Jimmy: Yeah, I've been very fortunate at M U C and Grady. Uh, it's, I get a huge team as part of my traumas and a lot of multidisciplinary interactions. And after the case, what happens is it's usually an impromptu teaching where I'm debriefing with my residents and I usually catch the other interns in lower level, um, physicians that are part of trauma team looking over engaged.

And all I like to do is introduce them to the case as well and get. Thoughts on certain things where I know that it is something that's gonna be on their boards. Hey, why'd you order this particular, you know, CTA or CT admin pelvis, or get some questions involved in, in their role in the case. And that way everyone can be part of the learning process and in a more formal.

Debriefs, like in post resuscitation in the cardiac arrest. I'm usually one that ones that ask for a debrief very quickly. I know people wanna run off and I say, Hey, what went well? There are some some different things that that could have happened and. It gets everyone's thoughts of it and see how we can improve his pharmacy, nursing, physician staff, and really go from there.

But depending on the, on the day, I'm try to engage very deeply as a debrief with my learners. And depending on the case, I really try to get involved with other specialties and ask them certain questions to let them know that I'm engaged with their learning as well. And I've noticed that a lot of the interns, I really like it when you're down here, can you really teach me a lot, even from the non pharmacy part?

Jason: Uh, Jimmy. Uh, I think, um, I love that idea of like collaborating with, in a multidisciplinary way. It's a great way of modeling a great interdisciplinary, um, you know, service with your, your learners. One of the things that comes to mind, and this is a bit tangential, um, so bear with me, but as you're having these like really challenging in depth conversations about like, well, what if this happens and what if this happens and what if this happens?

Uh, I, I can just envision myself as a learner. Why is this dude asking me so many questions? Like, is he just trying to make me look stupid? So how do you avoid that? How do you like strike that balance to like not do like a classic like right, like pimp the student or the learner. Like how do you strike that

Jimmy: balance?

That's the challenge. And I think. That's definitely a challenge, and I think one of the things I've been fortunate over a period of time is that people are starting to know me before taking my rotation. Whether it's just they, they've heard about the rotation from other people and they know that I like to ask a lot of questions, scenarios, but I'm hoping they also know that I, I try to make it engaging and I try to be more personable, whereas not at least not very serious conversation.

A lot of the times when I'm teaching, I'm smiling. I'm trying to make all of my nonverbal communication very positive and open. I say, Hey, This is just your thought process. I just want get this, I just want to, I just wanna make you great. And I try to do a lot of positive feedback when they're doing well.

And I try to make sure I minimize the degree of negativity of saying things like, You're wrong. I try to say, Hey, that's probably not the best answer. I don't know what, what are your nursing staff think about that. What does the other team gonna think about that? Those are there. There are different ways to do that.

So I try to minimize the negative complexity of it because I realize there's a fine line you play. And the medical residents are always there, especially the surgeon's like, Oh, he's gotta, You gotta watch out. Jimmy's gonna camp

David: you. Jimmy's coming. Jimmy's coming for

Jimmy: you, baby. It's funny. He's like, Why do you know stuff about cts and x-rays and stuff?

I'm like, Someone who's asked me these questions you're attending, asked these questions. I'm trying to help you not get pimped by them on rounds. So that's how I phrase it to the other medical residents and it really just becomes a really cool environment in where I try to just be very p and make it a joking, um, away, but just I want them to be curious and I try to promote that same curiosity when I'm doing the.

The, the, the questioning I'm saying, this is the question I'm asking myself. So I try to make it to where they're, they're aware of it and I try to make the interactions, the non-verbal communication, and even the way I phrase certain things from a verbal, they're very positive towards them, to where I can make them think, Hey, this is actually fun.

This is, I'm, I'm curious now.

Jason: I love that, Jimmy. I think the curiosity is like one of the great ways to like disarm that like, gut reaction of like, someone's, someone's trying to make me look dumb. So I I really appreciate that. Dave, you were gonna say something?

David: Yeah. This is bringing back like, I don't know, you know, back when I was, my first week as a, as a PGY two.

My own pharmacist shared a, uh, an office with our ICU pharmacist and he had like this article like laminated up on his wall and it was called The Art of like, as you through this, you know, you really hear the truth to that, Right? The art of doing like, you know, not overly burdening somebody, but get them, get them on track to, you know, to be able to think ahead.

Right. Anyway, I'm, I'm digressing a little bit down, but, um, I, I wanna, I wanna get to another, I don't know, topic that can kind of relate to this in the, in the field of medical emergencies, in, in really that sometimes medical emergencies unfortunately end in negative clinical outcomes, whether that be a, a patient fatality, whether that be a failed resuscitation.

Um, a number of different negative outcomes that unfortunately you're going to see in clinical practice and unfortunately in the emergency department, you are gonna see. So I guess, um, I, I wanna start by, by opening up openly and saying how you manage these failed interactions, failed challenging situations, um, in any miscommunication that that can come with them.

Jimmy: Yeah, so it's definitely tough and I'm not expert. I would say that it's an. And something I've tried to learn over the years, and a lot of it starts intra resuscitation because we're fortunate now after, you know, 15, 20 minutes into the case, uh, most of us have a good sense of how this is gonna end. And again, you may have some surprises, but for the most part, the information you've gathered in the scenario that you've played in your mind, one of the scenarios is always gonna be what, What if we fail?

And I tried, depending on the learner and where they are in their career. I try to be very conscious when it comes to my student. Uh, one of my, in my emergency medicine lack, I bring in five or so students every Friday to shadow me in the er. And last week I had a case where they were there and we had an intubation.

I thought part of the process, one of the scenarios is that this patient may go into cardiac arrest and we had just talked to the family members and they said, Do one round of cpr, and that's it. So she has our very high probabilities of not, you know, making it. . So through that process, I positioned my students at that point towards the door and I said, Ask this.

Go on. I don't want you to ask me if it becomes too much at any point, I want you to step out. Not this is not part of your grade, this is not part of anything. I want you to do some, It's not important, It's not important to me that you, you learned this right now,

David: but do you think that that is a necessary need in a emergency department rotation?

Students or learners need to have that

Jimmy: experience? I think so. I, I'm fortunate to say that. Not the first. It doesn't need to happen the first time, every time. So I, I know that my, my students are gonna be in the ER three or four times. So from there I say, Okay, the first time, this is what we're gonna be expected to see.

I let them know, Hey, this patient may die. I'm gonna be very honest with you. I wanna make sure that you have that in your mindset before we walk into this room. Are you okay with that or do you want, you wanna hang out right now and as we, as you progress through the rotation, as you progress through the time, then you can start having conversations about how to deal with it.

But I think initially I tried to position the students and let them know through the phase of resuscitation how we're going, things are, may not be going well. If you wanna step out, this is okay. And then once we go through the process, I have a student for for weeks and I say, Hey, this is what's going on.

Let's debrief the same exact way. What could we have done better? What could we have done differently? But now let's transition to the emotional side of this because I believe that's a a big part in last week, I got my students who put 'em in the room and say, Hey, this is how I deal with tough cases.

Usually it, it involves something personal to me. So whether it's someone like a child or it's someone who looks like a family member, call, uh, I've cried on shit multiple times. I've felt these things, and I let them out immediately and I talk to people, let them know what I go through, and, and I share that.

Okay, so I have to walk this off. I have to have to do this to get myself through the case and let them know that all these things, because if you say, Hey, I've cried, I've called people. I've have tough shift. I have to walk out for a second. Then it makes it to where they're okay, they're okay when they have to do it.

So I try again to put into phrase in phases, because I believe the first time they go through this, they doesn't need to be the first time they see everything. But after a while, I try to transition them all the way through it and even check it up on S and learners the day after when they've had a tough case.

Mash casual. C is a big one. Very challenging case involving ob. All these things where I may check in and say, Hey, how are you doing? When I talk about it not, and I can just leave the door open for that.

David: So it sounds like it's, so, it almost sounds like it's like this surprise effect Yeah. Of saying that like, you know, if a, if a learner's not prepared, I mean, I, I'm, I'm gonna parallel this to my oncology practice for not emergency department trained, but like, when I had students, learners, et cetera, you know, and you had a newly diagnosed patient with a, with a metastatic cancer in, and a student goes in there, you have to have the expectation.

That that patient, family member, et cetera, may have some, some very hard emotions in that conversation and it may bring up. But I, I, I found preparing students for these conversations, preparing residents for what could happen in these scenarios was, was really effective at, at having them deal with these mixed emotions that come up in clinical practice.

Jason: Absolutely. Can I just say Jimmy is, is someone who has like a unfortunately trauma filled background, um, with like my own kind of challenges and struggles as a a person. Um, I, I am incredibly appreciative of you taking that time to like, Explicitly tell people like your grade is not attached to your reaction and how you manage these things.

Your social and emotional intelligence is something that will build over time. And now something like day one, I'm just gonna like dump you in on like a. You know, uh, postpartum case, right? Like, I think about like my first, literally it was my first week back from, uh, paternity leave with my first child.

We'd already had multiple miscarriages at that point, and I had an OB case in the or. Plan C-section was not going well, not looking well. There was no backup, there was no one around. I had two learners and it's like me trying to figure out like, what am I gonna do about like myself as a person, as like, I'm literally watching this person that could have been my wife like three weeks ago.

Uh, it's like we all struggle with it. It doesn't, it doesn't matter if you're a brand new student and you've not experienced it. If you are a practitioner that's been doing this for 15, 20 years, like there are cases that will get to you and, and make it really challenging. So I, I applaud you for, um, Like sharing that piece of advice for people, um, because I think we all have this idea that like, well, you're in, you're in medicine.

You need to have like a stiff upper lip and like, you just gotta keep going. Like, no, sometimes you don't. Maybe you need to like, call someone, find help. And, and I really love that idea with connecting with that family member that like maybe brought that up for you. That that's some, uh, really great advice and I just wanna like, hone in on that as like the emotional intelligence piece.

So thank you Jimmy.

Jimmy: Thank you. It's tough and I think the more we are in these states, and I think that we're fortunate to be experienced with these things and see it so often that we know at the end of the day, none of this stuff matters. A lot of these, you know, I like to say, you know, I like to say pharmacy is very concern, surrogate markers of professionalism.

And this is some, these are one of the things that I've heard people say before. Oh, I had my student cry on me. I had my, my resident cry on me because of blah, blah, blah. And it's like, That doesn't matter. Again, I've, I've done some, some things that I really appreciate and I've also cried on shifts, so that to me, doesn't make it any better or worse.

It really doesn't, doesn't matter much. Our students and learner should know that they should. They're not gonna be impacted by that. And any preceptors out there that are, you know, judging their students or learners based on their reaction to, so, And they're literally two, one to two years into their career.

You know, I, I have a problem with that. I hear you.

Jason: I hear you. Um, Taken a slight twist into the positive direction. Uh, when you have like a, I think about myself as like a PGY two critical care resident that did some time in the ed. Like when you have a case that just everything works out perfect, you like sedation is spot on, rsi, spot on, you get pressure started, like all of a sudden they start looking like way better.

They pink up, they look great. Like how do you like manage the emotions of like that extreme success and then like pivot that to. Maybe additional learning opportunities or like what do you do to like temper that resident from that walks out of that like case and as like, boom, I nailed that. Don't talk to me.

I got this, I'm out.

Jimmy: Absolutely. Those are, I think those are the hardest cases to learn from. Um, I actually, Cause again, with my, my background in sports, when everything goes well, you don't practice those things that get you there. The, the fundamentals. And one of the things that makes it unique is in those moments where I celebrate the win very quickly.

That can be as something as, Hey, you did a phenomenal job on that. I'm buying dinner, but before I buy dinner, let's talk about this a little bit more. Let's talk about what, what if, What if this would've happened? What if that would've happened? And then what I notice is that they go from like, ah, All right.

Uh, okay. , I was, I was really happy about that, but I think we know, and especially in the er, in in the unit, you know, you can never celebrate too early. I've had cases where I thought we did a great job. We've got ro blood pressures looking good, titrated off pressures, and then they go to the unit and code again and don't make it.

So I think it's more of a, a standpoint. So, okay, what are the next steps? I keep, I keep reminding my resident, my learners, what's the next medication? What's the next step? You know, what's the, what if this happens? So if we get a great patient, we resuscitate them, we get sedation on board. Okay? If the patient becomes hypertensive and agitated, now what if the patient becomes, uh, hypertensive and agitated?

Now what? And try to make it to where you have a, you keep a plan going, you try to transition that to additional learning. And what I like to do is I like to ask certain questions that I know they probably haven't progressed to. And make it to where they can have some more questions to go home with. You know, I make all my learners have a, um, an Excel sheet with di questions for every rotation to where I say, Okay, the end of the week, give me your response to all the questions I ask during the week.

So one of the things that I do is that during certain moments where we're high fiving, that's great. That's a phenomenal job. We're gonna celebrate this, but there's something, a part of this that we could have done better. So I talk about those parts of the, of the case, and there are some other aspects that we didn't get to.

Yet. So I try to really dig deeper into that and then play the devils advocate. What if, what if this happens? Then what if that happened? It is continually changing the scenario. I, I, I think I'm fell in love with simulations and just a thought process with that. And you can continuously change the CI scenario and get additional learning aspects out of one case.

Jason: I love that it's like you've, um, to bring it back to sports, it's like you've taken the Tom Brady Methadone brought into healthcare, right? Which is like, Oh, I don't

David: use Tom Brady. .

Jason: You could like never be perfect, right? Like, there, there's no such thing as perfect. There's only like, striving for perfection and like you'll always be moving there.

So that's yeah. About Tom Brady, but ,

David: I'm gonna, I'm gonna, I'm gonna mix the, the two last thoughts together and get your perspective on this. So, in a case of a maybe. Failed resuscitation when you're dealing with mixed emotions. I, I guess how do you bring up successful management of that case with a resident or learner that ultimately feels defeated because the outcome was negative, but the way they handled that situation might have been, you know, pristine.

It might have been like everything they could have done. They, they managed it well. They held themselves, they were resourceful. I guess, how do you, how do you overcome that and, and work that balance into a, into a negative outcome case?

Jimmy: I think what I've, what I've learned through that timing is gonna be everything and reading your residents and where they are emotionally at that time.

There's, there's sometimes where I would say after the tough resuscitation, Hey, take 15. Take 10, 15, 30 minutes, go eat, go do different things, and just detach from the situation for a second and kind of get along with those, Get away from the environment, get away from the stimuli. We're fortunate for our resident office is like very far from the ed.

I make them go elsewhere for a second and give them time to like be okay. And once we come back, then I can start engaging into the, the, the process is, that was actually pretty good about that. Cuz usually, again, the great thing about the ER and, and acute care in general. There's times where it's like, Hey, we tried, we did, we did all the things.

We did these things well. And usually during that timeframe, when they're away, I can get, gather, um, feedback from the team. And one thing that I noticed is that all of the residents love getting appreciation from other specialties. When the nurse say, Hey, that you did a phenomenal drop getting, getting those drugs set.

When the, when the physician tells them, Hey, I, we couldn't have done anything with you, without you being there. Those things really prep them up. And then once I kind of beef up their spirits with the things that we did well, and then we can start getting to more, It's all, I hate to make it this way, but it's all about the case.

The case. What was the actual case? What did we do? Did we do those things correctly? And for next time? What, what else can we do better? How can we modify, But I think taking some time away from the, from that scenario, getting away from that environment, beefing them up with some positive feedback if they did well.

Um, I'm not a fan of always giving great feedback if, if you are horrible and I had to step in and take over the case, but I think they did well. They try their, or they taught their best from what the skillset that they. It's always a way to say, Hey, this is what you've done well, you've learned this particular skill set.

You, you've made the right decisions based off what you know, and I can't ask, I can't ask need more from you from that standpoint, but this is some different ways from to learn and ask their opinion

how you think the case went, How do you think all the, the different, the different specialties performed and really just try to, to make it to where, I try to not make it personal if I can.

Um, but at the same time, it's like giving them a positive feedback and asking them what, how, what is the learning process from this case? And, and try to move on from that and get their, get their, their mindsets on something else. It's tough, .

Jason: If it was easy, everyone would do it. Jimmy.

Any last suggestions for particularly maybe new practitioners? Um, It. Yeah. Let me start that over. Jimmy. Any, uh, any suggestions from new practitioners? Maybe in a variety of settings, Say like the floor icu, um, you know, that maybe don't run into medical emergencies all the time, but, uh, do periodically and, and maybe need, like, to make split decisions, like any last minute tips or advice for, for those, um, situations outside the ed?

Jimmy: I think one of the biggest thing that I would take from this, and I guess the model that I, I, I keep, you know, preaching about, thinking out loud. It's okay to tell, tell your learner. Sit there, watch everything, and we're gonna discuss things afterwards and, and you can discuss things when you're ready as a new practitioner, because sometimes a new practitioner, you're very unsure of what you're doing.

Sometimes you're unsure of how to, how to, you know, discuss these things. It's okay to take a moment. Take care of your task and then later on a different time then discuss these things with the, with the resident or learner. And then also I think one of the biggest things that I, I struggle with initially is not having the answers to the questions upfront.

I struggle with initially is not having the answers to the questions upfront. And for me, I realized that was okay. And one of the things that my. My residents and learners told me they respect me more for me telling them what I didn't know and going to look the information up myself. I wouldn't go send them to get the answer.

Sometimes I would go myself and find and find the answer and then we'll talk about that as well. Because I think there's a, a group of people out there who they don't know, they played a game where you should know that, uh, you should just get back to me, you know, next day while they look it up and find the answer.

But I think you're saying that you don't know. And Yeah, that's the easy

David: way. Yeah. Figure till you like, Yeah, just figure

Jason: out, This is a recurring theme, Jimmy. Yeah. You're, you're our second guest that has said the same thing and, and I think, yeah, having that vulnerability to tell someone like, I don't know, And then what you do to like make, uh, like rectify that situation is really important.

It's modeling vulnerability. It's modeling, like understanding that you're never gonna be a hundred percent. Like confident in every answer that you have. Cause it's not possible. And,

David: and it teaches your learner to say like, it's okay to say, I don't know. Mm-hmm. , right? Like when they're the preceptor in like a year or two down the line and it teaches them that it's to, to, and it teaches make method, which, which isn't, isn't, you know, it's not great for

Jimmy: Precep.

Absolutely. That I've actually went to the front to where even if they're not there, if I make a wrong recommendation or if I have a, if, if I look at a case incorrectly, I will bring it to their attention. Because what happens is it, What it really does is it allows them to say, Well, if he brings this up to me, Then it's okay.

And when I'm questioning them, they notice it's okay for them not to know as well, just in those moments. So I think it's made it to where it's a, it is a, a better environment to where if I don't know something and I bring that up, if I made a mistake and I bring that up and I show them the steps that I've done to go about, Rectifying that answer.

It helps them build skill sets to understand how to problem solve, but it also opens up that vulnerability to where when I'm asking a lot of questions or I'm doing my teaching out loud thing, it's okay. They don't feel like I'm pimping them as much and it builds a better relationship.

David: So, so true, Jimmy.

Um, as, as we wrap up on time, um, you know, I, I wanted to thank you, Jimmy, for, for being part of this discussion. Um, one thing we, we really like to gauge every guest we bring on this podcast, uh, is what is one thing you took from a path or mentor and involve that in your current.

Jimmy: Today. I think, uh, the biggest thing, and Jim Pano out of Avid Health, he, he really did a good job of pro producing the type of preceptor I am today.

He would just always say question everything. Uh, it's something very simple, but I think it's not just a, a term more so than it is a particular, a lifestyle as a, as a learner. And I think when he says question everything, it's like, question me, uh, question the literature and. He's always said, Huh, that's interesting.

I wonder we should look into that. And he would just show me, just question all these different things. And what it did was it made me understand that initially you learn in a black and white fashion in a completely gray world. And once I understood that curiosity can help you navigate the gray better and question things, it really led to, it's a much higher job satisfaction and really just me.

I like to say that I'm just in love with, with emergency medicine and just pharmacy in general, and that's the one thing that I've, I've took from, from Jim pr, just questioning everything and displaying that, that same enthusiasm to question everything.

Jason: I can definitively say, Jimmy, you are, uh, like the model person for always looking to learn and educate.

I mean, you, you do it in your spare time, you do it at work, you do it, uh, in your, your second job, . Um, so, um, strong work there, bud. I, I appreciate that. Um, I just wanted to pop in to say thanks Jimmy, uh, for doing this. Uh, you know, we've gotten to work on a few things, uh, prior to this and, um, anytime I get a chance to pick your brain about, uh, any topic has always been illuminating and, and I really appreciate you taking the time to chat

Jimmy: with us today.

I'm just thankful for you guys. I, I think the listeners for listening me talk for the last few minutes and just think of the opportunity. I'm, I'm really happy with the work you guys are doing. A space that we really needed, and especially in a more casual way, and I think most people want to have preceptor development.

They feel a little overwhelmed with the, I would say, dryness of the information. And I'm just being honest, you know, uh, how dry a lot of information need. But you guys have done something really special in being able to get the key concepts, uh, get the key topics and talk in a manner, in a way that preceptors get.

So I don't want to underemphasize the work that you guys are doing. This is gonna be big. It's gonna be huge. And now, and then for the years to come, so. So to work with you guys, and again, everything you've asked me to do, I'm just gonna do because I really appreciate what other people are passionate about certain things, and precepting and teaching is, you know, something I, I really live by.

David: I really appreciate that, Jimmy. I'm blushing if it's afternoon. Well

Jason: All right, listeners, thank you. Thank you so much for joining us today.

Jimmy: All right guys, you just got done. Listen to our latest episode with Precep Responsibly, discussing teaching, doing medical core emergencies. And I really think those guys are doing a phenomenal job. And as you guys can tell, it's a great episode and we're gonna do more work with them. We're gonna do more work with some of the other podcasts that are out there, cuz again, we're just a community.

So, uh, for our, our third year anniversary, if you guys will listen to this, uh, we're gonna be giving out. All month. So what I want you to do is tag us on social media and let us know what was your favorite episode this month, or shoot us at dm, let us know, uh, some, some feedback of what, what you experienced with us over the last three years.

So I thank you guys and you know how we, in every episode you not be a pharmacist, you don't work in an ed, but everything you do, Make sure you Pharm so hard. Closes in oys tail.

Whatever she's looking for isn't in there. Perfect. Perfect.