

Residents as Teachers

Table of Contents

Cover Letter to Program Director or Interested Faculty	2
Sample Letter to Invite Residents to the Workshop	3
Workshop Overview	4
Resident "Notes" for Leadership and Organization Workshop	5
Leadership and Organization Workshop	6–8
Pretest	9–11
Scenario #1 Resident-Teacher Primer	13
Scenario #1 Intern-Learner Primer	14
Scenario #1 Audience Evaluation Form	15
Scenario #2 Resident-Teacher Primer	17
Scenario #2 Student-Learner Primer	18
Scenario #2 Audience Evaluation Form	19
Resident "Notes" for Teaching Workshop	21
Teaching Workshop	22–26
Scenario #4 Resident Primer	27
Scenario #4 Attending Primer	28
Scenario #4 Audience Evaluation Form	29
Resident "Notes" for Feedback Workshop	31
Feedback Workshop	32–33
Scenario #5 Audience Evaluation Form	35
Scenario #6 Resident-Teacher Primer	37
Scenario #6 Intern-Learner Primer	38
Scenario #6 Audience Evaluation Form	39
Posttest	41
Bibliography	43



Dear Pediatric Program Director or Interested Faculty,

Enclosed is the American Academy of Pediatrics' Residents as Teachers workshop packet. This packet was created to help train residents to be excellent teachers. Residents are asked to teach, in addition to the many other formidable tasks involved in good patient care. All residents have received 4 years of medical training prior to residency, with much additional instruction during the course of residency to prepare them to provide quality care to patients and their families. However, many residents are given no, or very cursory, training for their responsibility as teachers of interns and fellow residents.

We have tried to make this program as flexible and user-friendly as possible. Even with minimal preparation, an instructor could use this workshop series to improve residents' teaching skills. The workshop directions and helpful hints are provided in parentheses throughout the manuscript for each workshop. Timing prompts are also included to keep the workshops on schedule.

As designed, the series is to be given as three 1-hour workshops. Some instructors have slowed the pace of the workshops, and given them over a slightly longer period of time, but this is not necessary. A quick read through the workshops beforehand may also allow the instructor to make minor adjustments in the case scenarios to make them conform better to specifics of your residency program. At programs where instruction is already given to improve residents' teaching abilities, these workshops may serve to compliment what already exist. If a retreat is planned, other topics such as stress management, dealing with depression, substance abuse, and personality/leadership style questionnaires could be added to complement the workshops.

Following are other pointers for a great workshop series:

- Interns and residents at all levels would likely benefit from the workshops. If practical, you may want to conduct the workshops for each resident level separately, since their concerns may vary.
- Although the course can be given at any time, residents appear most able to accept alternative solutions and to modify their teaching and leadership styles when they are experiencing anxiety about assuming a new role. July may be the optimal time in most residency programs.
- The ideal course instructor would be an excellent teacher, respected by the residents prior to the workshop series. Recent chief residents bring a unique perspective, which may prove valuable.
- A relaxed atmosphere will likely promote discussion. We recommend trying to avoid "the resident conference room," if practical. Providing lunch or refreshments also lends an air of informality, and may improve attendance.
- If at all possible, residents should be freed of their patient care responsibilities during the workshops. Poor attendance should be expected if residents are not given adequate "free" time to attend. If an off-site retreat is not possible, scheduling workshops when residents would usually have conferences may help minimize interruptions.
- A sample invitation letter is provided, which should be sent to residents several weeks before the workshops. Additional reminders should be posted in high-traffic locations, and announcements made at resident conferences.

We believe the workshops are both fun, informative, and "user-friendly." We welcome questions regarding the workshops, or comments intended for their improvement. Thank you for taking an interest in your residents' responsibilities as teachers. By doing so, the residency experience is greatly enhanced at all levels, and ultimately the care of children is improved.

Kindest Regards,

The American Academy of Pediatrics, Resident Section

141 Northland Park Blvd
 Elk Grove Village, IL 60007-1068
 Phone: 847-434-4000
 Fax: 847-434-8000
 E-mail: info@aap.org
 URL: www.aap.org

Executive Committee

President
 Louis J. Cooper, MD, FAAP

President-Elect
 L. Stephen Edwards, MD, FAAP

Executive Director
 Joe W. Sanders, Jr, MD, FAAP

Board of Directors

District I
 Christa M. Ciofalo, MD, LC, FAAP
 Newton Center, MA

District II
 Herbert M. Corwin, MD, FAAP
 Syracuse, NY

District III
 Ann L. Kord, MD, FAAP
 Philadelphia, PA

District IV
 David T. Bayne, Jr, MD, FAAP
 Crossroads, MD

District V
 Stanley A. Singer, MD, FAAP
 Birmingham, AL

District VI
 William Edgar Michel, MD, FAAP
 Madison, WI

District VII
 Gray C. Peck, MD, FAAP
 New Orleans, LA

District VIII
 Jan D. Burgess, MD, FAAP
 Federal Way, WA

District IX
 Bruce J. White, MD, FAAP
 Huntington Beach, CA

District X
 Charles W. Jaffe, MD, FAAP
 Atlanta, GA

Immediate Past President
 Susan Benson, MD, FAAP



Dear Resident,

As you are well aware, a major part of your responsibilities is to teach students, interns, and fellow residents. However, although you may feel confident in your patient care responsibilities, you may simultaneously feel woefully unprepared for the teaching duties you are asked to perform. This is to be expected since you have probably received little or no training in how to be an effective teacher.

A variety of workshops have been designed by the American Academy of Pediatrics Section on Residents to improve residents' abilities as teachers. The workshops are full of useful information. Because they are interactive and informal, most residents also feel they are a lot of fun. "Fun" may not be a word you associate with teaching but, by improving your teaching skills, your level of enjoyment may surprise you.

The workshops will cover leadership and organization skills, teaching techniques, and feedback. The first workshop will be held:

PLACE: _____

DATE: _____

TIME: _____

Please plan to attend. I look forward to seeing you there!

Sincerely,

141 Northbrook Park Blvd
Elk Grove Village, IL 60007-1068
Phone: 847-434-4000
Fax: 847-434-8000
E-mail: info@aap.org
http://www.aap.org

Executive Committee

President
Louis J. Cooper, MD, FAAP

President-Elect
L. Stephen Edwards, MD, FAAP

Executive Director
Joe W. Sargent, Jr, MD, FAAP

Board of Directors

District I
Clara M. Ciofalo, MD, LC, FAAP
Newton Center, MA

District II
Robert M. Corwin, MD, FAAP
Syracuse, NY

District III
Ann L. Kord, MD, FAAP
Philadelphia, PA

District IV
David T. Bayne, Jr, MD, FAAP
Cressboro, NC

District V
Stanley A. Singer, MD, FAAP
Birmingham, AL

District VI
Kathryn Lynn Michel, MD, FAAP
Madison, IN

District VII
Guy C. Peck, MD, FAAP
New Orleans, LA

District VIII
Jan D. Burgess, MD, FAAP
Fenton, MO, USA

District IX
James J. Witt, MD, FAAP
Huntington Beach, CA

District X
Charles W. Jaffe, MD, FAAP
Atlanta, GA

Immediate Past President
Susan Bennett, MD, FAAP

Residents as Teachers

Workshop Overview

1. Leadership and Organization Workshop (40 minutes, plus Pretest)

Objectives:

1. Learn how and why to establish resident as team leader
2. Learn how to set expectations of team members
 - Role of each team member
 - Format for pre-rounds and rounds
 - Goals for notes and presentations
 - When and how to ask for help
3. Learn to identify and make plans to meet the learners' goals
4. Understand why you must plan for feedback

Format:

- A. Introduction (3 minutes)
- B. Pretest (15 minutes)
- C. Basics of Leadership and Organization (4 minutes)
- D. Scenario #1 (5 minutes)
- E. Discussion Scenario #1 (9 minutes)
- F. Scenario #2 (5 minutes)
- G. Discussion of Scenario #2 (9 minutes)
- H. Summary and Review (5 minutes)
- I. Questions and Answers

2. Teaching Workshop (60 minutes)

Objectives:

1. Learn to allow learners time to answer questions
2. Be comfortable admitting what you don't know
3. Be a good (unspoken) example
4. Understand adult learning theory and how to apply it
5. Know how to get a commitment from the learner
6. Know how to effectively question the learner
7. Learn how to identify and teach key points (general rules)

8. Effectively incorporate priming and modeling into teaching strategy
9. Learn how to develop a teaching plan with the attending

Format:

- A. Introduction (5 minutes)
- B. Understanding Adult Learning Theory (10 minutes)
- C. Putting Theory to Work (5 minutes)
- D. Scenario #3 — With Discussion (15 minutes)
- E. Using Priming as a Teaching Tool (5 minutes)
- F. Using Modeling as a Teaching Tool (3 minutes)
- G. Negotiating a Teaching Plan With the Attending (3 minutes)
- H. Scenario #4 (5 minutes)
- I. Discussion of Scenario #4 (5 minutes)
- J. Conclusion (4 minutes)
- K. Questions and Answers

3. Feedback Workshop (40 minutes, plus Posttest)

Objectives:

1. Plan for feedback (review)
2. Understand the difference between feedback and evaluation
3. Understand when to give feedback
4. Learn the basics of effective feedback
5. Learn how to correct what is wrong and reinforce what is right

Format:

- A. Introduction (3 minutes)
- B. Qualities of Feedback (15 minutes)
- C. Scenario #5 (5 minutes)
- D. Discussion of Scenario #5 (5 minutes)
- E. Scenario #6 (5 minutes)
- F. Discussion of Scenario #6 (5 minutes)
- G. Summarizing Statements (2 minutes)
- H. Question-and-Answer Session
- I. Posttest (15 minutes)

Residents as Teachers

Leadership and Organization Workshop

Notes

Basics of Leadership and Organization:

- Establish the resident in the leadership position.
- Establish the expectations and role for each team member.
- Provide direction for work rounds, attending rounds, presentations, notes, and other responsibilities.
- Request, and make plans to meet, each learner's specific goals for the rotation.
- Let each member know how and when to ask for help.
- Establish the purpose of, and plan for, feedback.

Remember: **L** establish Leadership position
 E establish Expectations for team members
 A Assess and plan for meeting the learners' goals
 D Develop a feedback plan

Residents as Teachers

Leadership and Organization Workshop

A. Introduction

Thank you for coming. The reason why we are conducting these workshops is because of the value we place on the role of residents as teachers. The stress of internship is appreciated, but relatively little attention has been given to the senior resident's complex role as team leader and teacher. Suddenly, on the 1st of July, the senior resident is expected to lead the team, run work rounds efficiently, manage and teach interns and medical students, communicate with the attending physician, and, most importantly, ensure good patient care. In many ways, the resident is even more important than the attending physician. In part, this is probably related to the large amount of time residents spend with students and interns, the directness of their supervision, and their closeness in age, professional development, and responsibilities. We hope that by providing these workshops we can help to prepare you for your role as teachers and role models, while having some fun!

B. Pretest

Before beginning this, our first workshop, we ask that everyone take the time to fill out the Pretest. This will allow you to assess your attitude toward teaching, personal teaching style, and areas where you desire improvement.

(Please give the Pretest now. It should take about 15 minutes to complete, then you may continue.)

C. Basics of Leadership and Organization

The topic for this hour's session is Leadership and Organization. The most effective teachers are usually good leaders as well. What is a teacher, anyway, but someone who leads another in the direction of increased learning?

Without an effective leader, a potential learner will often lack the direction to move ahead. Although frequently omitted, the first day's orientation to the service is high on the list of teaching behaviors that learners value most. This is one of the most important jobs that you

will do as team leader. Orientation to the service should accomplish several goals:

1. Establish the resident in the leadership position. This will usually take care of itself if the other objectives are accomplished.
2. Establish the expectations and role for each team member.
3. Provide direction for work rounds, attending rounds, presentations, notes, and other responsibilities.
4. Request, and make plans to meet, each learner's specific goals for the rotation.
5. Let each member know how and when to ask for help.
6. Establish the purpose of, and plan for, feedback.

Although covering the above topics teaches nothing specific about medicine, the framework that is generated provides a format where learning is fostered. We will discuss specifics of teaching and feedback in future sessions. Today we hope to concentrate on getting the team off on the right foot!

Today's workshop consists of two brief case scenarios. Each will highlight different aspects of leadership. The cases are meant to be fun springboards for discussion, and should not be viewed as tests. Given the time restraints and lack of preparation, you may not cover all of the topics in your scenario. That's okay. Have fun, and see how much you can accomplish!

D. Scenario #1

For the first scenario, I will need two volunteers. Who is willing to volunteer?

(After obtaining two volunteers, send them out of the room with their primers, and brief the remaining residents with the following overview.)

Overview of Scenario #1. The resident's ambitious goal during this interaction is to establish a leadership role,

and develop a plan for the team, which includes the role of each team member, and expectations for patient care and rounding. Also, instruction should be given on when and how to ask for help.

It is 10 minutes before grand rounds, and the first day of the April rotation. The setting is the team meeting room for one of the pediatric ward teams. The team will need to leave for grand rounds in about 5 minutes. The resident will need to be very organized.

(Pass out the Audience Evaluation Forms for Scenario #1. Allow approximately 5 minutes for the role-play of Scenario #1. Afterward, be certain to thank your volunteers.)

E. Discussion of Scenario #1

(Take about 5 minutes to discuss Scenario #1, using the Audience Evaluation Forms as a guide.)

F. Scenario #2

Let's proceed directly into another scenario before summarizing. I need two more volunteers. Who will help us out?

(Once again, send the volunteers out of the room with the Primers for Scenario #2. Prepare the audience by reading the Overview for Scenario #2.)

Overview for Scenario #2: The resident's goal during this exercise is to assess the third-year medical student's goals, develop a plan to meet these goals in the context of the team's purpose (patient care), and develop a plan for feedback. The student's scheduling needs should also be addressed.

The setting is a quiet corner of the nurses station on the pediatric ward. The student and resident have just been introduced. The resident will be presenting the first case in morning report, which begins in about 10 minutes.

(Allow approximately 10 minutes for the role-play. Again, thank your volunteers.)

G. Discussion of Scenario #2

(Discuss the second scenario using the Audience Evaluation Form for Scenario #2 as a guide.)

H. Summary and Review

The purpose of this workshop was to provide helpful suggestions for effective leadership of a pediatric medical team.

Hopefully:

1. We have verified the importance of defining the leadership position.

This, preferably, is done in a nonthreatening manner, and with the support of the other team members. Establishing control does not mean dictating. Establishing control primarily means setting expectations for, and clarifying the goals of, individual team members. This alone will usually define the resident's leadership position.

2. We have learned effective means of establishing expectations for team members.

It is important for residents to understand that interns and students do not automatically know what is expected of them since they work with a wide variety of residents with a wide array of styles and expectations. Most conflicts can be avoided if the time is invested early in the rotation to review expectations.

Specifically, team members should understand their expectations in regard to:

- Patient care (supervision, pre-rounding, etc)
 - Rounds (who will present?)
 - Presentations and Notes (length, content, etc)
 - Getting help (who do I ask, when do I ask, etc)
3. We have taken note of the importance of obtaining and planning for the learner's goals.

This is probably one of the most important points, and the one most often overlooked. The most effective leaders will plan not only for how members can contribute to the team, but also how the team can satisfy each of the member's needs. Attention to this aspect can prevent disappointment and burnout by providing structure for meeting each member's personalized learning objectives.

Also, a great deal of stress can be alleviated, and potential conflict avoided, by looking ahead. Everyone has obligations outside of their medical responsibilities from time to time. By asking for schedule requests early in the rotation, you not only reduce stress, but also give yourself opportunity to plan structured teaching and feedback without conflict.

4. We have learned the value in discussing feedback early in the rotation, and setting a plan to see that it occurs.

Feedback is viewed by many to be one of the more difficult responsibilities of leadership. In part, this is because a discussion of feedback is often postponed until after problems have arisen. In this context, feedback takes on a connotation of disciplining, rather than of a two-directional tool to improve communication and meet mutual goals. Although we will discuss feedback in a future session, the point to remember from today is

that feedback can only be of value if it occurs, and it will probably only occur if you plan for it.

Remember:

- L** establish **L**eadership position
- E** establish **E**xpectations for team members
- A** **A**ssess and plan for meeting the learner's goals
- D** **D**evelop a feedback plan

I. Questions and Answers

Are there any questions on what we have discussed today?

(Answer questions and dismiss the group.)

Residents as Teachers

Pretest

PART I (please circle)

1. Type of training:
Categorical Peds Combined Peds Program Other
2. Year of training:
1 2 3 4 Other _____
3. Have you taken a course to train you to be a better teacher?
Yes No

PART II (please circle)

Use this scale to answer all remaining questions.

- 1 = Never/Untrue
- 2 = Rarely/Some Truth
- 3 = Sometimes/True as Often as Not
- 4 = Frequently/Basically True
- 5 = Always/Definitely True
- N/A = Not Answerable

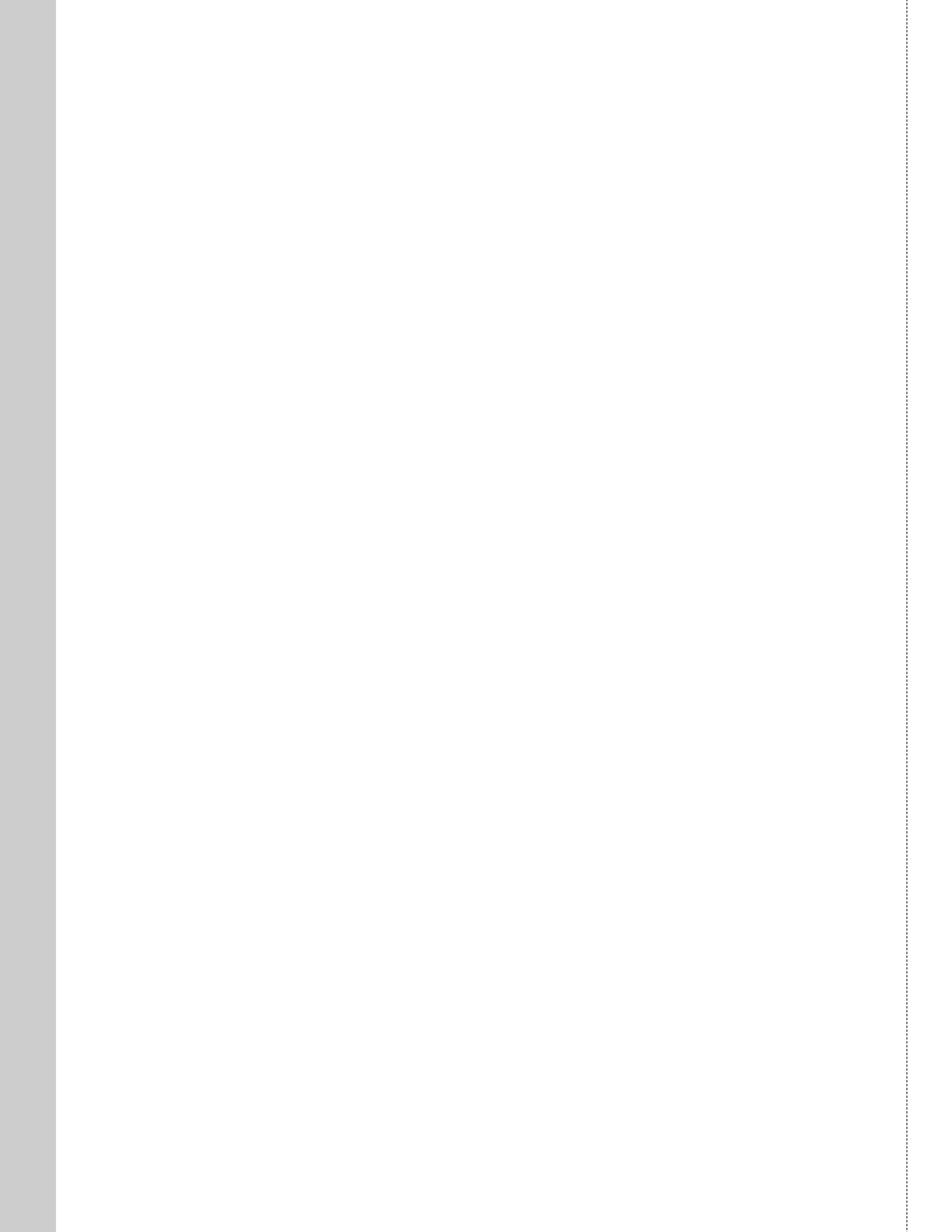
4. I feel well prepared to teach.
1 2 3 4 5 N/A
5. I am enthusiastic about teaching.
1 2 3 4 5 N/A
6. I have confidence in my teaching ability.
1 2 3 4 5 N/A
7. I am aware of what is expected of me as a teacher.
1 2 3 4 5 N/A
8. My anxiety regarding teaching is at "a healthy level."
1 2 3 4 5 N/A

PART III (please circle)

9. I assume control of the team.
1 2 3 4 5 N/A
10. I explain the role of each team member at the start of each rotation.
1 2 3 4 5 N/A
11. I establish a workable format for pre-rounds and rounds.
1 2 3 4 5 N/A
12. I review goals for notes and presentations at the start of each rotation.
1 2 3 4 5 N/A
13. I solicit learning goals from members of my team at the start of each rotation.
1 2 3 4 5 N/A
14. I devise a plan with the learners to meet their learning objectives.
1 2 3 4 5 N/A
15. I establish and communicate a plan for feedback at the beginning of each rotation.
1 2 3 4 5 N/A

PART IV (please circle)

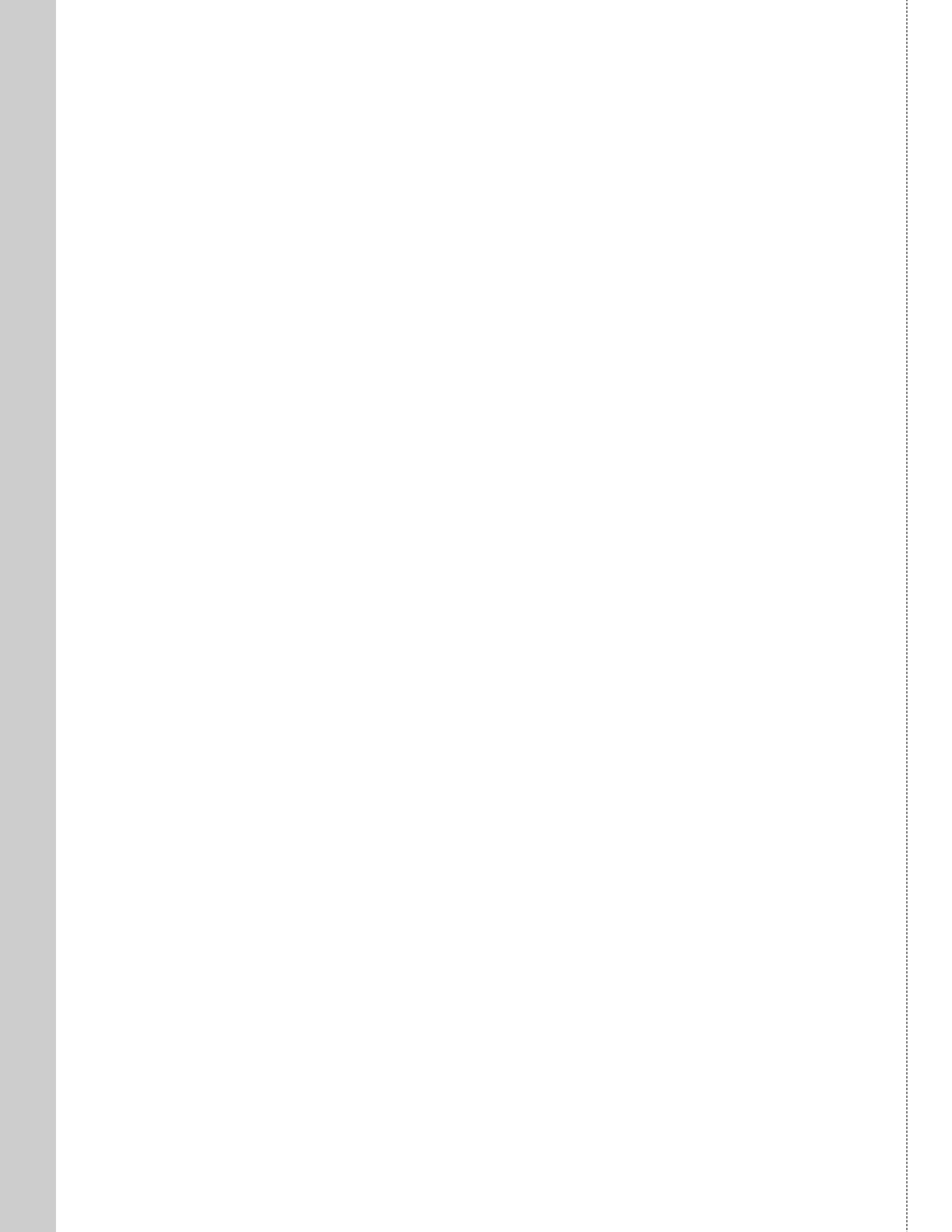
16. I give clear direction regarding specific expectations for notes and presentations.
1 2 3 4 5 N/A
17. I encourage my learners to commit to theories, diagnoses, and/or plans regarding patients they have seen.
1 2 3 4 5 N/A
18. I frequently ask learners to provide supportive evidence for their theories, diagnoses, and/or plans, so that I can better understand their thinking and knowledge base.
1 2 3 4 5 N/A



Residents as Teachers

Pretest (continued)

19. I try to teach general rules, in addition to caring for the patient, so that the underlying principle is clearly communicated.
1 2 3 4 5 N/A
20. I encourage bedside teaching.
1 2 3 4 5 N/A
21. I promote understanding of key cases, rather than devoting a small amount of time to many cases.
1 2 3 4 5 N/A
22. I involve the attending with the teaching plan, prior to, or very early in, the rotation.
1 2 3 4 5 N/A
23. I admit when "I don't know" (but will find out) and encourage my learners to do the same.
1 2 3 4 5 N/A
24. I teach by positive example (promptness, enthusiasm, professionalism).
1 2 3 4 5 N/A
25. I wait at least 3 seconds for a response when asking my learners questions.
1 2 3 4 5 N/A
- PART V** *(please circle)*
26. I understand the differences between giving someone feedback, and a compliment or criticism.
1 2 3 4 5 N/A
27. Learners working with me are aware of the extent to which I will be providing feedback.
1 2 3 4 5 N/A
28. I provide daily feedback to my learners.
1 2 3 4 5 N/A
29. I follow through with prescheduled (mid-rotation, and end of the rotation) feedback sessions.
1 2 3 4 5 N/A
30. I provide ongoing feedback as soon after the observed behavior as is practical.
1 2 3 4 5 N/A
31. I base feedback, as much as possible, on firsthand data.
1 2 3 4 5 N/A
32. I elicit the learner's perspective prior to offering feedback on issues of conflict.
1 2 3 4 5 N/A
33. I provide feedback that is descriptive, rather than generalized, in nature.
1 2 3 4 5 N/A
34. My feedback is concerned with decisions and actions that can be altered, rather than perceived intentions and interpretations.
1 2 3 4 5 N/A
35. I always follow negative feedback with guidance in solving the problem.
1 2 3 4 5 N/A
36. I provide positive as well as negative feedback to my learners.
1 2 3 4 5 N/A



Residents as Teachers

Leadership and Organization Workshop

Scenario #1

Resident-Teacher Primer

You are a 10th-month resident, and it is the first day of your 2nd month as team leader. Your first month, in August, did not go as well as you had hoped. Rounds were long, disorganized, and repetitive. The intern was rather aggressive and, as a result, the medical students tended to contribute very little. You enjoy bedside teaching, and would like for this to be the focus of attending rounds. You also enjoy the camaraderie of working closely with an intern, and hope to pre-round together. This should also provide ample opportunity for teaching points, before the workday gets too busy. You are also particularly interested in answering questions that your intern might have. You suspect that several minor problems in August might have been avoided if the intern would have come to you sooner. You are confident that, with improved organization, this month will go much better than the last.

Your goals this month are to organize the team effectively. You want each member to know what is expected of them regarding patient care (pre-rounding, write-ups, etc), rounding, and getting help when needed. They will also need to be familiar with your plan for teaching and supervision.

There are more topics you would like to cover, but for now your team desperately needs structure! Unfortunately, grand rounds will be starting soon, so you have just 5 minutes to see what you can accomplish.

Residents as Teachers

Leadership and Organization Workshop

Scenario #1

Intern-Learner Primer

You are a 10th-month intern, and it is the first day of your 3rd month on the pediatric wards. You love pediatrics, but tend to become frustrated with the disorganization of rounding. Your last resident allowed you to round independently, and would get together with you to “card-flip” later in the morning. You feel this went well, usually got home fairly early, and enjoyed the autonomy. In fact, in order to maximize autonomy, you make it a rule not to ask questions unless you feel a patient may be in danger. You would rather treat the patient conservatively and look it up later. (Naturally, you won’t offer this to the resident, unless you are specifically asked.) You are interested in primary care pediatrics and would enjoy learning more about appropriate follow-up of some of the chronic diseases you are sure to encounter this month. (Do not offer this unless asked.)

You need to leave for grand rounds in about 5 minutes.

Residents as Teachers

Leadership and Organization Workshop

Scenario #1

Audience Evaluation Form

Did the resident: *(yes/no/partially, please give comments)*

1. Establish a leadership role?

2. Clarify expectations regarding:

a. Patient responsibilities (pre-rounding, notes, etc)?

b. Structure and purpose of rounds?

c. Role of each team member?

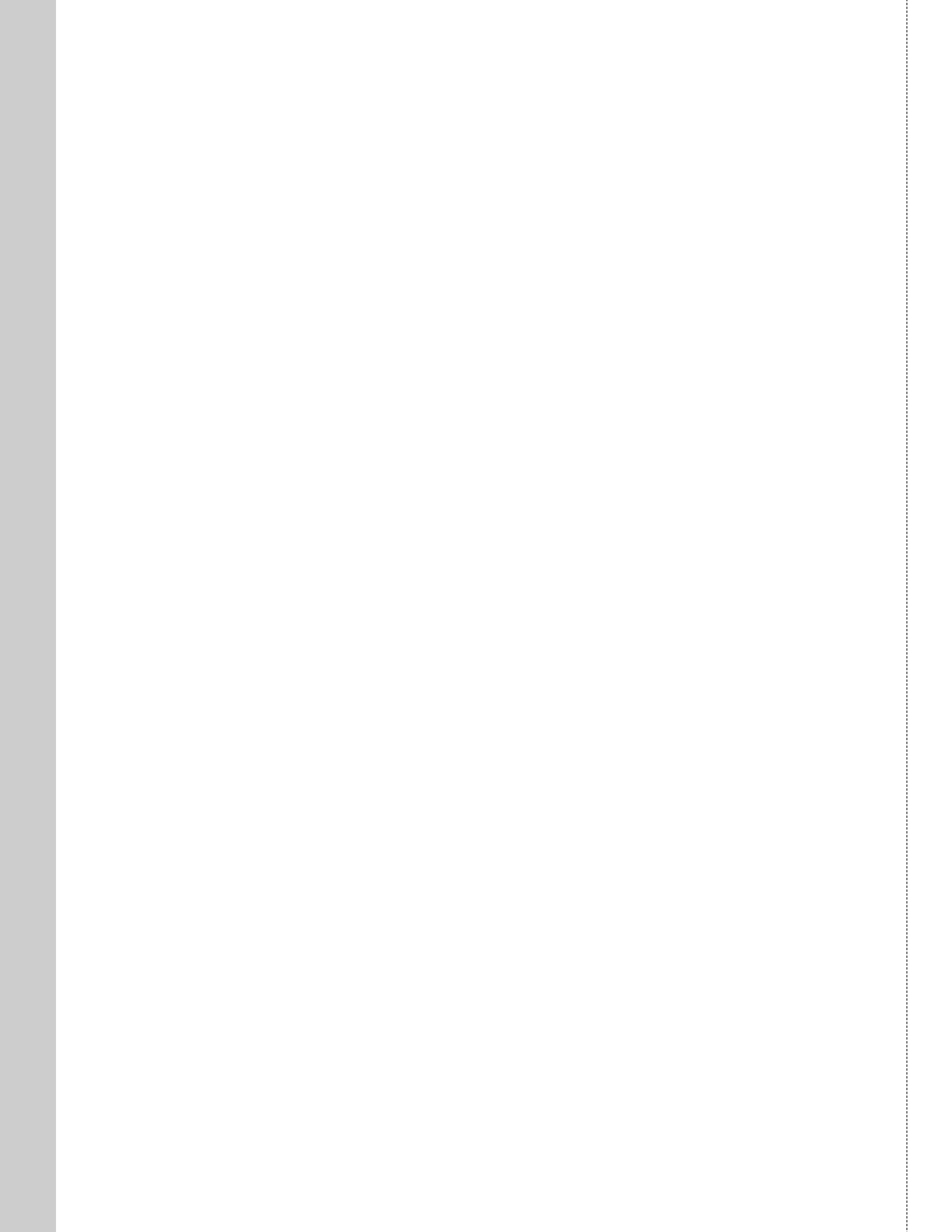
d. When to call for help?

e. Format for supervision and teaching?

3. Ensure mutual understanding and acceptance of expectations?

4. Present a positive and enthusiastic attitude about the rotation?

5. Other comments:



Residents as Teachers

Leadership and Organization Workshop

Scenario #2

Resident-Teacher Primer

As a new second-year resident and team leader, you have just been assigned your first third-year medical student. To be an effective resident, you know you will need to understand the student's goals and develop a plan to help the student move toward his or her destination, while taking optimal care of the patients. You will need to develop a plan, as well as a means to see if everyone's expectations are being met. Weekends may be an optimal time for feedback, since they tend to be somewhat slower.

You have just been introduced to the medical student in the nurses station. You have 5 minutes to talk before you must leave to present the case for morning report.

Residents as Teachers

Leadership and Organization Workshop

Scenario #2

Student-Learner Primer

You are about to begin your first rotation as a third-year medical student. You are excited about pediatrics since you went to medical school with the goal of becoming a PICU attending, like your mother. You consider it “critical” that you receive an “A” on this rotation since you would like to obtain a competitive residency position. You are not interested in the “mundane” cases, and hope you can select only the most seriously ill children to follow. In addition, you already have airline tickets to an out-of-town wedding in 2 weeks. To your dismay, you learned minutes earlier that your team is on call that weekend. Hoping to make a good first impression, you have decided not to mention your travel plans until you are asked if you will need any time off.

Residents as Teachers

Leadership and Organization Workshop

Scenario #2

Audience Evaluation Form

Did the resident: *(yes/no/partially, please give comments)*

1. Elicit the student's learning expectations?

2. Develop a plan that incorporated the student's learning expectations?

3. Develop a plan regarding the timing of feedback sessions?

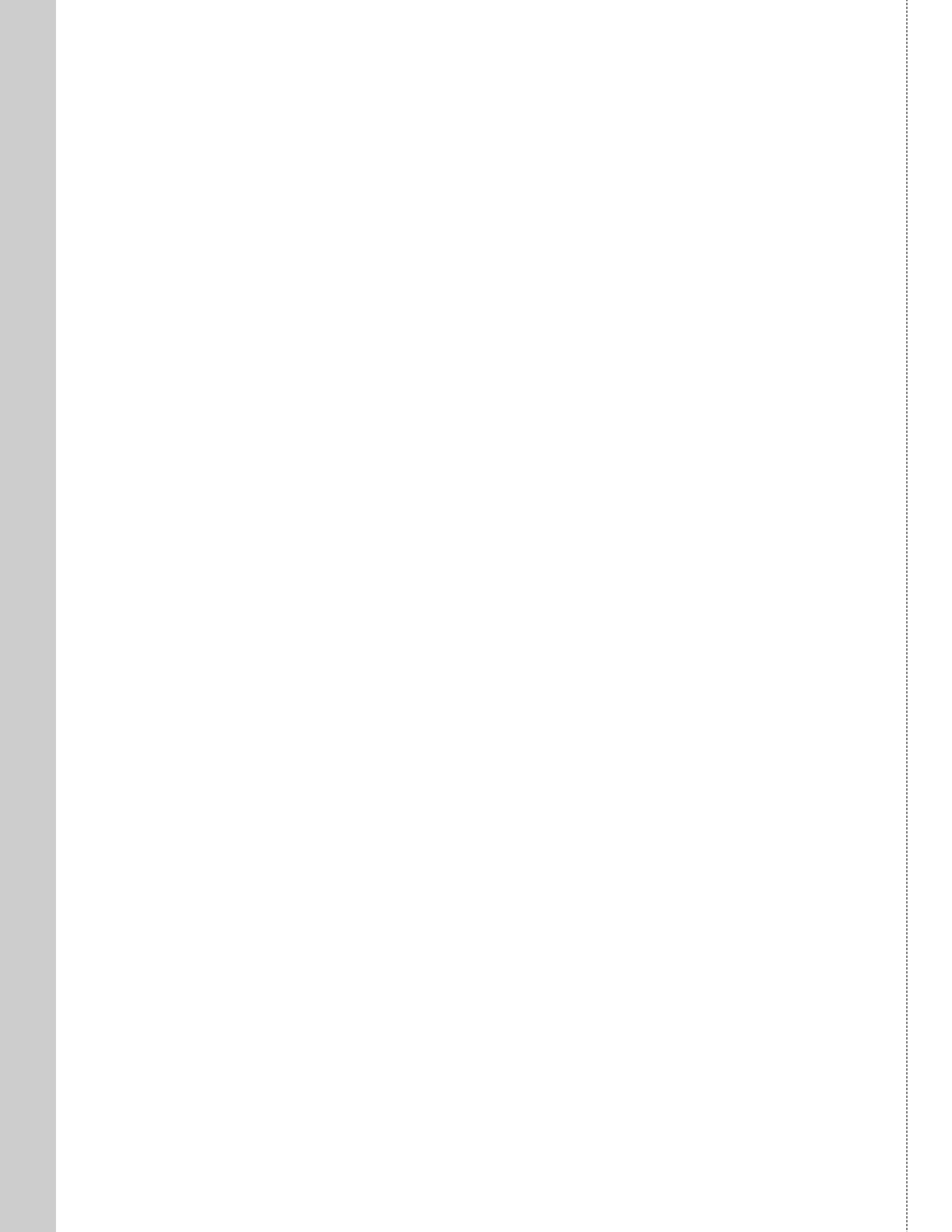
4. Take into consideration the student's scheduling needs?

5. Identify what the student will be evaluated on?

6. Ensure mutual understanding and acceptance of the plan?

7. Present a positive and enthusiastic vision of the rotation?

8. Additional comments:



Residents as Teachers

Teaching Workshop

Notes

1. Key Concepts for Good Teachers:

- Wait 3 seconds after asking a question
- If you don't know, say you don't know
- Remember example speaks louder than words

2. Adult Learning Theory:

- Learners need to know what is expected
- Adults learn best when they are invested in the learning process
- Teach at appropriate level
- Learners need to understand the relevance of what is being taught

3. Therefore, Teach by:

- Giving direction
- Getting a commitment
- Questioning to illicit the learner's thought process
- Teaching general rules

4. Priming as a Teaching Tool:

5. Modeling as a Teaching Tool:

6. Negotiate a Plan With the Attending by:

- Establishing partnership early on
- Utilizing bedside teaching
- Concentrating on best teaching cases

Residents as Teachers

Teaching Workshop

A. Introduction

Thank you very much for returning! To review, during our first session we covered a great deal. The major areas we discussed were the importance of establishing a role as team leader, setting expectations for each member of the team, making plans to meet the learner's goals, and the need to orchestrate a feedback plan from the start of the rotation. Hopefully, by putting these concepts into place, you will be able to create an environment conducive to learning.

During our next session we will discuss correcting mistakes, reinforcing what has been done right, and giving more formalized feedback. Today, we will concentrate on some specific questions regarding what we more traditionally look at as teaching; that is, how we present information in a way that can be learned.

Before we go into adult learning theory, however, I just want to mention a few concepts of which you may be aware, but that bear repeating. These concepts grow from nothing other than good manners and common sense, but are often overlooked in the high-pressure and competitive atmosphere in which we sometimes work.

1. Wait 3 seconds after asking a question before you move on. Three seconds is a relatively long time, and this takes some effort. However, you will never miss the extra 2 seconds you spend, and it will greatly improve your communication skills by tripling your ability to be a good listener!
2. If you don't know, say you don't know. You will be amazed at how smart this can make you look!
3. You are a walking textbook. Well, maybe not exactly, but people are studying you more than you might realize. Those around you learn at least as much by your actions, as by your words. Your promptness, compassion, professionalism, and many other unspoken traits say more about you than your words ever will.

Those things said, I will trust you to practice these concepts as a matter of living. Today we will address the more "tangible" aspects of teaching and, therefore, of learning.

B. Understanding Adult Learning Theory

To be an effective teacher, we need to understand a few basics of adult learning theory, but don't think that this is a theory that we will place on a shelf and not use. We will work with this theory in very practical ways over the next hour to illustrate its usefulness. As experienced adult learners, even if you have not taken the time to think about it, you probably have a pretty good idea of what helps you learn well. Let's list a few things that improve our ability to learn.

(If a chalkboard is available, write suggestions where everyone can see them. Comment briefly on the answers, but take no more than 1 to 2 minutes to cover this portion of the workshop. If needed, prompt your learners or give additional answers to cover the major topics of adult learning theory. When completed, congratulate the participants, and summarize, as follows.)

Very good. To help make sense of our answers, let's organize and condense them into the following areas:

1. Learners need to know what is expected.

(Indicate which answers you received fit into this category.)

Even the best-intentioned student cannot give a great presentation if he or she does not understand the desirable components of a great presentation. How can we accomplish this goal?

(Hopefully you will receive the rather obvious answer.)

The learner has to be told. As simple as it sounds, this is often overlooked. Instruction should be clear, concise, and, if complicated, written. This, of course, applies to oral presentations as well as written notes.

2. Adults learn best when they are invested in the learning process.

(Indicate which answers you received fit into this category.)

A "sideline" approach to learning is rarely as effective as a "hands-on" approach. Specifically, how might you induce a learner to invest in learning a concept you consider important?

(Wait for a few answers.)

While there are many parts to the process, and many correct ways to say it, what it really boils down to is getting a commitment from the learner. Having the learner commit to a diagnosis, plan, or theory actively involves the learner in the patient care decision at hand. At the same time, it will help to clarify the learner's understanding of the problem.

3. Teaching is only effective if it is given at the appropriate level.

(Indicate which answers fit into this category.)

We all know how frustrating it is for someone to “talk down” to us, or to teach “over our head.” It is rare that we simply collect knowledge. We usually learn by adding understanding of a problem to previously acquired knowledge and experience. Therefore, *questions that illicit the learner's thought process* are more informative than questions based on a “textbook” understanding of the disease.

How would you decide what level of instruction was appropriate for your learner?

(Wait for a few answers.)

Whereas, you may use several indicators to decide, such as prior rotations completed and level of confidence, the best way to assess the learner's knowledge is through effective questioning. Effective questioning will allow you to evaluate what the student knows, and possibly discover areas where deficits exist.

4. Learners need to understand the relevance of what is being taught.

(Indicate which answers fit into this category.)

What is clearly important to the pediatric senior resident is not necessarily of obvious importance to the future orthopedist, or even the most enthusiastic pediatric intern. Most learners, however, will be interested in learning what they perceive to be general rules of pediatrics. *General rules*, since they are seen as more than one person's opinions, are weighted more heavily in the learner's mind and, therefore, more easily remembered.

General rules also accomplish several other important objectives. First, they allow you to teach what you know. Many residents feel overwhelmed by the responsibility of teaching. Many only think of what they don't know, and underestimate the value of the general rules they use every day. Also, by teaching general rules, you reduce the chance that the learner will become overwhelmed with trivia, learning either a less important fact or, worse, nothing at all.

C. Putting Theory to Work

Now I would like for us to put into practice the key concepts we just learned about. Let's begin by discussing how we are going to let the learner know what is expected — you tell the learner. Sounds easy, doesn't it? Apparently it's not as easy as it sounds. Even when teachers believe they have given instruction, it is often not perceived as clear guidance to the learner, either because it was vague, or not at a level the learner could appreciate.

When giving instruction, it is critical that you:

- Assess the learner's level of understanding
- Provide guidance appropriate to the learner's level of understanding
- Are perceived as nonjudgmental regarding the learner's level of understanding

Most commonly, we assume learner's know more than they actually do. Asking if they *can* do something is not nearly as informative as asking *how* they would do something. Also, taking time to discover where they feel deficient often will save time, and produce a better product (note, presentation, etc) in the long run. If learners feel they are being “judged,” they are unlikely to ask for needed clarification.

Let's try some examples. Rather than asking, “Do you know how to write a note?” what could you ask?

(Listen for answers such as: “How do you plan to organize your note?”)

Rather than stating, “I'd like you to organize your presentation better” what could you ask?

(Listen for answers such as: “How do you plan to present the assessment and plan for this patient on rounds?”)

And, rather than asking, “Are you having trouble with your notes?” you could ask:

(Listen for answers such as: “Which aspect of your notes do you feel least comfortable with?”)

D. Scenario #3 — With Discussion

(This scenario does not include primers or an evaluation.)

Next, I'd like to work on the other concepts of adult learning which we discussed. By role-playing, we will have the opportunity to practice getting a commitment, assessing the student's understanding via appropriate questioning, and teaching a general rule. Who would like to volunteer? I will walk you through the process, so it is not as overwhelming as it may sound.

(Procure a volunteer.)

In this scenario, you will be the teacher and I will be your new ward intern. I have just presented you with the story of a 13-year-old white female, with a 6-year history of insulin dependent diabetes mellitus (IDDM), received in transfer from the PICU. Her diabetes has previously been in good control, but she has now had three hospitalizations for diabetic ketoacidosis (DKA) in the last 3 months. She denied being noncompliant with her insulin. The PICU course was unremarkable, and her labs have stabilized in acceptable ranges. Her vitals are within normal limits, and her physical exam was notable only for a somewhat flat affect and weight at the 10th percentile for age.

So that's our scenario! Initially we would like the learner to commit, so that he or she becomes invested in solving the question at hand. A commitment does not have to be a diagnosis. It can be a treatment option, reason for the patient's noncompliance, theory of disease, deciding on whom to consult, or many other questions directly related to patient care.

A point to remember is that if the question can be answered with a simple "yes" or "no," it is not a question requiring commitment. Also, asking for agreement with your assessment, or requesting more data, are not means of obtaining a commitment.

What question would you ask to obtain a commitment?

(Once an appropriate question has been asked, congratulate your volunteer and provide him or her with a reasonable answer. Feel free to confabulate.)

Examples of other reasonable questions that would require commitment are:

- "What do you think is going on with this patient?"
- "What lab tests do you feel are indicated?"
- "What would you like to accomplish during this hospitalization?"
- "Why do you think the patient has been noncompliant?"

Examples of questions that do *not* require the learner to commit are:

- "Sounds like she's depressed doesn't it?"
- "Anything else?"
- "Do you know what her blood sugar is now?"

Now that the intern has committed to _____, we need to probe for supporting evidence. Hopefully the information you collect will allow you to target your instruction to a level appropriate for this learner. By keeping your questions centered on the problem at hand, you maintain interest, discover what the learner

knows or needs to know, and defer offering your opinion temporarily. You do not want to grill your learner on a generic problem.

How would you go about probing for evidence that supports the intern's contention that _____?

(Try to obtain several appropriate questions that probe for supporting evidence. Again feel free to confabulate your answers.)

Examples of other questions that effectively probe for additional information are:

- "What were the major findings that lead to your conclusion?"
- "What other possibility did you consider? What kept you from that choice?"

Examples of questions that do *not* probe for supporting evidence are:

- "What are the possible causes of diabetic ketoacidosis?"
- "I don't think this is depression. Don't you have any other ideas?"
- "Don't you think this is more likely related to an eating disorder?"
- "What else do you know about her home life?"

At this point you have had the learner commit to _____, and give evidence in support of his or her conclusion. You now have an understanding of the intern's comprehension on the problem, and how he or she arrived at that conclusion. You are ready to offer your opinion and to teach a general rule appropriate to the learner's level of understanding.

You want your instruction to be both memorable and transferable. A standardized approach to a class of problems will carry more weight than an idiosyncratic approach, such as your personal opinion. In other words, don't solve the problem; give a means of solving the problem.

What would you like to teach your intern regarding this case?

(Give adequate time for the resident to answer, offering assistance only if necessary.)

Other possible examples are:

- "Adolescence is frequently a time of poor control of chronic diseases for many reasons, including peer pressure, social stresses, increased independence, and physiologic changes."
- "Noncompliance with medications is the most common cause of poor blood sugar control, but we

should consider other possibilities before coming to this conclusion (dietary indiscretion, inadequate insulin dose, spoiled insulin, etc).”

Answers that do not encompass general rules are:

- “This is most likely due to her noncompliance.”
- “If her social situation were better, she probably would be more compliant with her medications.”
- “I think patients that are noncompliant are often subclinically depressed.”

(Remember to thank your volunteer profusely.)

E. Using Priming as a Teaching Tool

What we have covered thus far basically encompasses teaching by the Socratic method. The hospital or clinic environment, however, is often hectic, and you will need to utilize skills other than effective questioning to instruct others. Priming and modeling are two techniques that are especially effective when time is at a premium, or if the subject matter is beyond the sophistication of the learner.

Who can tell me what priming is?

(Hopefully, someone will be familiar with the term. After listening to several answers, proceed by clarifying.)

Priming is a means of setting the stage for expected learning. In priming, you prepare the learner’s mind for the task at hand. Effective priming will allow the learner to benefit from the most relevant patient information, a subtopic which may be easily overlooked, or an area where the learner needs to improve. Used correctly, priming can save time and pave the way to teaching a general rule. Priming does not involve mind reading on the learner’s part.

How might you prime a student before he or she sees a patient with a chief complaint of “wheezing” in the outpatient clinic?

(Wait for a few answers, then you may want to offer further suggestions, as follow.)

Other examples of priming would be:

- “What are some important causes of wheezing? How would you differentiate between them based on history, exam, or studies?”
- “If you decide this patient has asthma, don’t forget to discuss possible triggers. What are some asthma triggers you will want to ask about?”

You can also ask the student to “prime him- or herself” by reading on the diagnosis of a patient who is scheduled for clinic or admission later that day.

F. Using Modeling as a Teaching Tool

Modeling is another effective teaching tool when time is limited or when the case is beyond the sophistication of the learner. Modeling is the most passive learning method we will discuss. The risk, therefore, with modeling is that the learner will become bored. The key to effective modeling is to specifically tell the learner what behavior or technique to observe during the encounter.

For example:

- “I’d like you to observe how I present bad news to this family.”
- “The problem here appears to be noncompliance. I’d like you to watch how I try to confront that issue during the interview.”

Modeling can even be as simple as thinking out loud. It is not imperative that you know all the answers. Pediatrics is often ambiguous and confusing. What is important is “modeling” the logic surrounding your analysis of the problem and plan for treatment, while acknowledging the limitations that may be present.

Modeling and priming do not replace the importance of teaching a general rule, but merely provide an alternative to how information is collected and the patient interacted with, while formulating the teachable rule.

G. Negotiating a Teaching Plan With the Attending

Interacting with the ward attending is certainly one of the most politically challenging aspects of the senior resident’s job. Without question, discussing plans for the team before problems develop markedly decreases the delicacy of such discussions.

Most attendings greatly appreciate the resident taking an active role in preparing for teaching during the rotation. Even if the attending has firm ideas about what they would like to do, most would enjoy constructive suggestions, new ideas, and the chance to clarify and confirm a plan for the month.

The senior resident is the best candidate to serve as manager of rounds. He or she has a combined knowledge of the patients’ medical conditions, personalities, and social situations as well as areas of interest of the different team members. This knowledge, along with the attending’s specific areas of knowledge and ability, can be used to maximize the value of the team experience.

Two concepts that have repeatedly been shown to maximize your “use” of the attending are: (1) to concentrate on a few interesting patients and (2) to utilize bedside teaching. Trying to discuss every patient is likely to be too time-consuming or superficial to be of any substantive

value. Seeing patients together will be more enjoyable and educational. Card-flipping does not allow for verification of impressions and physical findings and undermines the attending's attempt to assist in patient management.

H. Scenario #4

Let's continue with a role-play to illustrate this point. I'll need two volunteers, one to be the resident and one to be the attending.

(After obtaining two volunteers, read the scenario overview to the group while the volunteers become familiar with their primers. This may be a good time to answer any questions that the group has. Pass out the Audience Evaluation Forms for Scenario #4 at this time.)

Overview for Scenario #4: This very wise senior resident has arranged a meeting with Dr Bean, his or her ward attending for the upcoming rotation. Dr Bean is a pediatric nephrologist known for his long, lecture-heavy rounds, and affinity for "card-rounds" in the hospital cafeteria. Our resident would like to convince Dr Bean to allow him or her to select a few patients for bedside teaching on rounds each day.

(Give the volunteers approximately 5 minutes for the role-play.)

I. Discussion of Scenario #4

(Thank the participants and take a few minutes to discuss the Audience Evaluation Forms. You may then wish to summarize, as follows.)

To review working with the attending, your goals should be to:

- Meet with the attending before a problem or pattern develops
- Establish yourself as manager of rounds
- Limit the number of patients discussed
- Plan for bedside teaching
- Establish goals for attending physician teaching

(If these goals are not met, you may wish to discuss appropriate steps that a resident in your program should take to resolve the conflict.)

J. Conclusion

We have covered a great deal today. Hopefully, you now have a better understanding of adult learning theory, and how you can use it to positively impact your role as teacher. We can summarize what we have learned as:

1. Learners need to know what is expected of them.

Asking how they would do something may be more valuable than asking them if they can do something.

2. Learners need to be invested in learning. Asking for a commitment, such as diagnosis or theory of disease will help to engage the learner.
3. Learners build upon what they know. Asking for the evidence they have used to support their conclusions will help you to understand both what they know and what they need to learn.
4. Concepts presented as general rules will be remembered more easily than information perceived as an isolated fact or opinion.
5. Priming functions as an effective teaching tool by allowing the learner to focus on the desired teaching point.
6. Modeling teaches by example, but requires specifically telling learners what to look for, so that they will not become overwhelmed or bored.
7. Bedside teaching is more personal and, therefore, more memorable than card-flipping.
8. Concentrating on a few patients during attending rounds, where general rules can be utilized, is likely to be more effective than skimming over many patients in a superficial manner.
9. The attending must be involved in the teaching plan for it to be effective. Addressing this issue early, before problems arise, will alleviate stress and prevent wasted time.

K. Questions and Answers

Are there any questions about what we have discussed?

(Answer questions.)

Thank you all very much for coming. I hope this has been valuable. A final session will be held _____. We will discuss correcting mistakes, reinforcing what is right, and giving effective feedback at that session. After the session on feedback, I will also ask you to take a quick Posttest to give me a little feedback on this course. Thank you.

Residents as Teachers

Teaching Workshop

Scenario #4

Resident Primer

This is your second month this year as a senior resident on the wards. The last such month you were frustrated by ineffective rounds, and have arranged a meeting with Dr Bean, a pediatric nephrologist, and your future ward attending. Surprisingly, Dr Bean sounded very enthusiastic about your request to discuss a teaching plan for the rotation. You feel strongly that bedside teaching on a few cases, selected by you, would be most desirable. You would also like to take advantage of Dr Bean's expertise in nephrology, possibly by asking for very brief talks on patient-oriented topics.

Unfortunately, Dr Bean is in the middle of a grant proposal, and can only give you 5 minutes. Given his reputation for card-flipping in the hospital cafeteria, and long, research-based lectures, you know you have your work cut out for you. See what you can accomplish.

Residents as Teachers

Teaching Workshop

Scenario #4

Attending Primer

As a pediatric nephrologist, you are required to attend on the wards 1 month a year. Although research is your first love, you enjoy the chance to refresh yourself on topics other than nephrology. Typically, you have conducted rounds in the relaxed atmosphere of the cafeteria. You have always card-flipped in the past — you feel strongly that you need to be up-to-date on all patients on the team. In past years you have offered to give extensive discussions on renal topics (recycled grand rounds), but are considering discontinuing this practice, since the interns always get interrupted and the interest seems marginal.

You are happy to meet with the resident before next month's ward rotation; perhaps someone will finally be interested in your grand rounds! Unfortunately, you have a major grant proposal due by 8:00 am tomorrow, so you have only allowed 5 minutes for this meeting.

Residents as Teachers

Teaching Workshop

Scenario #4

Audience Evaluation Form

Did the resident: *(yes/no/partially, please give comments)*

1. Appear well organized?

2. Explain the importance of limiting rounds to a few patients?

3. Explain the importance of bedside teaching?

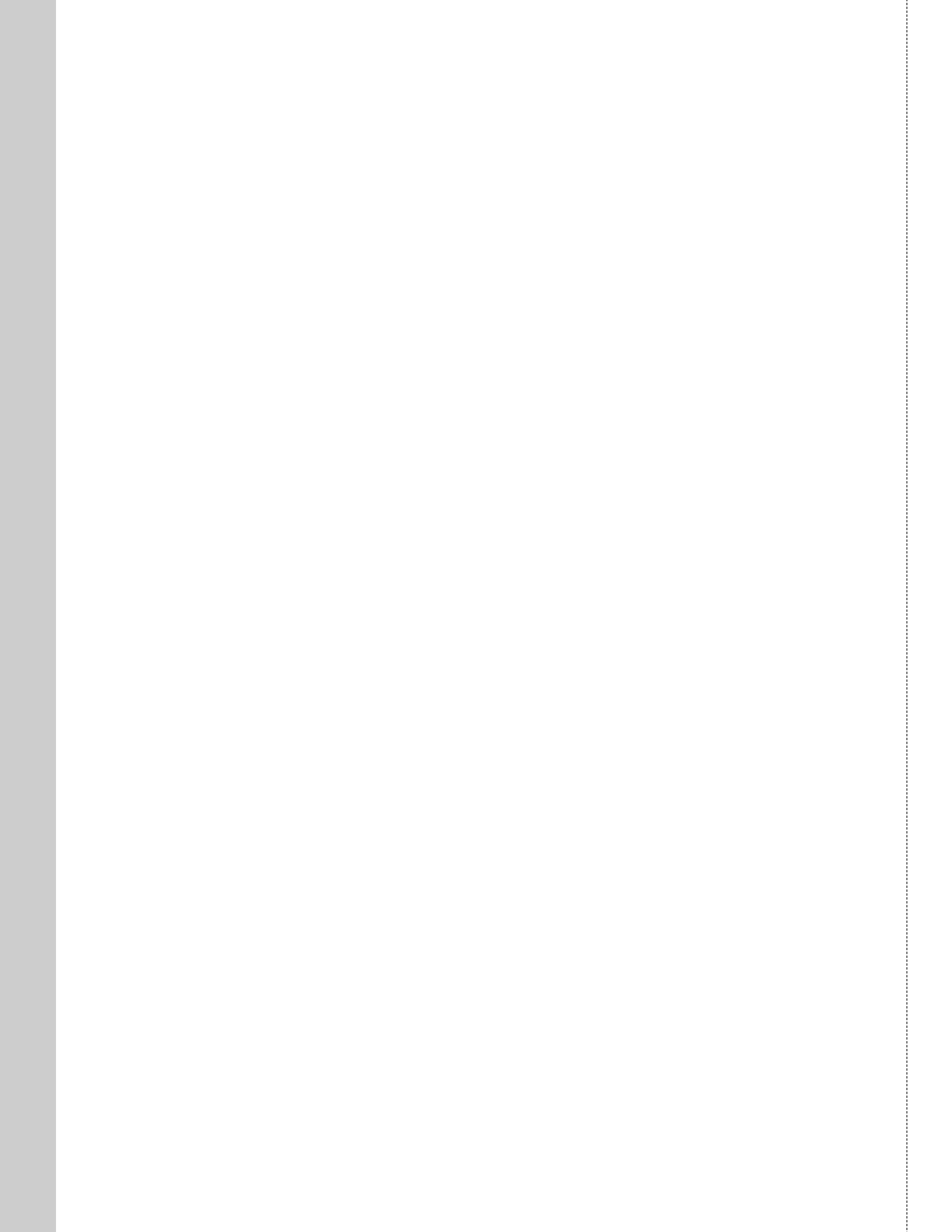
4. Offer to assist with selecting patients for rounds?

5. Discuss the attending's role regarding expectations for teaching?

6. Work to resolve areas of conflict in a manner that met mutual goals?

7. Remain pleasant and respectful?

8. Other comments:



Residents as Teachers

Feedback Workshop

Notes

Qualities of Feedback

Feedback is:

1. Expected:
2. Well-timed:
3. Based on Firsthand Data:
4. Regulated in Quantity:
5. Eliciting the Learner's Perspective:
6. Descriptive and Nonjudgmental:
7. Concerned With Decisions and Actions:
8. Providing Guidance to Resolve the Problem:
9. Limited to Remediable Behavior:
10. Remembering the Positive:

Residents as Teachers

Feedback Workshop

A. Introduction

Welcome to the final session on residents as teachers. In the previous workshops we have discussed the importance of good leadership and organizational skills, as well as specific guidance on teaching strategies. Today we will focus on feedback.

Residents almost universally agree that giving feedback is stressful. The best way to reduce that stress is to learn to give feedback effectively. We will learn today how to give nonconfrontational, constructive feedback. Feedback that benefits the learner is more easily appreciated and, hence, much easier to give.

First, let's define feedback. Feedback is a process of sharing observations and recommendations with a learner. It is just as important to note that feedback is NOT equivalent to evaluation. An evaluation must be performed to provide effective feedback, but feedback does much more than just compliment or criticize performance. Ongoing feedback will provide a basis for the evaluation — most likely the assignment of a letter grade — at the end of a rotation.

Feedback really occurs in two forms: ongoing and cumulative. The resident who has worked closely with the interns and students is well qualified to give either form.

B. Qualities of Feedback

Please give me qualities that you think are important for feedback to be effective.

(Create a list of suggestions on the chalkboard, commenting as appropriate. It may be easier for some learners to think of poor feedback experiences, and what would have made the feedback more effective. While generating the list, or quickly afterward, organize the answers into the following categories. Provide the learners with the "Summary of Feedback" sheet following this discussion.)

Feedback is:

1. Expected. As we mentioned in the first session, telling learners that you will be providing feedback

on a daily basis and at predetermined intervals will prepare the learner for your constructive comments. If not prewarned, many learners will assume that feedback equates to poor performance on their part.

2. Well-timed. Ongoing feedback should be given as soon after the observed behavior as is practical. Cumulative feedback should be given in a private, comfortable setting, at a time when both the resident and learner can speak without distractions.
3. Based on Firsthand Data. This is exactly why residents are best equipped to provide feedback! Secondhand data will often lack specificity, or worse, authenticity. In either case, you are more likely to produce resentment than learning.
4. Regulated in Quantity. Enough is enough. Too much feedback, regardless of form, will be seen as berating. The more frequent error, however, is to provide much too little feedback.
5. Eliciting the Learner's Perspective. This is especially important if you are giving feedback concerning a conflict. If you have heard both sides of a confrontation, you will be better able to address the true issues.
6. Descriptive and Nonjudgmental. The more specific you can be about what needs to be changed, the more likely the learner is to understand the problem and be able to address it. Always remember, you are correcting the behavior, not the person.
7. Concerned With Decisions and Actions, Rather Than Assumed Intentions and Interpretations. In other words, concentrate on WHAT was done or said, rather than WHY you think it was done or said. If the "why" is important, ask.
8. Providing Guidance to Resolve the Problem. Without suggestions for a means to improve, your "feedback" will be little more than criticism. If you cannot provide guidance, reconsider the feedback. In the case of positive feedback, you can use your comments to reinforce a desired behavior.

9. Limited to Remediable Behavior. If the behavior is not remediable, it is likely to be personality based. Stay focused on the behavior, even if you feel it originates from a less-than-ideal personality.
10. Remembering the Positive. It is fine to compliment the person, but do not confuse this with positive feedback, which is based on the criteria just discussed. Feedback does not have to be negative.

Are there any questions?

(Answer questions before continuing with the workshop.)

C. Scenario #5

(This scenario does not include primers.)

I need a volunteer. Here, we will demonstrate the process of daily, or ongoing, feedback. Who would like to help me out?

(After enlisting a volunteer, pass out the "Audience Evaluation Form" for Scenario #5, then continue.)

Your part is pretty easy — I need you to be a resident. You have just come out of a new patient's room with Pat, your third-year medical student. The patient was a 5 year old with new onset seizures. Pat conducted an exhaustive interview. As a matter of fact, you were in the room nearly 2 hours. During the encounter, you were paged twice with new admissions, which should arrive on the ward at any time. The history, including a detailed review of system, left no stone unturned. Pat's exam was complete, except Pat conducted only cursory skin and eye exams on this patient. The child's mother has neurofibromatosis.

The other students have warned you that Pat has a reputation for similar problems on earlier rotations. You are concerned about the busy month ahead with Pat. What feedback would you offer?

D. Discussion of Scenario #5

(Respond as Pat. Once the feedback scenario is completed, thank your volunteer, and ask him or her to be seated. Review the Audience Evaluation Form, and summarize the discussion.)

E. Scenario #6

I need two additional volunteers for the last scenario. This scenario is concerned with cumulative feedback. Who would like to participate?

(Have the two volunteers read their Primers for Scenario #6 outside the room while you set the stage for the audience by reading the Overview for Scenario #6. Provide the audience with the Audience Evaluation Form for Scenario #6.)

Overview for Scenario #6: It is halfway through the ward month. The resident is now meeting with the intern, as they had planned at the beginning of the month. In general, they have gotten along well, and they like one another. Although the intern is very bright, the resident is frustrated with the intern's lack of compulsion in regard to patient care. On several occasions, this has prolonged hospitalization by either delaying appropriate treatment or failing to follow up patient progress as quickly as was possible. It was agreed, early in the rotation, that the intern would be responsible for the details of patient care, but the resident now fears the intern cannot be trusted to follow up independently.

(Give the volunteers approximately 8 minutes to perform their role-play.)

F. Discussion of Scenario #6

(Thank the volunteers, and review the Audience Evaluation Form with everyone.)

G. Summarizing Statements

Hopefully this session has helped to solidify your understanding of feedback. Good feedback is neither a compliment nor a criticism. Effective feedback will give constructive suggestions to reinforce or modify a decision or action. By remaining centered on performance, rather than personality, the learner will more easily understand and accept your remarks. The added benefit is that once you see that your feedback is likely to be appreciated, your anxiety regarding this topic will diminish.

Except for the Posttest, this completes the series of workshops on residents as teachers. I certainly hope this has been of value to you. Your honest feedback on the course will be appreciated.

H. Question-and-Answer Session

Does anyone have any questions or comments regarding this or any of the preceding workshops?

(After questions have been answered, proceed to the Posttest. The residents should be given approximately 15 minutes to complete the Posttest.)

Thank you!

Residents as Teachers

Feedback Workshop

Scenario #5

Audience Evaluation Form

Did the resident: *(yes/no/partially, please give comments)*

1. Base feedback on firsthand data?

2. Regulate quantity of feedback?

3. Elicit the learner's perspective?

4. Use descriptive and nonjudgmental language?

5. Focus on decisions and actions, rather than assumed intentions and interpretations?

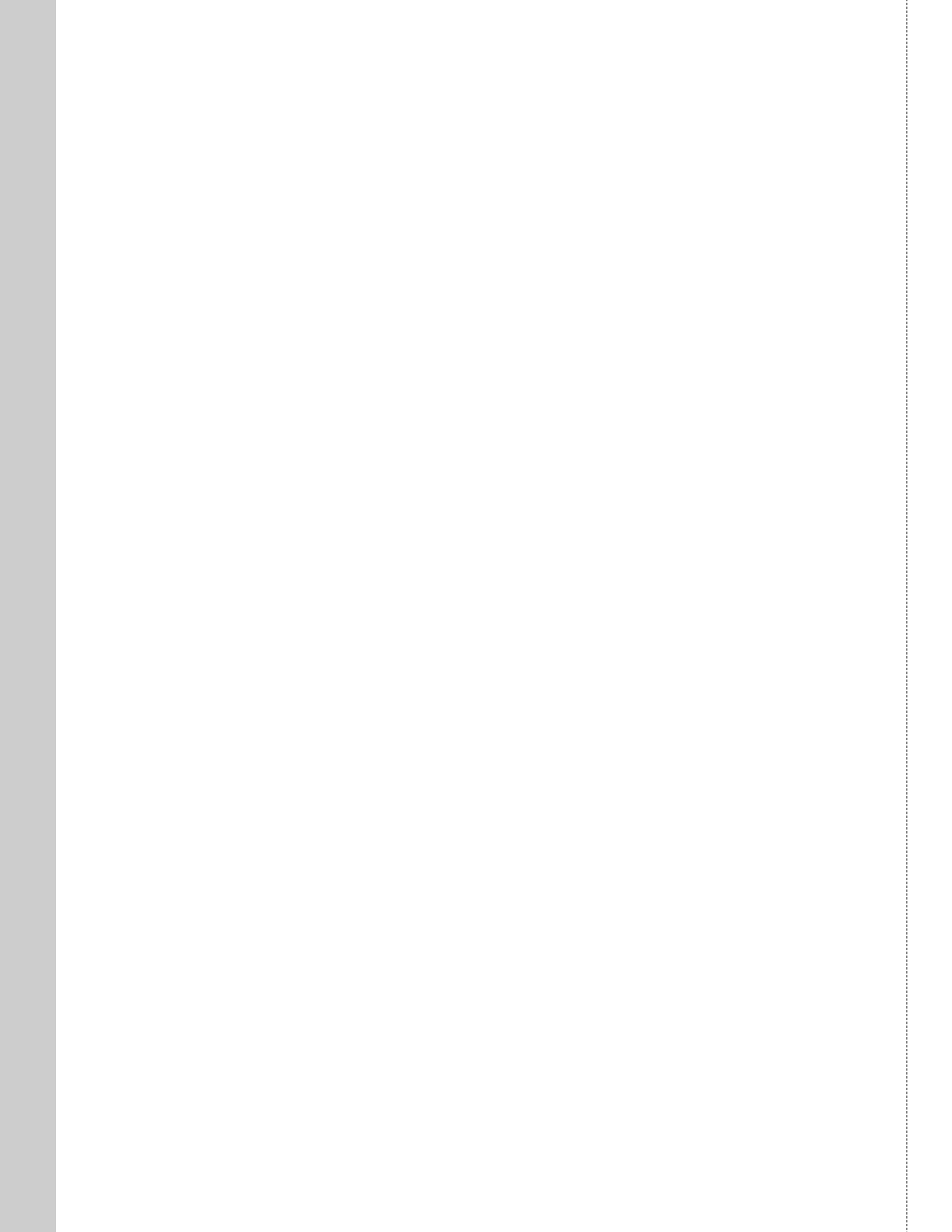
6. Provide guidance to resolve the problem?

7. Limit comments to remediable behavior?

8. Include positive as well as negative feedback?

9. Extra credit: Did the resident teach a general rule?

10. Other comments:



Residents as Teachers

Feedback Workshop

Scenario #6

Resident-Teacher Primer

You are about to give prearranged, mid-month feedback to your intern. He or she has been prompt to rounds, professionally dressed, and very pleasant. You are quite impressed with the intern's knowledge base, and recognize him or her as a voracious reader of the pediatric literature.

However (and you just knew there was going to be a however, didn't you?), the intern does not follow up labs, tests, and treatments as closely as you would like. Twice, a patient's discharge was delayed by failing to wean nebulizations appropriately. Also, a renal patient ultimately waited an extra day before being scheduled for nephrectomy (although no "real harm" was done), because an ultrasound result was not followed up in a timely manner. You would like your intern to give more attention to such details of patient care. After all, the intern did agree that the details of patient care would be his or her responsibility to follow up, and report to you.

Take this opportunity to provide constructive feedback (extra points for teaching a general rule!). See what you can accomplish in 8 minutes.

Residents as Teachers

Feedback Workshop

Scenario #6

Intern-Learner Primer

You are about to attend the mid-month feedback session with your resident. You have rather enjoyed working with him or her, even if he or she seems a bit compulsive. The resident has appeared somewhat irritated with the speed at which things occur, but then, we all get frustrated from time to time. You feel sure no one has been harmed by any delay on your part.

You are confident that you are about to be flooded with praise. You are prompt to rounds, dress professionally, and are well-liked. You are also bright (and modest!). You find time to read for a couple of hours on even the busiest days. Several times on rounds, you have provided the correct answer, when you are pretty sure even your resident didn't know. This should be a piece of cake!

Residents as Teachers

Feedback Workshop

Scenario # 6

Audience Evaluation Form

Did the resident:

(yes/no/partially, please give comments)

1. Base feedback on firsthand data?

2. Regulate quantity of feedback?

3. Elicit the learner's perspective?

4. Use descriptive and nonjudgmental language?

5. Focus on decisions and actions, rather than assumed intentions and interpretations?

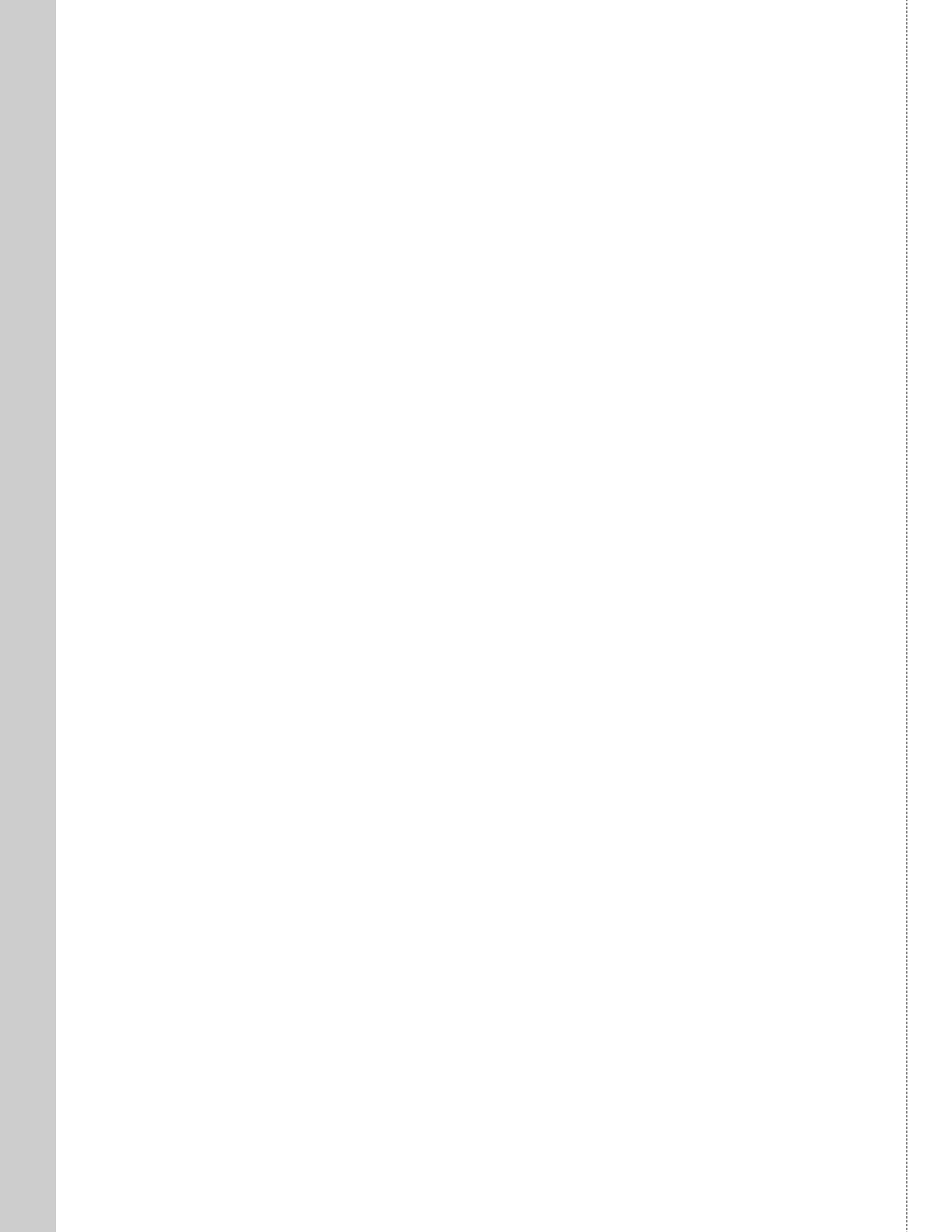
6. Provide guidance to resolve the problem?

7. Limit comments to remediable behavior?

8. Include positive as well as negative feedback?

9. Extra credit: Did the resident teach a general rule?

10. Other comments:



Residents as Teachers

Posttest

PART I (please circle)

1. Type of training:
Categorical Peds Combined Peds Program Other
2. Year of training:
1 2 3 4 Other _____
3. Besides this course, have you taken a course to train you to be a better teacher?
Yes No
4. How many sessions of this course did you attend?
1 2 3

PART II (please circle)

Use this scale for Part II:

- 1 = Torture/Learned Nothing
- 2 = Not Very Enjoyable/Learned a Little
- 3 = Tolerable/Learned a Few Things I Didn't Know
- 4 = Somewhat Enjoyable/Learned a Respectable Amount
- 5 = Very Enjoyable/Learned a Great Deal
- D/A = Didn't Attend

5. How enjoyable was the session on Organization and Leadership?
1 2 3 4 5 D/A
6. How much did you learn at the session on Organization and Leadership?
1 2 3 4 5 D/A
7. How enjoyable was the session on Teaching Skills?
1 2 3 4 5 D/A
8. How much did you learn at the session on Teaching Skills?
1 2 3 4 5 D/A
9. How enjoyable was the session on Feedback?
1 2 3 4 5 D/A
10. How much did you learn at the session on Feedback?
1 2 3 4 5 D/A

PART III (please circle)

Use this scale for Part III:

- 1 = Never/Untrue
- 2 = Rarely/Some Truth
- 3 = Sometimes/True as Often as Not
- 4 = Frequently/Basically True
- 5 = Always/Definitely True
- N/A = Not Answerable

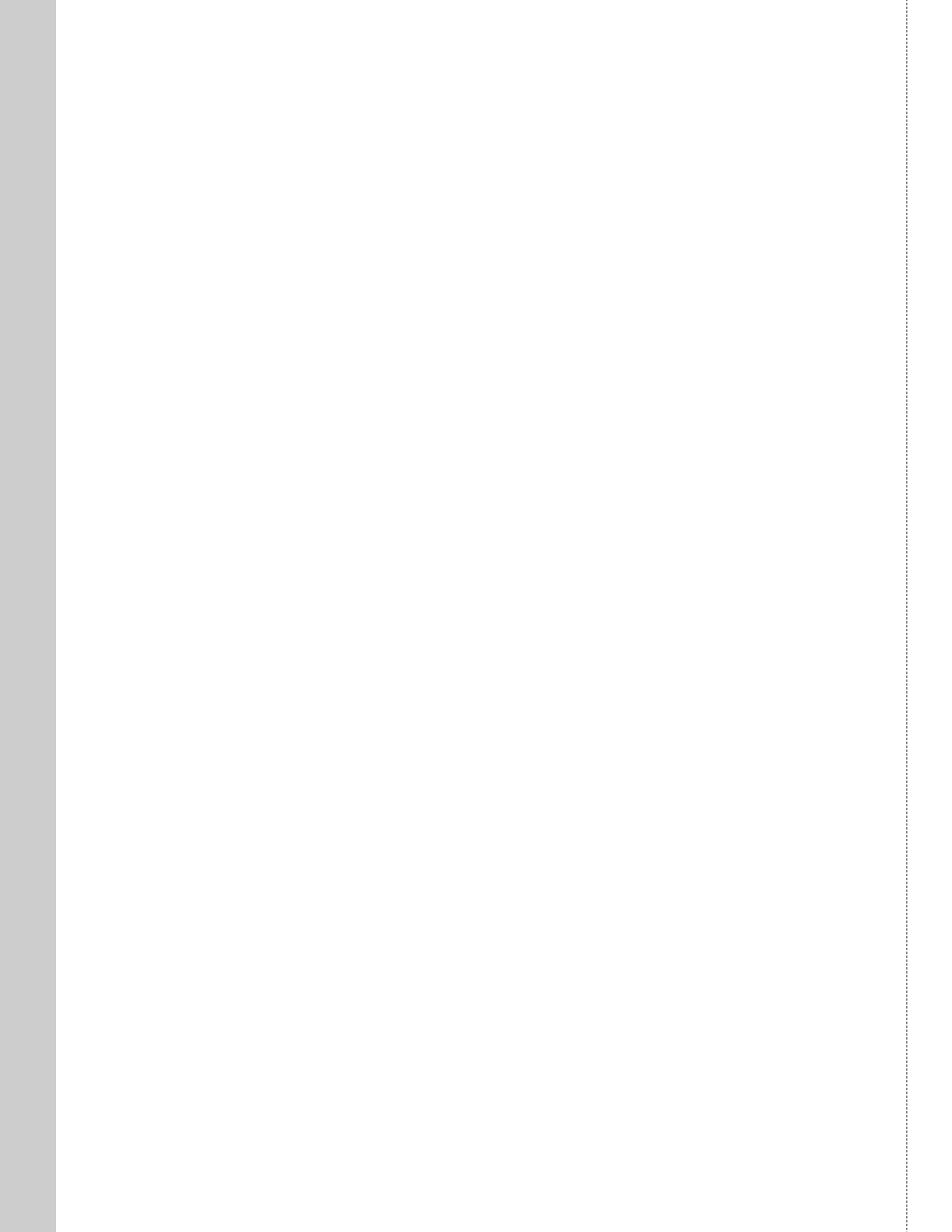
11. I feel well prepared to teach.
1 2 3 4 5 N/A
12. I am enthusiastic about teaching.
1 2 3 4 5 N/A
13. I have confidence in my teaching ability.
1 2 3 4 5 N/A
14. I am aware of what is expected of me as a teacher.
1 2 3 4 5 N/A
15. My anxiety regarding teaching is at "a healthy level."
1 2 3 4 5 N/A

PART IV (please write in answer)

16. I would increase attention to, or add, the following items:

17. I would decrease attention to, or delete, the following items:

18. Other comments or suggestions:



Residents as Teachers

Bibliography

- Berquist W, Phillips S. *A Handbook for Faculty Development*. Dansville, NY: The Council for the Advancement of Small Colleges; 1975: vol 1
- Ende J. Feedback in Clinical Medical Education. *JAMA*. 1983;250(6):777-781
- Ende J. What If Osler Were One of Us? Inpatient Teaching Today. *J Gen Intern Med*. 1997;12(suppl 2):s41-s48
- Gordon MJ. *Assessment of Student Affect: A Clinical Approach*. St Louis, MO: CV Mosby; 1978
- Johnson CE, Bachur R, Hafler JP. Developing Residents as Teachers: Process and Content. *Pediatrics*. 1996;97(6):907-916
- Johnson CE, First LR. *Resident Teaching: A Manual to Make It Successful*. Boston, MA: Harvard Medical School, Office of Educational Development; 1996
- Kaplan CB, Siegel B, Madill JM, Epstein RM. Communication and the Medical Interview. *J Gen Intern Med*. 1997;12(suppl 2):s49-s55
- Lipkin M Jr, Quill TE, Napodano RJ. The Medical Interview: A Core Curriculum for Residencies in Internal Medicine. *Ann Intern Med*. 1984;100:277-284
- Lovejoy F, Armstrong E. *Resident as Teacher Program*. Boston, MA: Harvard Medical School, Pediatric Faculty Development Project; 1995-1996
- McGee SR, Irby DM. Teaching in the Outpatient Clinic Practical Tips. *J Gen Intern Med*. 1997;12(suppl 2):s34-s40
- Meyer B, Gordon K. *The One Minute Preceptor*. University of Washington School of Medicine, Department of Family Medicine
- Rider EA. *Guidelines for Providing Constructive Feedback*. Boston, MA: Resident as Teacher Curriculum, Children's Hospital, 1994
- Roberts KB, DeWitt TG, Goldberg RL, Scheiner AP. A Program to Develop Residents as Teachers. *Arch Pediatr Adolesc Med*. 1994;148:405-410
- Schwenk T, Whitman N. *The Physician as Teacher*. Baltimore, MD: Williams and Wilkins; 1987
- Schwenk TL, Whitman N. *Residents as Teachers: A Guide to Educational Practice*. Salt Lake City, UT: University of Utah School of Medicine, Department of Family and Preventive Medicine; 1984
- Sheal PR. *How to Develop and Present Staff Training Courses*. New York, NY: Nichols Publishing; 1989:12-29
- Wipf JE, Pinsky LE, Burke W. Turning Interns into Senior Residents: Preparing Residents for Their Teaching and Leadership Roles. *Acad Med*. 1995;70(7):591-596
- Weinholtz D, Edwards J. *Teaching During Rounds: A Handbook for Attending Physicians and Residents*. Baltimore, MD: Johns Hopkins University Press; 1992
- Westberg J, Jason H. *Collaborative Clinical Education: The Foundation of Effective Health Care*. New York, NY: Springer Publishing, 1993

The AAP Section on Residents
wishes to thank Bradley Bullock, MD
for his contributions to this handbook.