Consultation Deck of Cases

(For Practice and Discussion)

Consulting in MedEd

Consultation Module
June, 2016

Case 1

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

Tasks for completion:

Using the remaining suggested readings from the reading list, create a 2-page report that highlights what you might recommend based on your assigned case.

A Case of CPD Conundrum

Your academic division is responsible for the continuing education and professional development of all the practicing physicians within your specialty for your region. This includes physicians practicing in both academic and community practices. Increasingly, the continuing professional development (CPD) director has been noting that there is apathy and poor attendance for live ('in person') events like Journal Club, Rounds, and conferences.

Your Continuing Professional Development (CPD) director has come to you as a clinician educator to ask for your advice. Currently the CPD office has the following types of events:

1) Grand Rounds - traditional single-person lectures once a month
2) Monthly Journal Club - combined with the residency program (with poor staff physician attendance)
3) One annual regional conference (with only about 20-40 physicians attending)

Your CPD director wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present CPD programming. He is familiar with different educational theories, and wishes for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

Tip: Scan through the reading list for ideas that inspire you for ideas, and then dive deep to see if that theory helps you develop your ideas further.

Suggested resources from the readings that may assist you with this case:

Development of expertise, competence:
Ericsson KA. Deliberate practice and acquisition of expert performance: a general overview. Acad Emerg Med. 2008 Nov;15(11):988-94. doi: 10.1111/j. 1553-2712.2008.00227.x.

Reznick RK, MacRae H. Teaching surgical skills--changes in the wind. N Engl J Med. 2006 Dec 21;355(25):2664-9.

Dunphy BC, Williamson SL. In pursuit of expertise. Toward an educational model for expertise development. Adv Health Sci Educ Theory Pract. 2004;9(2):107-27.

McGaghie W, Issenberg S, Cohen E, Barsuk J, Wayne D. Medical education featuring mastery learning with deliberate practice can lead to better health for individuals and populations. Acad Med. 2011 Nov;86(11):e8-9.

Adult learning principles
Knowles MS. The adult learner: a neglected species. 4th ed. Houston (TX): Gulf Publishing; 1990.

Knowles S, Holton E, Swanson R. The adult learner: the definitive classic in adult education and human resource development. 5th edition. Houston: Gulf Publishing. 1998.

Norman GR. The adult learner: a mythical species. Acad Med. 1999;74(8):886–9.

Workplace learning
Alice Y. Kolb and David A. Kolb. Learning Styles and Learning Spaces: Enhancing Experiential Learning in Higher Education. Academy of Management Learning & Education, 2005, 4(2)Jun:193-212

Community of practice
Sherbino J, Snell L, Dath D, Dojeiji S, Abbott C, Frank JR. A national clinician-educator program: a model of an effective community of practice. Med Educ Online. 2010; Dec 6;15.

Wenger E, McDermott R, Snyder W. Communities of practice and their value to organizations. In: Cultivating communities of practice. Boston: Harvard Business School Press; 2002. p. 1–47.*

Wenger E. Communities of Practice: Learning, meaning and identity. Cambridge University Press. 1998.*

Cox M, Richlin L. Building Faculty Learning Communities: New Directions for Teaching and Learning, No. 97. 2004.

*Other readings by Lave and Wenger would be appropriate as well.

Reflective practice
Schon DA. Educating the reflective practitioner: toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass; 1987. (This is a whole book, so not probably something to read for this assignment, but a must-read for all CEs.)

Eva K, Regehr G. Self-assessment in the health professions: a reformulation and research agenda. Acad. Medicine.2005; 80(10 Suppl):S46-54.

Mann K. et al. Reflection and reflective practice in health professions education: A systematic review. Adv in Health Sci Educ. 2007

Life-long learning
Parboosingh J, Campbell C, et al. on behalf of the Scholar Lifelong Learning working group. Pursuing excellence in practice: a CanMEDS Scholar program on lifelong learning. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2008.

Self Assessment
White CB, Gruppen LD, PhD. Self-Assessment and Self-Regulated Learning. Association for the Study of Medical Education, editor. Edinburgh, UK.

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Case 2

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of Admissions Decisions

The local residency program is re-considering their admissions process. For the past few years, they have had an inordinate problem identifying 'trouble residents', and the program director feels that perhaps fine-tuning the residency selection process would be a way to select residents who might be more resilient. In this situation, 'trouble residents' are residents who display frequent deficits in any or multiple of the ACGME milestones - especially around Professionalism & Interpersonal and Communication Skills.

Your program director has approached you to review the education literature and propose 3 possible innovations (or changes) to the local residency program's existing resident selection process. The current process has the following component:

1) File Review - with a locally derived selection schema that values the residency's three core values (i.e. Leadership Potential, Scholarly/Research Potential, Clinical Care). The file review includes the medical school transcripts (which are largely Pass/Fail), 3 letters of reference, and a Curriculum Vitae (CV).
2) Letter of Interest - 500 words written by the Candidate regarding why they wish to match to this residency program, and why they feel they would be a good fit.
3) Traditional Interview x 2 - each candidate undergoes two traditional interview stations with 2 raters in each room (usually one faculty member and resident)
4) Faculty & Resident input session - end-of-day session where faculty members or residents may raise concerns or advocate for candidates.

Your residency program director wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance the present resident selection process. He is familiar with different educational theories, and wishes for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

Tip: Scan through the reading list for ideas that inspire you for ideas, and then dive deep to see if that theory helps you develop your ideas further

Suggested resources from the readings that may assist you with this case:

Student selection and admission
Eva KW, Reiter HI, Rosenfeld J, Trinh K, Wood TJ, Normal GR. Association between a medical school admission process using the multiple mini-interview and national licensing examination scores. JAMA. 2012;308(21):2233–40.

Young M, Razack S et al. Calling for a broader conceptualization of diversity: surface and deep diversity in four Canadian medical schools. Acad Med. 2012 Nov;87(11): 1501-10. doi: 10.1097/ACM.0b013e31826daf74.

Societal responsiveness
Cruess SR, Johnston S, Cruess RL. Professionalism for medicine: opportunities and obligations. Iowa Orthop J. 2004;24:9-14.

Interprofessional education
Hammick M et al. Interprofessional education. BEME Guide no. 9 2007, Vol. 29, No. 8 , Pages 735-751 doi:10.1080/01421590701682576)

Residency Accreditation:
http://www.royalcollege.ca/portal/page/portal/rc/credentials/accreditation
http://www.acgme.org/What-We-Do/Accreditation/Milestones/Overview

https://www.acgme.org/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones.pdf

Workplace learning
Alice Y. Kolb and David A. Kolb. Learning Styles and Learning Spaces: Enhancing Experiential Learning in Higher Education. Academy of Management Learning & Education, 2005, 4(2)Jun:193-212

Reflective practice
Schon DA. Educating the reflective practitioner: toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass; 1987. (This is a whole book, so not probably something to read for this assignment, but a must-read for all CEs.)

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Case 3

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of a Catastrophic Classroom

Jill, an emergency physician, is a recently-hired junior faculty member at the St. Elsewhere Emergency Medicine (EM) residency program. She completed her own training 5 years ago at a well-respected residency, where she was chief resident, and then stayed on as a faculty member. She had a strong interest in resident education and was active on the CORD listserv. But there was a well-established leadership team at her home program and limited opportunity for advancement.
Jill took a position at St. Elsewhere, a less-established residency, that offered her a leadership role. Her first challenge in this new role was a revamp of their weekly half-day educational conference.

This is how the St. Elsewhere residency program's informational web page described about their conference:

"Our residents are relieved from regular hospital duties (i.e. they receive protected time) to attend conference. The sessions are held in a Campbell-Morrison memorial lecture hall at St. Elsewhere every Wednesday from 7:30 am to 12:30 pm for their educational conference. The day begins with a Morbidity and Mortality conference, followed by various lectures delivered by senior residents or faculty members. Lecture topics are on a repeating curriculum on a 1.5-year cycle, thereby ensuring that the residents see every topic as both a junior and senior resident. Our curriculum is based on the EM Model and uses guided readings from prominent EM textbooks."

When Jill emailed the current program director (PD) about who the last curriculum lead was within the faculty, and how s/he designed the curriculum. The PD quickly wrote back stating that he couldn't remember, and that he thinks it was always that way. He wrote: "I think this is the way things are done because this is the way things have always been done."

Jill's First St. Elsewhere's EM Conference Experience

Jill arrived early and sat in the back of the hall taking notes throughout the first conference. She was joined in the back of the lecture hall by a rotating cast of 3-4 faculty members who came and went throughout the conference. Only one other faculty member attended the whole conference but he worked on his laptop the whole time.

The Morbidity & Mortality (M&M) conference was a series of typical case presentations lead by a senior resident. The resident involved in the management of the case stood before the group as well, answering questions about his thought process and management choice. Several residents took questions clearly placing blame on their choices, and one of the residents became quite tearful and had to leave the podium mid-presentation.

A 4-question multiple choice quiz followed M&M, about the week's assigned reading. Residents perfunctorily completed the quiz. Correct answers were provided by the residency coordinator afterward. No discussion followed.
M&M was followed by several PowerPoint-driven, didactic lectures. One was given by a senior resident, and included a detailed review of the Kreb's Cycle. Another was given by a faculty member on renal emergencies but the slide deck was clearly prepared by someone else, as evidenced by the fact that the other person's name was still listed on the title slide.

Throughout the conference most residents were slumped in their chairs staring at their smartphones. One resident slept in the front row.
There was confusion over which faculty member was supposed to deliver the final lecture and the assigned person was not present or reachable by phone. As such, the conference ended 45 minutes early.

Jill Meets with the Stakeholders
Jill met with one of the chief residents, Rob, to discuss conference. Rob is well-respected among the residents and besides being clinically excellent is a reliable advocate with the administration. He expressed frustration about conference. The format is largely unchanged from when he was an intern. He feels too much of the teaching is done by senior residents – which though beneficial for junior residents, leaves senior residents' needs unfulfilled. Early on he had hoped to stay at the program when he graduated but now he is actively looking for an academic position elsewhere.

Jill heard more complaints from faculty after their last staff meeting. Several staff members complained that there was no CME credit for them if they attended. One faculty member, who had previously been a regular presenter at conference, complained about the lack of financial incentive (i.e. "There is no buy-down! It's essentially volunteer work!") or even recognition throughout the residency for active involvement in the educational conference ("I don't even get a thank-you letter!"). Others complained that the early start time made coordinating childcare difficult. Some expressed surprise to learn of any concern over the quality of conference.
Jill also met with the program director, Ravi. He has been in the position for 5 years. Two of those years were complicated by conditional accreditation by the ACGME.

When asked about conference he became exasperated. His primary goal is to stick to the ACGME requirements, especially those concerning total conference time and faculty supervision. He acknowledges his focus has been on duty hour compliance and implementing resident assessment based on the new milestones, rather than educational innovation.

Jill Seeks Advice

Jill wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present academic programming. She is only vaguely familiar with different educational theories, and wishes for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique “pitches” for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each ‘pitch’. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

Suggested resources from the readings that may assist you with this case:

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Interprofessional education
Hammick M et al. Interprofessional education. BEME Guide no. 9 2007, Vol. 29, No. 8 , Pages 735-751 doi:10.1080/01421590701682576)

Reflective practice
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Mann K. et al. Reflection and reflective practice in health professions education: A systematic review. Adv in Health Sci Educ. 2007

Ericsson KA. Deliberate practice and acquisition of expert performance: a general overview. Acad Emerg Med. 2008 Nov;15(11):988-94. doi: 10.1111/j. 1553-2712.2008.00227.x.

Reznick RK, MacRae H. Teaching surgical skills--changes in the wind. N Engl J Med. 2006 Dec 21;355(25):2664-9.

Dunphy BC, Williamson SL. In pursuit of expertise. Toward an educational model for expertise development. Adv Health Sci Educ Theory Pract. 2004;9(2):107-27.

McGaghie W, Issenberg S, Cohen E, Barsuk J, Wayne D. Medical education featuring mastery learning with deliberate practice can lead to better health for individuals and populations. Acad Med. 2011 Nov;86(11):e8-9.

Adult learning principles
Knowles MS. The adult learner: a neglected species. 4th ed. Houston (TX): Gulf Publishing; 1990.

Knowles S, Holton E, Swanson R. The adult learner: the definitive classic in adult education and human resource development. 5th edition. Houston: Gulf Publishing. 1998.

Norman GR. The adult learner: a mythical species. Acad Med. 1999;74(8):886–9.

Life-long learning

Parboosingh J, Campbell C, et al. on behalf of the Scholar Lifelong Learning working group. Pursuing excellence in practice: a CanMEDS Scholar program on lifelong learning. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2008.

Self Assessment

White CB, Gruppen LD, PhD. Self-Assessment and Self-Regulated Learning. Association for the Study of Medical Education, editor. Edinburgh, UK.

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Case 4

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of fostering Rookie Researchers

Your department chair (Dr. Dennis) has asked you to perform a consultation for the research team in your department. The department has been suffering a loss of talent. Residents are completing their training and leaving your group, enticed by surrounding clinically-oriented community centers. Very few residents are staying to become part of your academic team, and as such, very little scholarly work is being produced.

Your chair feels that the research program and residency research curriculum is failing. He realizes that changes must be made to ramp up the interest in scholarly pursuits. There have been a few thought leaders in educational scholarship and research locally that have stuck around, and he wants to find a way to 'cash in' on this area of local talent.

There are only a few scholarly mentors within the department, most of them junior-to-mid-career faculty members with a strong interest in medical education. There are also a few non-physician research associates and scientists. Many of the most senior scientists have engaged in research, and were historically successful in obtaining national grants. Now, however, they are approaching retirement no longer wish to supervise residents. There is a head of research, Dr. Simpson, but she is very busy as the vice-chair of education and residency research director.

Under Dr. Simpson's supervision, some of your program's current senior residents have won local hospital-level grants. The residency director, Dr. Patel, is worried that the department is depending on these university-level grants, and has not devoted local resources to fostering 'in house talent'.

There is also a human resources crunch with regards to supervisors. Many residents are approaching the most junior faculty members for supervision, since they feel these faculty members are the most approachable and friendly. That said, the junior faculty who have signed onto supervise feel very ill-equipped to be supervisors themselves. Drs. Lerner and Warner are both trying to fill the void in terms of the residents' needs, but that these two young clinician educators feel out of their depth in these supervisory roles. Dr. Lerner has just begun her formal training in medical education and is only just starting to complete her own independent projects; Dr. Warner had completed his PhD prior to medical school, but has not yet supervised any junior learners on research before. Both have confessed to Dr. Dennis that they

are lost with regards to how best to supervise all the residents in the program whom have made requests of them.

Meanwhile, during the last accreditation review, the residents voiced their dismay that they are being ‘made to do research’. The program has since made some strides to be more inclusive of the types of scholarly activity they consider acceptable (including quality assurance and medical education projects now in addition to research).

Dr. Dennis has asked you to consult and provide insights on how to capitalize on this unique situation. He wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present educational research system. He is familiar with different educational theories, and wishes for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique “pitches” for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each ‘pitch’. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

Suggested resources from the readings that may assist you with this case:

Leadership
Perry M, Hopson L, House JB, et al. Model for Developing Educational Research Productivity: The Medical Education Research Group. West J Emerg Med. 2015 Nov; 16(6):947-51.

Bisordi J, Abouljoud M. Physician leadership initiatives at small or mid-size organizations. Healthc (Amst). Epub 2015 Oct 20. (LINK: https://drive.google.com/open?id=0BxMuEugzNmTYTWtOa2pfRGhpU2c)

Stoller JK. Developing physician-leaders: a call to action. J Gen Intern Med. 2009 Jul; 24(7):876-8. (LINK: https://drive.google.com/open?id=0BxMuEugzNmTYdms5TTdqQWJNVWc)

Bronson D, Ellison E. Crafting successful training programs for physician leaders. Healthc (Amst). Epub 2015 Oct 20. (LINK: https://drive.google.com/open?id=0BxMuEugzNmTYLWlDMmt6dm9DWVE)

Faculty Development
Steinert Y, Naismith L, Mann K. Faculty development initiatives designed to promote leadership in medical education. A BEME systematic review: BEME Guide No. 19. Med Teach. 2012;34(6):483-503. (LINK: https://drive.google.com/open?id=0BxMuEugzNmTYZFBoRENHSUJVSEE)

Farley H, Casaletto J, Ankel F, et al. An assessment of the faculty development needs of junior clinical faculty in emergency medicine. Acad Emerg Med. 2008 Jul;15(7): 664-8. (LINK: https://drive.google.com/open?id=0BxMuEugzNmTYVkJhZ0xFOV9WZFU)

Reflective practice
Schon DA. Educating the reflective practitioner: toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass; 1987. (This is a whole book, so not probably something to read for this assignment, but a must-read for all CEs.)

Eva K, Regehr G. Self-assessment in the health professions: a reformulation and research agenda. Acad. Medicine.2005; 80(10 Suppl):S46-54.

Mann K. et al. Reflection and reflective practice in health professions education: A systematic review. Adv in Health Sci Educ. 2007

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Case 5

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of Uninterested Learner

You have noticed that over the first half of the academic year, your Emergency Department is filled with Emergency Medicine-bound fourth year medical students actively engaged and eager to learn. However, after January, there is a transition from the active fourth year medical student to post-acceptance to residency fourth year medical students who are neither interested in Emergency Medicine nor seeing patients.

While on a shift, you overheard two post-acceptance fourth years talking. One student stated “I don’t see the point of being here. I’m not going into Emergency Medicine. I just want to go home.” The other student replied “Yeah, I just signed up for this because the schedule is light.”

The fourth year clerkship director has approached you to review the literature and help her to increase engagement among the less interested medical students. She has asked you to propose three innovations based upon DIFFERENT educational theories to help revamp the fourth year medical student rotation.

As a team, create three unique “pitches” for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each ‘pitch’. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

Suggested resources from the readings that may assist you with this case:

Adult learning principles

Knowles MS. The adult learner: a neglected species. 4th ed. Houston (TX): Gulf Publishing; 1990.

Knowles S, Holton E, Swanson R. The adult learner: the definitive classic in adult education and human resource development. 5th edition. Houston: Gulf Publishing. 1998.

Norman GR. The adult learner: a mythical species. Acad Med. 1999;74(8):886–9.

Workplace learning

Alice Y. Kolb and David A. Kolb. Learning Styles and Learning Spaces: Enhancing Experiential Learning in Higher Education. Academy of Management Learning & Education, 2005, 4(2)Jun:193-212.

Interprofessional education

Hammick M et al. Interprofessional education. BEME Guide no. 9. Med Teach. 2007 Oct;29(8):735-51.

Experiential Learning

Mughal F, Zafar A. Experiential Learning from a Constructivist Perspective-Reconceptualizing the Kolbian Cycle. International Journal of Learning and Development. 2011;1(2):27-37.

Kolb, D. A. Experiential Learning: Experiences as a source of learning and development, Englewood Cliffs, NJ: Prentice-Hall; 1984.

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Case 6

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of Simulation Curriculum

Your department chair & clinical chief have asked you to develop an *in situ,* interdisciplinary simulation program for your emergency department. Currently, your program only uses simulation teach medical students and residents, but your new clinical chief came from a site that used to do *in situ* interdisciplinary simulation, and he felt that this improved the teaming processes in his last working environment.

The nursing educators seem overwhelmed by this idea, and they are very happy to have you (some newly trained clinician educators) participating in developing this program. They have had complaints that two of the attendings in your group are very disruptive and patronizing during high stress resuscitations. They have found that those two doctors tended to be *'difficult'*, belittling the suggestions of the nurses, respiratory therapists, paramedics, and residents during these resuscitations.

Your simulation centre director has generously leant you two mobile simulation mannequins to use in your sessions. Her only stipulation in exchange for lending yout the equipment is that she wishes you to find some way to make this project scholarly.

Your chair and chief wish for you to propose three (3) suggestions based on educational theory or evidence to create the new simulation programming. They are familiar with different educational theories, and wish for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

Suggested resources from the readings that may assist you with this case:

Interprofessional education
Hammick M et al. Interprofessional education. BEME Guide no. 9 2007, Vol. 29, No. 8 , Pages 735-751 doi:10.1080/01421590701682576)

Lingard, L. Collective Competence, TEDxBayfield.
https://www.youtube.com/watch?v=vl-hifp4u40

Lingard L. Rethinking competence in the context of teamwork. The question of competence: Reconsidering medical education in the twenty-first century. 2012 Oct 16:42-69.

Development of expertise, competence:
Ericsson KA. Deliberate practice and acquisition of expert performance: a general overview. Acad Emerg Med. 2008 Nov;15(11):988-94. doi: 10.1111/j. 1553-2712.2008.00227.x.

Reznick RK, MacRae H. Teaching surgical skills--changes in the wind. N Engl J Med. 2006 Dec 21;355(25):2664-9.

Dunphy BC, Williamson SL. In pursuit of expertise. Toward an educational model for expertise development. Adv Health Sci Educ Theory Pract. 2004;9(2):107-27.

McGaghie W, Issenberg S, Cohen E, Barsuk J, Wayne D. Medical education featuring mastery learning with deliberate practice can lead to better health for individuals and populations. Acad Med. 2011 Nov;86(11):e8-9.

Reflective practice
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Adult learning principles

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Norman GR. The adult learner: a mythical species. Acad Med. 1999;74(8):886–9.

Life-long learning

Parboosingh J, Campbell C, et al. on behalf of the Scholar Lifelong Learning working group. Pursuing excellence in practice: a CanMEDS Scholar program on lifelong learning. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2008.

Self Assessment

White CB, Gruppen LD, PhD. Self-Assessment and Self-Regulated Learning. Association for the Study of Medical Education, editor. Edinburgh, UK.

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Case 7

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Your assignment:

To complete a Clinician Educator Consult.

A Case of Outlier Residents

Your program director (PD) has asked you to review your residency program's clinical competency committee procedures for designing plans for outlier residents. Presently, they review each of the residents every 3 months or so. At these meetings they review the following materials:

1) Their in-training exam results (only available once a year);
2) Their monthly end-of-rotation reports;
3) Their daily shift assessments (one per shift is 'mandatory' but some of the at-risk residents tend to have vast amounts of missing data).

In the past year there have been a few incidents that have triggered the PD's interest in devising individual learning plans. First, one of the residents (Brian T.) that has been recently placed on 'remediation' was later diagnosed with a learning disorder. Another resident that was flagged as 'at risk' was found to have a series of life events (a divorce, her mother's death) that triggered a drop in her academic and clinical performance (Susan M.). Finally, our PD has encountered a very exceptional resident (Rodrigo C.) whom has trained previously for three years in another country and has recently immigrated to your country, and successfully matched to your first year pool. It seems very obvious to her that this third resident should be more rapidly advanced in some fashion, as he is excelling in the program very early on (e.g. in the first 6 months).

Your program director wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present clinical competency committee design of individualized learning plans. She is familiar with different educational theories, and wish for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

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Lingard, L. Collective Competence, TEDxBayfield.
https://www.youtube.com/watch?v=vl-hifp4u40

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Mann K. et al. Reflection and reflective practice in health professions education: A systematic review. Adv in Health Sci Educ. 2007

Adult learning principles

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Norman GR. The adult learner: a mythical species. Acad Med. 1999;74(8):886–9.

Life-long learning

Parboosingh J, Campbell C, et al. on behalf of the Scholar Lifelong Learning working group. Pursuing excellence in practice: a CanMEDS Scholar program on lifelong learning. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2008.

Self Assessment

White CB, Gruppen LD, PhD. Self-Assessment and Self-Regulated Learning. Association for the Study of Medical Education, editor. Edinburgh, UK.

Consulting in MedEd

Consultation Module
June, 2016

Case 8

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of Faculty Feedback

Your chair has asked you to help him fix the present faculty feedback system. In the past few years your group has hired a lot of new faculty members into the group, to the point that your group is now 45% faculty who have been in practice < 5 years. The chair now feels there is a 'breath of fresh air' within the system, and really wants to take advantage of this new atmosphere. He fears that if he is not responsive to their needs, he will lose a chance to engage this large cohort of junior faculty, and they will begin to 'check out' like other mid-career faculty in their group.

The faculty members now are constantly asking him for feedback about their teaching performance. There is inconsistent use of daily feedback forms for faculty members, but also there is an institutional policy that feedback from learners need to be aggregated to protect their confidentiality from the faculty members. He has observed that many junior or struggling teachers often shy away from asking learners to fill out feedback forms. As such, junior or struggling teachers also rarely receive enough evaluations to aggregate - and therefore they generally receive less feedback. Generally, the top performers tend to get more student and resident evaluations, he hypothesizes because these individuals actually ask for feedback To incentivize high performance there are various teaching awards. There is one annual award for best teacher in each of the three learner categories (Best clerkship teacher; Best residency instructor; Best faculty member).

Most people, however, fall into the middle zone of faculty performance - they are solid, stalwart teachers who do a good job. Your chair feels that with feedback, mentorship, or *some other systemic change* that your department could really take advantage of this new set of circumstances.

Your chair wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present faculty evaluation system. They are familiar with different educational theories, and wish for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

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Self Assessment

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Consulting in MedEd

Consultation Module
June, 2016

Case 9

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of Wellness Problems

Your chief resident approaches you with a conundrum. Recently, she has completed an internal poll of the residents for her resident quality project, and she has discovered that there is has been a marked rise of residents who are feeling stressed and displaying some signs of burn out. She had chosen to actually engage in this project because she had heard at a chief resident's gathering that an emergency medicine resident was recently admitted to the with suicidal ideation and substance abuse issues.

This has also been accompanied with a few pieces of feedback from faculty members that some of the junior residents are arriving late for shifts or sometimes calling in for shifts all together (at the very last minute). She has also noted that the residents seem very checked out at the weekly academic proceedings (e.g. Thursday Conference Day).

Anecdotally, you know that there have also been complaints from the program director and program administrator of various faculty members about one or two PGY2 residents. The chief resident discloses that some of these residents are having significant work-life balance issues. She discloses to you that a week ago, she had a PGY2 resident in her office hours, literally in tears. When explaining his problem, the junior resident seemed to be very overwhelmed with his duties as a father of a newborn infant, his role in leading a multiple research and quality assurance projects, and staying on top of his shift requirements.

Your chief resident wishes for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present the wellness programming. She are a bit familiar with different educational theories, and wish for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

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Self Assessment

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Consulting in MedEd

Consult Worksheet	You should complete one worksheet PER proposal. Recall you will need to propose 3 different ideas.
Overview of innovation *Briefly describe (in <100 words) the concept of your innovation - This is your elevator pitch to describe the project.*	
Core Conceptual Framework *Please name and then briefly describe the conceptual framework or educational theory that underpins your particular idea.* *Please use plain language that non-CEs would understand if possible.*	
Idea in Depth *Write a description of your proposed educational innovation.* *Use up to 500 words to describe the innovation in depth.* *You may use point form if necessary.*	

Consulting in MedEd

Consultation Module
June, 2016

Case 10

A key skill of being a clinician educator is the ability to advise those around you on key educational matters. At times this takes the form of advice via consults. These will often result in opportunities to engage in further scholarly activity, such as innovative educational programming.

Your assignment:

To complete a Clinician Educator Consult.

A Case of the Quality Curriculum

Your program director has been asked by the chair to introduce quality improvement to the residents in your program. This is something that is of great importance for the hospital presently, and your chair feels that it is important to impress upon our junior colleagues skills to improve the system.

One of the important leaders in this field is a nursing manager in your emergency department (ED). He has been working with the clinical chief of your institution's ED to streamline a number of systems. That said, your program director seems uncomfortable with asking a non-faculty member to lead the residency program's quality curriculum.

Meanwhile, the clinical chief feels strongly that the programming you create should involve other multidisciplinary team members. Her point of view is that the residents have to learn how to work within the "real workplace", where they should learn to work with managers, nurses, respiratory therapists, and even doctors from other disciplines.

Your chair and chief wish for you to propose three (3) suggestions based on educational theory or evidence to improve or enhance present quality improvement programming. They are familiar with different educational theories, and wish for each of the suggestions to be based on a DIFFERENT educational theory or conceptual framework.

As a team, create three unique "pitches" for novel programming that is based on a different conceptual framework. See appendix A for a worksheet that will help you work through each 'pitch'. You may use any medical education literature available to you, but the following suggested readings have been specifically curated to augment your work on this case.

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Young L, Baker P, Waller S, Hodgson L, Moor M. Knowing your allies: Medical education and interprofessional exposure. Journal of Interprofessional Care. 2007 Jan 1;21(2):155-63.

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Self Assessment
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Appendix A

Consult Worksheet	You should complete one worksheet PER proposal. Recall you will need to propose 3 different ideas.
Overview of innovation *Briefly describe (in <100 words) the concept of your innovation - This is your elevator pitch to describe the project.*	
Core Conceptual Framework *Please name and then briefly describe the conceptual framework or educational theory that underpins your particular idea.* *Please use plain language that non-CEs would understand if possible.*	
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