EMORY | WOODRUFF HEALTH SCIENCES CENTER | Woodruff Health Educators Academy

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WHEA EXPLORATIONS IN TEACHING AND LEARNING

In This Volume:

EDITOR'S NOTE

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One of the program deliverables for the WHEA Teaching Fellowship is a Small Teaching Report. Fellows are asked to pick a topic/concept that was covered during the program and use the Experiential Learning Cycle to 'test' out a small but powerful modification to their teaching design or practices. This newsletter represents a compilation of reports from the 2023-24 WHEA Teaching Fellows.

DIRECTOR'S REFLECTIONS

Taryn Taylor, MD, MEd
Co-Director
WHEA Teaching Fellowship

The WHEA Teaching Fellowship was developed to support the professional development of individuals who are passionate about teaching and learning.

Each cohort of the WHEA Teaching fellowship amazes me with their insight and creativity and this group of scholars is certainly no different. They have applied principles of curriculum and instructional design to aspects of their current teaching practice, expertly interweaving fundamentals of adult learning theory. This has promoted versatility in content delivery and fostered the creation of safe learning environments, allowing them to meet the needs of diverse learners. Join us as we celebrate their "wins" and learn from their reflections.

NOTE: Our fellows use the mnemonic “Hook ‘em, Teach ‘em, Assess ‘em” to chunk and apply Gagne’s Nine Events of Instruction model. This mnemonic was developed by Richard Ramonell, MD during his time as a learner in the EUSOM GME’s Medical Education Track.

Written by Belinda Adeji Gomez, PhD, MBA, RN, Senior Manager, Clinical Services & Operations, Faith Community Nurse, Emory Family Medicine Clinic, Emory Family Practice Associates of Atlanta

TITLE:
Teaching Kids Basic Healthy Lifestyle

CONTEXT:
This is a monthly teaching session in a classroom environment, for elementary school students in one of the Gwinnett County Public school (GCPS) system. I used the problem focused type curriculum design to expose the learners to real life issues, as well as, providing them with skills that are transferable. Teaching healthy lifestyle is quite simply not done in elementary schools due to the fact it is not a “tested subject” and receives no funding.

I employed two steps of the Kern's Six Step Approach (Problem Identification and Needs Assessment) to identify and assess needs to initiate the curriculum design. The curriculum design is still in the preparation stage. I will work on completing it using the remaining four steps of Kern’s approach.

LESSONS LEARNED:
I learned that though presented consecutively, curriculum design is a continuous and repeated process. All steps influence each other. With regards to “Problem Focused Curriculum design, both generalized and targeted needs assessment are necessarily to make an informed decision. This was unexpected.

IMPLICATIONS FOR FUTURE PRACTICE:
In the future, I would explore more on the need’s assessment. Knowing who the stakeholders are, targeted learners, and what the gaps are. Also, if possible, employing document review, survey, focus group, and one-on-one interviews to conduct needs assessments. Employing all four types will provide a broad scope of needs assessment for curriculum designing.

TEACHING TIPS:
Through focused consideration on the existing state (medical knowledge, community need, learner time/access) one can develop the appropriate format for assessing needs before developing a curriculum.

Written by Saja Asakrah MD, PhD
Assistant Professor in Hematopathology, Department of Pathology and Laboratory Medicine, Emory University School of Medicine

TITLE:
Hematology Laboratory Workshop

CONTEXT:
The second-year medical students take a one-month clinical hematology course. This course provides lectures covering benign and malignant hematological disorders with emphasis on clinical symptoms and management. At the end of this course the students will receive a 3-hour interactive laboratory workshop that focuses on microscopic morphology, ancillary testing, and diagnosis. However, these laboratory topics are not well covered in the course lectures and condensing such broad and important information in 2 hours can be challenging. The feedback we got at the end of the workshop (the topic is hard, complicated, and condensed)

SELECTED TEACHING & LEARNING TOPIC:
To improve this workshop, I implemented the following steps:

I used the entrance and exit quizzes technique to prepare the student for the topic, measure their background knowledge and the knowledge they gained from the workshop at the end. The exit question served as feedback to the workshop. The quiz included 3 basic multi-choice questions using poll everywhere

“Tell me why I am here and what I am learning?”. I started the workshop with the objectives and talked about why it’s important to understand hematology morphology and laboratory testing and how it will affect their medical career even if they are not pursuing laboratory medicine specialty. I gave them a real clinical scenario of a patient that was mismanaged because the physician misinterpreted the laboratory results. This strategy helped gain the students' attention and interest.

I broke down the 2 hours to 1 hour introduction lecture to provide base line knowledge in morphology, and ancillary testing in benign and malignant hematological disorders. The remainder time we practiced clinical cases with a poll everywhere quiz at the end of each case. These cases made the session more interactive.

LESSONS LEARNED:

The changes I applied improved engagement, interest, and knowledge retention based on my experience during the class as compared to prior classes and based on the data collected from the exit quiz.

IMPLICATIONS FOR FUTURE PRACTICE:

An additional change I am planning for future workshops is to break it down to two sessions instead of one, as it was hard to keep the students' attention and enthusiasm for two hours straight. I may make it two sessions with a 30-minute break in the middle on the same day, or two sessions on two different days.

Written by Marian Axente, PhD, DABR Assistant Professor, Department of Radiation Oncology, Winship Cancer Institute, Woodruff Health Sciences Center, Emory University School of Medicine

TITLE:
Using polling software to introduce active learning methods to competency based didactic in radiation oncology residency

CONTEXT:
The learners are PGY2-4 Radiation Oncology (RO) MD residents that attend the radiotherapy physics classes until they pass their required physics portion of the board accreditation exam, typically in their 4th year. The teaching setting is in-person classroom with a virtual teleconference link option via Zoom. The class has a standard lecture format, with multiple physics faculty implementing the standard PowerPoint format with varying in-class methods of addressing the topics.

SELECTED TEACHING & LEARNING TOPIC:
Objective: To form a solid medical physics foundational knowledge aligned with competency-based learning outcomes.

Background and/or theoretical framework and importance to the field: New results in cognitive science research changed best practices recommendations for medical education, including increased utilization of active learning strategies. Active learning has been demonstrated to increase retention, develop critical thinking skills, and foster collaboration in all fields of medical education. Developing an active learning teaching platform for medical physics in Radiation Oncology has sparked education reform in our department.

A traditional lecture-based medical physics course is to be transformed to a flipped-classroom format. Curated didactic material is available before class unlocking meeting time for active learning activities. Class facilitators implemented polling software (polleverywhere.com) with certification exam style questions designed to assess learner knowledge of assigned topics. Each poll question was followed by slides explaining the tested principle, and a second question on the same topic. This synchronous didactic format allowed for immediate in-class learner feedback and discussion opportunities. Learner assessment leverages the polling software tools, tracking in-class engagement and longitudinal response history. In-class assessments will be combined with weekly

topical self-applied quizzes from a dynamic database of exam type questions, as well as annual standard exams. The learners will have access to their in-class and out-of-class passing rates, and an anonymized peer comparison.

LESSONS LEARNED:

5-point Likert scale and free-form comment feedback survey was applied to current learners, assessing the flipped-classroom format and initial implementation strategy. Upon successful course transformation, this would represent the first active learning-based course in the department.

IMPLICATIONS FOR FUTURE PRACTICE:

Survey results highlighted a successful implementation for the initial trial. This format was reproduced by collaborating faculty, with ongoing efforts to update existing lectures. This active learning format is transferable to other competency-based didactics (e.g. radiobiology). Furthermore, the polling software is versatile, offering options beyond exam type questions, hence providing further opportunities as a platform for active learning strategies.

Written by Donna Beal MPH, MCHES
Adjunct Faculty, Executive MPH Program, Rollins School of Public Health, Emory University

TITLE:

Nonprofit Management: Planning & Performance Measures for Nonprofits

CONTEXT:

This hybrid course introduces the basic concepts and vocabulary needed to operate, make decisions, and evaluate a nonprofit organization or other local agency. Learners come together in-person at the beginning of the 11-week course and at the end. In between, all content is offered through Canvas in a go-at-your-own-pace setting.

This course is required of all EMPH Prevention Science students and is offered in the summer semester.

SELECTED TEACHING & LEARNING TOPIC:

For eleven weeks, student groups had been working to develop a Recommendation Report on an existing nonprofit. This report needed to include an Executive Summary, History, Mission, Organizational Structure, Financial Health, Planning, Operations and Internal Controls, Diversity, Equity and Inclusion, plus Recommendations and an Overall Summary. There is a considerable amount of content covered during the course and it can often overwhelm the students. Additionally, the closing weekend for the course requires a presentation which can increase student stress.

Knowing that the students might be feeling a bit overwhelmed and stressed, during closing weekend for my course, I used the Exit Ticket Learning Assessment Technique and invited the students to create a Meme which answered this question, “What is one thing you were surprised to learn about nonprofits?” Below are just a few of the memes created.

As a way of bringing humor into the day, I then shared the memes at the beginning of the closing weekend and invited the students to discuss the meme and the content and Think-Pair-Share with each other about them.

LESSONS LEARNED:
Through this activity, I could identify which students had really understood the course content and which ones were still struggling. It also helped the students by "breaking the ice" and getting them to talk with each other and present to the room.

There were no points assigned to this activity yet 90% of the students participated. The activity helped us to laugh and generated discussions.

Interestingly, I had one student express their dislike of the activity on my course evaluation.

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:
I will use this activity again and allow for more Think-Pair-Share time.

However, I have also decided to change one of my online course discussions into a creative project. Working in pairs, students will be invited to make a video on either the important elements to understand in a Form 990 or the important lines to pay attention to in an organization's Profit & Loss or Balance Sheet.

If you plan to use this same technique, I would recommend that you supply meme generator sites and make the activity low risk for the students.

Written by Nupur Dalal, MD, FAAP
Assistant Professor, Division of Hospice and Palliative Medicine, Emory University School of Medicine

TITLE:
Skillfully Relating to Suffering and Dying in Palliative Care and Beyond

CONTEXT:
This is an on-the-go teaching in one to two week chunks for medical students, internal medicine residents and palliative care fellows within the in-patient Hospice and Palliative Care rotation at EUHM.

SELECTED TEACHING & LEARNING TOPIC:
I used Kolb's model to start with Concrete Experiences by asking learners to describe a memorable and potentially distressing interaction involving a suffering or dying patient.

Then asked them to Reflect on what was so distressing and describe this. I used this a starting point to Introduce new knowledge: In a follow up discussion, we talked in general terms about the role of identity and identification in suffering and the importance of cultivating awareness around the identity we form in our profession, what assumptions we make about who we are as professionals and what constitutes a good doctor or being successful. We also discussed the role of identifying with a patient's suffering or acknowledging it fully without identifying it. Additional concepts around views, coping mechanisms and the conditioning that forms these perspectives were discussed.

I asked them to look out during the rotation for challenging interactions or those with a strong emotional component and to observe what identity roles or perspectives they are bringing to this interaction (coming back to Concrete)

We then repeated reflection, now making room for application of the prior discussion to insights (abstract conceptualization) and making a plan for active experimentation.

LESSONS LEARNED:
Using this framework made it very clear that my biggest barrier is that learners are coming on and off the rotation at various times. This high level of unpredictability makes it difficult to structure learning throughout the week in multiple steps. It also means that I do not always follow through because I do not have an organized structure for the learners that do stay with me for a full 1-2 weeks.

IMPLICATIONS FOR FUTURE PRACTICE:

Foremost, I need to make a stepwise plan. First, I can compress this and break this down into concrete steps:

- Importance of the topic (hook)

1. Recall a distressing experience
2. Show them that by others having difficult experiences, this is a common topic
3. Inspire active engagement: ask them to write and reflect on what they think made it distressing, first through free response and then by asking questions about how they identified in the situation with their role and with the patient.

- Discuss and provide a handout for them to introduce and elaborate on the knowledge I am sharing about identification

1. Ask them to look out for experiences during the week that felt difficult (can be 4-7/10 difficulty—workable range, not 8-10/10) and use the same prompt questions about identification

- Ask them to share what they have learned and what they might want to do differently next time and if present for a second week, ask them to apply this to new interactions, to re-iterate this cycle.

By writing this out and organizing it, I leave less to chance, hold myself accountable and have a more concrete system to then evolve

Written by Kathleen Diatta, PhD, RN, NE-BC Unit Director, PACU/POHA, Emory Healthcare

TITLE:
EHC PACU Nurse Residency Program

CONTEXT:
This is a 4-week residency program for nurses who are new to the perianesthesia nursing specialty. The program includes multiple teaching modalities such as classroom didactic, simulation, observation, and independent learning modules.

SELECTED TEACHING & LEARNING TOPIC:
The program is based on Benner's Novice to Expert theoretical framework and the Structure of Observed Learning Outcomes (SOLO) to ensure assessment strategies align with the learning outcomes of the program. Each student will participate in two 8-hour didactic courses weekly. The courses will be a combination of didactic classroom learning, Essentials of Critical Care Orientation (ECCO) online program, Healthstream Learning Center (HLC) modules, and TED Talks. In addition, each student will work two 12-hour days each week with a preceptor in multiple clinical settings including the operating room (OR), pre-anesthesia testing (PAT), surgical ICU, pre-operative holding area (POHA), and postanesthesia care unit (PACU). The purpose of exposing the students to all of these different clinical settings is to provide the learner with an overview of a patient's perioperative trajectory. Upon completion of the 4-week program, the students continue with their preceptors for an additional 4-6 weeks of clinical, competency, and skills-based training.

LESSONS LEARNED:
I learned that a 6-week program, which was initially created, was too long. Students lost interest and did not like that the program was Monday-Friday. In addition, the students do not learn or appreciate an educator reading to them from a PowerPoint. The students wanted more time in the clinical setting and less time in the classroom. They also requested more opportunities for independent learning that is specific to what they need to know. The student feedback has been crucial to the revision of this program. One thing that is glaring to me is how easy it is to fall into teaching how I was taught versus how today's students learn.

IMPLICATIONS FOR FUTURE PRACTICE:

Using assessment data of both the student and the program ensures student engagement and program quality. Sharing program outcomes with the stakeholders (i.e., students, instructors, senior nursing leadership) allows for ongoing program improvement, recruitment and retention, and staff/student satisfaction.

Written by Meriem Fadli, MD
Specialist Physician, Metabolic Physiology and Clinical Nutrition, Algeria
Humphrey Fellow at Rollins School of Public Health, Emory University

TITLE:
Assessing learning in a professional development course for dietitians

CONTEXT:
The learners in this professional development course are dietitians who deliver healthcare services to patients in both inpatient and outpatient settings, addressing a range of diseases. The course spans 12 months, taking place primarily in person at the hospital for most sessions (one session per month), with occasional online sessions. Evaluation milestones include assessments in month 4, month 8, and a final evaluation at the conclusion of the 12-month course.

SELECTED TEACHING & LEARNING TOPIC:
I focused on incorporating various learning assessment techniques into each lecture. I began with a Background Knowledge Probe using simple questionnaires to swiftly assess foundational knowledge before the session. During the lecture, I introduced different assessment techniques, including quizzes every 15 to 20 minutes. These quizzes took the form of case studies, role plays, or entry/exit tickets. Additionally, I assigned homework for each lesson, typically in the form of case studies or Mind Maps, where participants were tasked with drawing a diagram to convey their understanding of complex concepts, procedures, or processes.

LESSONS LEARNED:
I effectively integrated new learning assessment techniques, incorporating quizzes after every 3 or 4 slides into my teaching approach. This interactive method has demonstrated success in maintaining learner attention and facilitating a more profound comprehension of the lessons, as participants can promptly apply newly acquired skills during the session. Surprisingly, this approach has also increased learner confidence and enthusiasm for the upcoming evaluations. Learners appear more comfortable as they have become accustomed to assessments, having already tested their knowledge and applied new skills through session activities and assignments.

IMPLICATIONS FOR FUTURE PRACTICE:
In the future, I plan to continue integrating frequent quizzes and interactive assessments into my teaching approach.

The positive impact on learner engagement and confidence suggests that maintaining this strategy is beneficial. However, I will gather more structured feedback from learners to continually refine and tailor the assessment methods based on their preferences and needs.

For someone considering implementing similar assessment techniques, I recommend to:

- Consider incorporating a mix of assessment formats to cater to diverse learning styles.
- Regularly seek feedback from participants to assess the effectiveness of the assessments and make necessary adjustments.
- Establish a supportive learning environment that encourages active participation and fosters a positive attitude toward assessments.

Written by Rev. Changyung "C.G." Gim, M.A., M.DIV.
ACPE Certified Educator, APC Board Certified Chaplain, Manager of Spiritual Health and Community Care, Emory DeKalb Operating Unit, Spiritual Health at Emory Healthcare

TITLE:
Promoting Well-Being of Learners

CONTEXT:
The learners with whom I work are adults who have completed a master's level graduate degree who are seeking clinical training for their specific spiritual care contexts. I work directly with three women currently – an Afro-Atlantic Caribbean, African-American, and Euro-American, two in their fifties, one in her sixties, all affiliated with a mainline Protestant tradition. This is their third unit out of four that they are required to complete to be Board Certification eligible.

The learning settings include three contexts:

- Clinical areas, working with inpatients, their care-partners, and staff
- Classroom where I meet with the group
- Individual Consultations where I meet with each learner separately

SELECTED TEACHING & LEARNING TOPIC:
I applied "Aligning Learning Needs and Outcomes." The learning outcomes I addressed are two: 1) Demonstrate how one uses self-care practices, including trauma informed approaches, for support of wellbeing, including when providing spiritual care. 2) Attend to one's own physical, emotional and spiritual well-being.

Universal Approach

- Presented material on why self-care is crucial in our practice of caring for people emotionally and spiritually, and facilitated discussion
- Invited learners to share their standing self-care practices
- Invited learners to create/maintain a self-care goal and to share them with the group
- Invited learners to reflect on behaviors that is congruent or incongruent with the learning outcomes
- Highlighted and celebrated self-care successes
- Modeled embodiment of self-care with my own swimming regimen, appropriate use of vacation and sick leave, and seeking consultation and otherwise using colleagues as a professional resource

- Instructed learners to a) facilitate reflection and discussion about self-care with care-seekers (inpatients, care-partners, and staff); b) assess supportive network of their care-seekers

Individual Approach

- Assessed for any Systemic Barriers to Effective Alignment for the individual's unique circumstances
- Advocated with the system leaders for the reasonable needs of the learner
- Facilitated reflection around self-care successes
- Invited the learner to assess any Personal Barriers to Effective Alignment
- Facilitated reflection and goal-setting around Personal Barriers to Effective Alignment

LESSONS LEARNED:

- Educator's promotion of learner's wellness is a unique and important (and inspirational?) resource for the learner's learning to embody self-care. Each learner was surprised at my (and my director's promotion of their well-being).
- One's relationship with self-care is deeply connected to their cultural and spiritual values.
- One's capacity to integrate self-care into professional life may be more difficult for persons of color and persons of minority groups than their counterparts in majority groups due to the undue psychological and practical concerns related to their life experiences.

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:

I might continue promoting well-being of the learners in the ways I've described above. The most important insight I have about its success is not so much what I do but how I do it. I have done a lot of work on my own sense of well-being, including assessing, reflecting, and making changes to my own personal barriers to alignment. Having done so, I can be compassionate with those who are having difficulty with self-care, and respectful and warm regard comes through in my work with learners about the difficulties of their self-care practice. Otherwise, teaching self-care can become another thing that I'm requiring them to do.

Written by Jessica Hammett, MD
Assistant Professor, Female Pelvic Medicine and Reconstructive Surgery, Department of Urology, Emory University School of Medicine
Medical Director, Ambulatory Urology Clinic at Emory, University Hospital

TITLE:
Surgical Counseling for Female Pelvic Surgery Prolapse Patients

CONTEXT:
This is a 3-month rotation in female pelvic reconstructive surgery for fourth year urology residents at Emory University Hospital.

SELECTED TEACHING & LEARNING TOPIC:
I used a Background Knowledge Probe from Learning Assessment Techniques (LATs) to evaluate resident baseline understanding of female reconstructive surgery counseling.

I asked the resident 5 questions regarding the diagnosis and treatment of pelvic organ prolapse and had them self-assess their confidence in their answers (scale 1-5; with 1 being I am unsure about the answers I chose and 5 being I am certain about the answers I chose). At the end of the rotation I used a Case Study from the LATs to re-evaluate their understanding. I presented a case involving a 65-year-old women with stage 3 uterovaginal prolapse, including all of her history of present illness, past medical and surgical history, and physical exam including the POP-Q scores. I then asked the resident to counsel me regarding non-surgical and surgical treatment options. We then discussed their recommendations to the patient and why they did or did not recommend certain surgeries.

LESSONS LEARNED:
I learned that three months is a short time frame to understand “hows and whys” of female prolapse surgery. The residents did comprehend the different types of prolapse repairs but often get stuck on the scenarios in which they should or should not be offered.

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:
I need to breakdown the different surgeries for each vaginal compartment into an easy to digest format create a way to indicate when certain surgeries should be performed concurrently. I was thinking of making it into a sort of puzzle game with a mix and match element. I still plan on doing both the Background Knowledge Probe and the Case Study in the future. I found it to be an excellent way to gauge the learner’s current understanding so that I can adapt my bedside teaching as the rotation

progresses. The Case Study is also great practice for the oral boards that the resident will take after residency graduation.

Written by Jackson Londeree, DO
Assistant Professor, Division of Pediatric Nephrology, Emory School of Medicine, Children's Healthcare of Atlanta

TITLE:
Universal Design for Learning Applied to Pediatric Nephrology Board PREP

CONTEXT:
The Emory pediatric nephrology board PREP curriculum has served to prepare pediatric nephrology fellows for their in-training exams and eventual pediatric subspecialty board exams. This has traditionally been done with a small group review of AAP PREP questions with an attending physician moderator. With the COVID-19 pandemic, this learning session transitioned to a virtual format and resulted in decreased fellow participation. I aimed to improve fellow board exam readiness, foster fellow participation, and optimize this learning activity using a universal design for learning.

SELECTED TEACHING & LEARNING TOPIC:
I used the universal design for learning Gagne's event number 5: "Provide learning guidance" to redesign a flexible approach to the board PREP curriculum teaching sessions. I redesigned the format of the PREP teaching sessions to in-person fellow-led sessions. The redesign goal was to engage the learners in more active learning activities while allowing me to shift the teaching focus to providing redirection, clarification, clinical examples, and test-taking pearls. I discussed the change ahead of time and got program leadership and learner feedback and buy-in before the first session. I gave my learners the autonomy to assign a lead fellow for each session and whether to use any supplemental materials or media when leading the sessions. They decided on a volunteer model for who would lead each month and fellow preference for the use of supplemental audiovisual materials or not. Beginning with the August PREP session this new format was implemented.

LESSONS LEARNED:
After three sessions this Fall, I've concluded that the new format of this meeting has provided many benefits, some unexpected results, and areas for improvement. First and foremost, the new format has allowed much more directed and specific teaching opportunities in my role moderating the sessions. Through prepared responses, test-taking advice, clinical connections, and clarifications I have been able to effectively address the aim of goals-directed teaching for specifically preparing my fellows for their subspecialty in training and board exams. The new format has also improved fellow involvement and engagement in this learning

activity significantly. Fellows are volunteering consistently to lead the month's questions and are largely coming prepared and engaged throughout the sessions. An unexpected result has been that the majority of the fellows prefer to prepare visual aids in the form of prepared PowerPoint slides for images, charts, and take-away points to supplement the PREP question answers provided to the group. Another unexpected finding has been the degree of fellow-to-fellow variability in preparedness and level of training which makes for an uneven experience month to month. I have received overwhelmingly positive feedback from the learners on the new format which is encouraging.

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:

In the future, I am looking forward to evaluating this new teaching format through anonymous questionnaires, discussions, and colleague observations of my teaching. I also hope to track fellow in training exam scores over time to evaluate for any improvement after this new format was introduced. In the future, I would like to have specific goals presented and upper-level fellows' demonstration of an ideal session at the beginning of each academic year to hopefully have less variation month to month in sessions. I would suggest that if someone wanted to try a similar teaching format, having an in-person setting is ideal for learner engagement and involvement when trying to give feedback, clarification, and pearls of wisdom in real time. Additionally, I would recommend getting learner buy-in beforehand and giving as much learner autonomy in the process as feasible to improve overall engagement. Overall, I am very happy with the new format with the incorporation of Gagne's "providing learning guidance" and hope to continue to improve this learning activity.

Written by Michael Lucido, MD, PhD
Assistant Professor, Department of Psychiatry and Behavioral Sciences, Transplant Behavioral Health, Emory University School of Medicine

TITLE:
Adapting Learner Feedback to Foster Growth

CONTEXT:
Learners for this teaching modification were PGY-3 psychiatry residents in outpatient psychopharmacology clinic. The clinic is set up such that after each patient the learner will present the patient and an assessment/plan, receive feedback, then we will go back in to see the patient to relay the plan. After the clinic day is complete, we have an educational supervision session on varied topics in psychopharmacology. Feedback is typically provided during resident presentations (formative) and through internet-based feedback at 6 months as 1 years (summative).

SELECTED TEACHING & LEARNING TOPIC:
Given the high frequency with which I need to provide formative feedback and the relatively low frequency of summative feedback, I wished to develop a mixed model of feedback to provide a better framework for defining and working toward learner goals. To do so, in addition to the formative feedback with each patient presentation, I implemented interval modes of feedback including written feedback (e.g. for documentation feedback) and face-to-face 3 month check-ins.

<u>Formative Feedback Modifications</u>
I have modified the current formative feedback structure utilizing an IDEA framework in which I (the educator) provide direct feedback on the presentation, assessment, and plan to the resident (the learner) – identifying the positive elements and the elements that require change or alteration – then encourage the resident to reconsider the approach and reframe the plan. The resident is provided the opportunity to dissent or disagree and provide their own input/reasoning behind their choices.

<u>Summative Feedback Modifications</u>
The current model for summative feedback, which is internet-based and occurs twice in the academic year, was augmented (as the current model is a departmental feature) to include a baseline meeting and check-ins every 3 months utilizing a modified ADAPT model.

Baseline visit: establish learner interests and goals for rotation, identify subjective

proficiencies and deficiencies for targeted feedback.

3-month check-in: check in on goal status and update plan for achievement, establish new interval goals as necessary, solicit subjective interpretation of proficiencies and deficiencies, provide summative feedback on academic and clinical progress, solicit feedback on clinic structure, workflow, and administration, solicit feedback on teaching style and delivery of formative feedback

6-month check-in: check in on goal status and update plan for achievement, establish new interval goals as necessary, solicit subjective interpretation of proficiencies and deficiencies, provide summative feedback on academic and clinical progress, solicit feedback on clinic structure, workflow, and administration, solicit feedback on teaching style and delivery of formative feedback. Perform assessment of clinical decision making and provide written feedback.

9-month check-in: check in on goal status and update plan for achievement, establish new interval goals as necessary, solicit subjective interpretation of proficiencies and deficiencies, provide summative feedback on academic and clinical progress, solicit feedback on clinic structure, workflow, and administration, solicit feedback on teaching style and delivery of formative feedback

12-month check-in: check in on goal status, discuss long term goal setting, review successes from this past year taking stock of all interval goal achievements and improvements previously noted, provide summative feedback on academic and clinical progress, solicit feedback on improvements to clinic design/structure. Perform assessment of clinical decision making and provide written feedback.

LESSONS LEARNED:

At the time of this report, I have conducted the baseline session and the 3- and 6-month check-ins. While the framework was established with the hope that it would be successful, I ultimately went into each of the timepoints with an expectation that based on the perceived successes and failures I would adapt the model to incorporate this feedback for the next timepoint. What I was somewhat surprised to find was that the learners had such difficulty identifying actionable goals for their education and professional development. I speculate that we are so driven toward predefined goals (e.g. ACGME pillars) that we lose sight of personal goals, or rather that we begin to identify these external goals as our own. While there was some hesitancy at the outset, the residents expressed feeling rewarded by the progress made on their own personally identified goals.

IMPLICATIONS FOR FUTURE PRACTICE:

Based on the experience I have had thus far, and in comparison to my experience proving feedback in this context prior to this academic year, I have found adoption

of more active feedback strategies appears to be exceedingly successful. The measure of success is fairly qualitative at this point, but based on solicited learner feedback they universally feel more comfortable receiving critical feedback, more comfortable providing critical feedback, and more likely to incorporate feedback when compared to their prior experiences on clinical rotations. I intend to continue this model with ongoing adaptation to the learner needs.

For those seeking to implement new feedback modalities, I first suggest identifying the goal of feedback in your context (e.g. course correction, professional development, etc.). With the goal of feedback in mind, it becomes an easier task to figure out which model or blend of models would best suit these needs. It is also worth noting that these models may not be one-size-fits-all and may require some modification or adaptation – rather use the spirit of the models as the guide to how to proceed.

Written by Andrew McReynolds, MD MCRE
Attending Physician, Pediatric Advanced Care Team, Children's Healthcare of Atlanta
Assistant Professor, Division of Palliative Care, Emory University

TITLE:
Adding reflective practice to improve clinical encounter debriefing

CONTEXT:
My learners are pediatric hospice and palliative medicine fellows on an inpatient consult service at Children's Healthcare of Atlanta. HPM fellows see many consults and develop skills in medical management of symptoms associated with serious illness as well as advanced communication skills in managing difficult conversations, delivering serious news, and delineating goals of care in the context of serious and often life limiting illness for children.

SELECTED TEACHING & LEARNING TOPIC:
I applied reflective practice. I initiated debriefing with components of Gibb's Reflective Cycle to create space for reflection not just on success or failure of a clinical encounter but on feelings and experience and then ultimately on modifiable behaviours for subsequent encounters. After that period of reflection we would move forward with a more clinically focused discussion about the encounter and next steps clinically.

LESSONS LEARNED:
It's surprisingly difficult to start in a place of personal feelings about a learning experience. It's a place where our fellows feel exposed and vulnerable. Nearly every time they open with something they feel didn't go well. Providing a little more structure and redirecting to "what went well" when they lead with something that didn't give some space for positive reinforcement and creates a safer environment to then move on in the cycle to questions more like "What else could you have done" or "What skills would you use next time to change the outcome"

IMPLICATIONS FOR FUTURE PRACTICE:
Overall I really like the emphasis on experience and reflection rather than diving straight in to clinical outcome. It allows for a more focused skills based discussion and helps set goals for next encounter that are more performance-driven than outcome-driven. Starting our debriefing with the clinical discussion de-emphasizes personal growth for learners so I hope to continue this pattern.

TEACHING TIPS:

Learners are so often their own toughest critics. Sometimes following them down that path can be demoralizing. Reflective teaching can and should be guided and you can use that guidance to create a safe learning environment to then address areas for growth.

Written by Andras Rab, MD
Assistant Professor, Emory University School of Medicine, Department of Pediatrics, Division of Pulmonology, Asthma, Cystic Fibrosis, and Sleep, Emory University, Children's Healthcare of Atlanta

TITLE:
Teaching research laboratory techniques and research concepts to undergraduate and graduate students

CONTEXT:
My learners are undergraduate or graduate students with diverse laboratory experiences, from no knowledge to some knowledge of research laboratory techniques. This is a one-on-one, hands-on learning experience that driven by the learner's prerequisite knowledge. Research requires an entirely different mindset from the students compared to what they are used to in classroom settings. Decades-old laboratory techniques can be learned from books, but novel research approaches are only presented in manuscripts or developed by individual research groups and have not yet been published. Accordingly, exposing students to research provides them with an experience of operating on the edge of knowledge and not being the consumer but rather the producer of it. My goal in teaching research concepts and diverse laboratory techniques to students is to help them develop critical thinking and induce the formation of their individual fact-based views on research topics.

SELECTED TEACHING & LEARNING TOPIC:
I started to build Gagne`s 9 events into my teaching style because exposing students to research is highly individual and mostly depends on motivation, understanding, engagement, and experience.

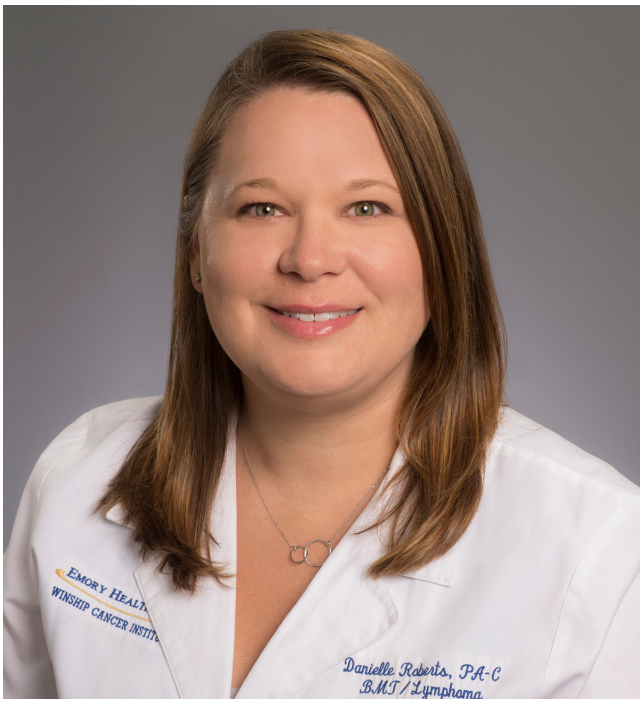
One of the most critical tasks for teaching research is to realize how to engage students to keep them on task and motivate them when the experiment result is not fulfilling. For this reason, I decided to concentrate on the “Hook `em” and “Teach `em” phases. I started to use cellular pathway charts to help students visualize and better understand the background of our research. I talked about how certain research successes in the given field transformed patients` lives and increased life expectancy. Also, I started using 3D-printed protein models to provide a better visualization and explanation of molecular pathomechanisms driven by mutation in the genes of interest by these models.

LESSONS LEARNED:

During discussions with students, they said that they liked the deeper explanation of the research background of interest. The PowerPoint diagrams or 3D models helped them better understand the concept. Talking about successful approaches in the research field, which aided patients to live better and longer, kept them excited despite the sometimes monotonous and repetitive work.

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:

According to the students` feedback, I will develop more graphical figures and look for other models that would help better describe the background of our research and visualize molecular pathomechanisms that lead to a deeper understanding of the research subject. Also, talking about the research field's success and the path led to it provides examples and meaning of how research can overcome challenging tasks. Also, keeping up with the good work despite the challenges could improve people's lives. The motivation of these examples can engage students and researchers in a more profound way.



Written by Danielle Roberts, PA-C
Associate Chief of Education for APPs, Winship Cancer Institute, Emory University
Co-Director Hematology/Oncology APP Fellowship, Winship Cancer Institute, Emory University

TITLE:
Hematology and Oncology Emergencies for Every Oncology APP

CONTEXT:
My learners are Advanced Practice Nurse Practioners and Physician Assistants.

The setting is a yearly conference for oncology APPs. This is a regional conference for Oncology APPs in all practice settings. The presentation is given via PowerPoint simultaneously to both live and virtual participates.

SELECTED TEACHING & LEARNING TOPICS:
Gagne's 9 Events of Instruction: Hook em, Teach em, Assess em.

Use of a new strategy of presenting the information using a survival TV platform, Naked and Afraid, "to hook" the audience. Every survival TV show has a medical provider to assess, diagnosis, and treat any emergency that happens on the show. It is the responsibility of the medical provider to bring items needed to address any issues that might happen; therefore, I start the presentation with having the audience pack their jump bag with the most common items needed to treat the majority of Hematology and oncology emergencies. To help guide the learners they are given a list of possible items to include in their jump bag and they only allowed to pick 10 items. Each person in the live audience is then given a bingo card with different items in jump back. I then proceed on with the presentation by presenting case vignettes through the eyes of the emergency provider. I teach em the common presentations of hem/onc emergencies and then I assess em by the audience providing the correct diagnosis and therapeutic treatment options. During the presentation the audience is checking off on their bingo card if they selected the correct items for their jump bags to treat emergencies they encountered; first one to BINGO wins a prize.

LESSONS LEARNED:
I learned that with changing how information is presented you can engage the audience to have fun and learn at the same time. I found that when your audience is mixed with both newer providers and seasoned providers it can be hard to engage participation especially

when your learner may feel there is not much they can learn. The feedback from this style of presentation allowed both the new and seasoned learner to be engaged in the topic and all felt that they taught something new. Another positive component was having the bingo card and prize that kept everyone involved through the presentation. The negative component from this type presentation is that the more novice oncology provider felt they needed more background information to fully understand all concepts that were presented.

IMPLICATIONS FOR FUTURE PRACTICE:
For future iterations of this course a pre-meeting poll or an entry ticket should be considered to continue to enhance the learner engagement. This would allow the presentation not to be become a one hit wonder. A pre-meeting learning module focused on the basic knowledge for this topic could be included for the more novice learner to reduce learning gaps. This would allow more participation across all types of learners.

TEACHING TIPS:
If someone was planning on applying this strategy to a similar topic I would ensure that it is clinically relevant and respectful of the learning environment.

Written by Maurice Selby, MD
Attending Physician, Department of Emergency Medicine, Grady Hospital
Assistant Professor, Emory University School of Medicine

TITLE:
Using Universal Learning Design to Teach Emergency Medicine Residents how to Optimize Care for Incarcerated and Patients

CONTEXT:
My learners are the Emory Emergency Medicine Residency Program is a 3-year training program with a total of 57 residents currently in the program (19 residents/class). As future independently practicing emergency physicians, our residents must be trained to deliver high-quality care to all patients, regardless of their socioeconomic status, educational level, cultural background, gender, race, religion, etc. As a result, our program stives to incorporate elements of diversity, equity, and inclusion in our didactic curriculum as well as topics dealing with larger aspects of our healthcare system and public health that significantly impact patient outcomes. This includes examining health and disease through a public health lens and strongly examining how social determinants of health affect the incidence and prevalence of disease in communities and the challenges in the diagnosis, treatment, and prevention of disease in various communities with a special emphasis on marginalized populations.

Our weekly Resident Conference is held in the Steiner Auditorium, which is located at 68 Armstrong Street SE in the heart of Atlanta, GA. This is a protected 4-hour period each week in which our residents that are not on off-service rotations are relieved from clinical duties to focus on the educational content during the conference day. The educational sessions/activities range from traditional didactic presentations to flipped classroom experiences and experiential learning activities such as simulation sessions and procedure labs. The Steiner auditorium is essentially a large lecture hall with a lectern with a computer and audio/visual setup that includes a projector and screen as well as a chalk board and pin board.

SELECTED TEACHING & LEARNING TOPIC:
I applied the Universal Design for Learning (UDL) as I felt it was the best conceptual framework considering the makeup and needs of our learners and the setting for the above presentation/didactic session.

Our learners' knowledgebase in emergency medicine varies with their level of training, with senior residents being more advanced with respect to foundational concepts in emergency medicine and therefore more apt to take on larger topics such as emergency department management and administration and quality improvement, while junior residents are striving to master basic principles and concepts that are critically important in caring for individual patients. In developing this educational session, one of the major goals was to speak to the interests and needs of the various learners involved in this session during the allotted conference timeslot for this session (45 minutes). For example, for our PGY-1s (and as a reminder to PGY-2s and 3s), it is important to remember that incarcerated patients are more likely to have sexually transmitted infections, mental health challenges and illness, but it is also crucial for senior residents (and juniors as well) to understand that incarcerated patients are one of the only groups of people in the United States that are constitutionally guaranteed the right to access and utilize medical care. While this plants the seed for junior residents with regard to ensuring that they understand that a person's status in the carceral system does not preclude them being seen and/or treated in the emergency department, more senior residents are challenged not only to recall and understand their duty to treat such patients, but they also must understand how to optimize the care of this patients through deeper understanding of incarcerated medicolegal rights and how to advocate for these vulnerable patients in order to address the factors that often serve as a precursor to a person being incarcerated.

I created a slide presentation and case-based learning session featuring 4 cases that is based on the 3 basic principles of UDL.

Engagement: Using imagery typically associated with incarcerated patients, I asked the learners to share what they felt or believed based on the images before them. Some of these images included an orange jumpsuit, a man pointing a gun at the viewer, and a person experiencing homelessness. The learners shared feelings of fear, anger, sadness, worry and other emotions and some expressed concerns that this patient would be difficult to care for various reasons, including concerns for safety and patient-centered concerns such as privacy, follow up, and overall vulnerability being an incarcerated patient. I then asked them what went through their minds when they had to care for individuals were incarcerated. This made the topic immediately relevant to all the learners in attendance as they were able to express the challenges that arise when caring for these patients. I then used statistics regarding the Georgia carceral system to demonstrate the immediacy of the topic for them and how it would impact their work on a frequent basis and that there was no way to avoid it.

Representation: Regarding how to optimize outcomes for incarcerated patients, I used cases to help illustrate the ways in which

patient care can be impacted when a patient is detained by police or incarcerated (please see 2 cases in the appendix below). Each case was accompanied by specific questions that learners discussed in small groups. This served as a primer on which the teaching points in the following slides was based. For example, the first case involved a patient that went to a primary care clinic, and it was noted by the treating clinician that the patient's blood pressure was uncontrolled and that he had missed multiple appointments since his last visit. The clinician is told by his medical assistant that he heard in the neighborhood that the patient had been in jail for some time following a robbery. In this context, I discuss the model for care for incarcerated patients and address everything from intake services and screenings to chronic disease management during carceral stays and continuity (or lack thereof) when a person is released from jail/prison.

Action & Expression: Learner groups were encouraged to share their answers to the questions associated with each case. This served as both a query of the learners' previous knowledge as well as a formative assessment that revealed knowledge gaps regarding incarcerated patients' rights and best practices in the optimization of patient care for such patients. The questions were phrased in an open-ended format to encourage not simply fact-based, lower-order knowledge, but nuanced and patient-specific answers that reflected the complexities and uncertainties that are encountered during actual clinical practice.

LESSONS LEARNED:
I learned that answering the "why", "what," and "how", of Universal Design Learning (UDL) can be very difficult when working with learners that are not at the same level. By re-establishing the relevance of a topic for advanced learners, one is more likely to capture their attention and simultaneously re-orient or review for them the important concepts or principles that they should know from before. Simultaneously, one can more clearly lay out the importance and relevance of a topic for more novice learners.

This was well received by our residents as some of the remarks on evaluations for that lecture included "I really enjoyed that lecture and the email that followed" (I emailed the residents following the lecture to expand on a conversation regarding the rights of incarcerated patients regarding informed consent, privacy, and designation of health proxies when they are incapacitated). Other comments included remarks on the interactivity of the session and how thought-provoking the cases were.

One unexpected outcome was the fact that the learners wanted to continue discussing some of the cases beyond the learning points that the cases were specifically designed to address. For example, rather than simply discussing that we should include questions pertaining to recent incarceration in a patient's social history (a major learning point from Case 1, along with strategies to normalize such questions.) the learners also wanted to discuss factors that can increase one's

likelihood of being arrested/detained and thus entangled in the criminal justice system. Ultimately, this led to conversations about mass incarceration, systemic racism, trust of the medical system amongst minority groups and in under-resourced and marginalized communities. While this was a great by-product of the activity, this required additional time and it was a challenge to leave the case/discussion to move on to complete the rest of the activity.

IMPLICATIONS FOR FUTURE PRACTICE:

In the future, I will give the learners the cases and questions well in advance of the session along with pre-reading resources so that they come to the session with some background information and some idea on how to approach the cases. This would allow for faster delivery of the didactic component of the presentation, thus allowing more time for discussion of the cases and to explore other learning points from the presentation.

TEACHING TIPS:

I think a key to applying UDL principles is to be comfortable surrendering some of the activity/session to the learners. In many cases, the learners are coming to a course or educational activity with some previous knowledge, some learning objectives/goals, and even questions that they can use to enhance their learning experience if given the opportunity. With careful planning on how and when you give the learners control, they can be empowered to potentiate their own learning and increase your effectiveness and efficiency as an educator.

APPENDIX:

Case 1: Dr. Wen works at a busy primary care practice in an urban community health center. Today he sees that Luke, a 43-year-old man with a diagnosis of hypertension and major depression, is scheduled for a visit. Luke has missed three visits in the last four months without warning and has not refilled his lisinopril or fluoxetine prescriptions during this time. Dr. Wen mentions this to his medical assistant, Jason, and expresses concern about Luke's blood pressure. Jason happens to live down the street from Luke and tells Dr. Wen, "I heard Luke's been locked up for the past couple of months because of a robbery."

When Luke finally arrives for an appointment, Jason reports his blood pressure is 141/87. When asked by Dr. Wen about his medication supply, Luke states he has been taking lisinopril and fluoxetine as directed until last week, when "my prescription ran out." Aware of the many health risks associated with incarceration —including loss of health insurance, loss of social supports, difficulty obtaining employment upon reentry, and higher rates of chronic disease—Dr. Wen asks Luke if he has recently been incarcerated or detained. Luke looks surprised and then becomes irate, yelling, "That's none of your business! Why are you asking about things that have nothing to do with you?"

- AMA J Ethics. 2017;19(9):885-893. doi: 10.1001/journalofethics.2017.19.9.ecas2-1709.

- What rights does the patient have in this situation? Have any of the patient's right been violated in this case?
- Is it likely or unlikely that Dr. Wen would have suspected/discovered Luke's recent incarceration as the reason for him not filling prescriptions and missing appointments without the history volunteered by the medical assistant?
- How might Dr. Wen have obtained the history pertaining to Luke's incarceration?
- How can incarceration status or history be clinically relevant?

Case 2: St. Clair Correctional Facility prisoner Marquette F. Cummings, Jr. was stabbed in the eye with a shank on January 6, 2014. He was life-flighted to the University of Alabama at Birmingham Hospital, where he was found to be in "critical condition."

Warden Carter Davenport included an instruction with Cummings' paperwork that "'no heroic measures' would be taken to save his life." That resulted in hospital staff entering a DNR order.

Sometime later, Davenport ordered that Cummings be removed from life support, which resulted in his death at the hospital on January 7, 2014.

Estate of Cummings v. Davenport, 906 F.3d 934 (11th Cir. 2018)

- What rights does this patient have in this situation? Have any of the patient's rights been violated in this case?
- What are the roles of hospital personnel (physicians, nursing, techs, support staff) with respects to the patient's care and rights?
- What are the hospital personnel and support staff role in maintaining custody of the patient? How might this conflict with caring for this patient?
- How would you have proceeded in caring for this patient with regard to end-of-life decision-making and palliative care?

Written by David Thylur, MD
Assistant Professor, Grady Psychiatry Consultation-Liaison Service, Dept. of Psychiatry and Behavioral Sciences, Emory University School of Medicine

TITLE:
Aligning instructional design with learning goals to teach physical examination maneuvers in psychiatry

CONTEXT:
My learners are third-year medical students and first-year psychiatry residents in an informal didactic session in a hospital conference room as part of ongoing noon clinical site didactic curriculum development.

SELECTED TEACHING & LEARNING TOPIC:
One of my areas of interest lies in a psychomotor syndrome called catatonia. Unlike many aspects of psychiatry which typically are diagnosed through patient interview and mental status examination, the diagnosis and recognition of catatonia is largely based on observation and physical examination.

During this course, we sometimes discuss what a "good" learning goal might be, how specificity is important, and the myriad other considerations that go into determining the learning goals. For instance, what do you expect learners to be able to do after the end of your teaching session? If you assess how well your audience learned the skill that you aim to teach them, did you achieve what you set out to do? Are there things that are being taught that don't need to be, and what is being left out that should be included?

During these discussions, I find ideas to change my teaching methods, and an explanation about a point-of-care ultrasound lecture that did not involve any hands-on practice gave me an idea about developing a didactic session centered around hands-on practice with physical exam maneuvers that are part of the skillset involved in the practice of hospital-based psychiatry. After all, it could be challenging to accurately to differentiate two different motor system findings by physical exam if a learner has never had the chance to have accurate and real-time feedback about how they manifest during a catatonia examination.

In order to align the instructional design with the learning goals (which were for learners to be able to accurately identify and differentiate findings in the Bush-Francis Catatonia Rating Scale), I thought that the teaching session would be most successful if everyone had the chance to

see an experienced examiner (the senior resident) perform the full catatonia exam, give learners time to practice the exam on each other, and then have an "assessment" where they tried to identify specific findings with a simulated patient (me) and receive feedback

I also encouraged them to develop their skills further, gave them resources to do so, and offered to give feedback for future patient encounters

LESSONS LEARNED:

Learners seemed to respond well to the session overall. I had hoped to have a good level of engagement as that is one of the areas I am hoping to help address as a part of my involvement in medical education.

The session, which involved splitting learners into small groups, quickly became chaotic while they were practicing physical exam maneuvers!

As the senior resident and I went around the room to help groups that had questions, I noticed that we probably were not able to be as available as we needed for the number of participants

People later shared that the didactic was helpful and requested it to be repeated again for other cohorts, which was encouraging positive feedback!

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:

I think I had moderate success aligning the instructional design (the session structure, the teaching methods, the learning content, and the learning goals) to better teach physical exam maneuvers that can be difficult to apply in clinical practice.

I want to continue trying to create learning environments and didactic sessions that more optimally support the specific type of learning that we are trying to support.

When implementing new teaching methods, it's important to think about the practical considerations during instructional design.

For instance, we would have benefited from choosing a more appropriate learning space, with more spaces for people to sit or spread out to practice the maneuvers

Two instructors may not be enough to teach this type of didactic. I need to consider the ratio of teachers to learners when doing less conventional teaching sessions.

I am looking forward to the next time I can teach this didactic session so I can implement some of what I learned. I may ask a couple residents working on the consult service to help teach the session so there are more people around to answer questions or demonstrate maneuvers. I will also do more to prep the space that we will be using so learners have an easier time. This was a fun departure from didactic formats I was more comfortable with, and I hope to find other opportunities to grow!

Written by Snehal Vala, MD, VALA Assistant Professor, Pediatric Pulmonology, Emory University School of Medicine, Department of Pediatrics , Division of Pulmonology, Allergy & Immunology, Cystic Fibrosis, and Sleep

TITLE:
Using web-based methods for learning pulmonary diseases topics

CONTEXT:
Each academic year, there are over 20 pediatric residents that rotate through pulmonology services. These services include inpatient, consulting, and clinic services. Currently teaching rotating residents is occurring at bedside, and in informal clinical settings. Residents who rotate in pulmonology division also voluntarily participate in weekly conferences designed for pulmonology fellows. I would like to create a core-curriculum for pediatric residents to include the 10 most common pulmonary diseases they encounter in their rotation with pulmonology, and in their future practices. I will implement this concept through web based-google drive, created with power point presentations on these 10 most common pulmonary diseases, and have residents access to these presentations at their convenience. This will help create a curriculum and reference for their practice.

SELECTED TEACHING & LEARNING TOPIC:
I have not implemented this project yet (awaiting the new academic year), but I would like to apply curriculum design and evaluation. Specifically, I would use the subject-centered approach to identify the 10 most common pulmonary diseases. Then I will create power point presentations on these 10 topics. Residents will have the opportunity to complete these 10 topics during their rotation with pulmonology. They will also complete a pre- and post-assessment questionnaire to assess knowledge gained.

LESSONS LEARNED:
With not implementing web-based learning methods yet, it is difficult to conclude outcome and lessons learned now. However, I anticipate flexibility the web-based methods may have to offer. Residents would have access to these topics, which they could complete at their convenient time during their rotation, while fulfilling their clinical roles.

IMPLICATIONS FOR FUTURE PRACTICE / TEACHING TIPS:
Offering flexibility to access topics with each resident's rotation, and constantly reevaluating/possibly making changes every so often based on feedback. I would

continue to use the pre and post questionnaire as a measure of the pulmonary resident's foundational gained knowledge and would recommend using this tool to someone considering applying it to their context. I would advise using the background knowledge probe-pre assessment questionnaire but to ensure completion of topics before actual completion of post assessment questionnaire.

Written by Joseph Vinson, MD
Assistant Professor, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine

TITLE:
Clinical Challenge Conference: Challenges and Successes

CONTEXT:
Relatively new monthly educational conference called "Clinical Challenge Conference," led by myself and other faculty within the Department of Psychiatry and Behavioral Sciences. Virtual meeting on the 3rd Friday of the month at 12:00.

We've conceived of the target audience as a "target" wherein faculty based in the Adult Psychiatry outpatient clinic form the innermost circle, followed by faculty from other sites/service lines within the Department, followed by trainees at our program, followed by trainees from a new Emory satellite program.

SELECTED TEACHING & LEARNING TOPIC:
Constructive alignment regarding goals in the affective domain (e.g., "caring" about one another, about our work, feeling a sense of belonging)

Intentional topic selection, audience selection, active facilitation and engagement, balancing degree and types of structure, each of which may help to address the affective domain.

Elicited informal feedback at the beginning and end of meetings and in my brief segment of the separate monthly staff meetings.

LESSONS LEARNED:
Confirmation of needs in the affective and social domains (e.g., passion for the work; demonstrating vulnerability; shared responsibility/sense of belonging; as a trainee, observing and reflecting on a discussion primarily between faculty rather than the traditional direction of knowledge transmission from faculty to trainee).

Last-minute changes were not always helpful in terms of structure and overall learning experience.

IMPLICATIONS FOR FUTURE PRACTICE:
Planning further (2-3 months) in advance would help maintain the right balance of structure

May help to review principles and strategies for effective group facilitation in a setting like this, which may be unfamiliar to some.

Periodic (e.g., year-end) feedback and review of the conference to re-orient and ensure ongoing constructive alignment.