

**Medical Resident
Clinic Director's
“Orientation Manual”**

Developed by the Medical Resident
Clinic Director's Interest Group

Society of General Internal Medicine

September, 2003

Editors

David C. Dugdale, M.D.
Director, General Internal Medicine
Center, University of Washington
Medical Center
4245 Roosevelt Way NE
Seattle, WA 98105
E-mail: dugdaled@u.washington.edu
Office: 206-598-5524

Mohan Nadkarni MD
Associate Professor, Internal Medicine
Medical Director, University Medical
Associates
Box 800744 Primary Care Center
University Of Virginia Health System
Charlottesville VA 22908
Office: 434 243-5796
Fax 434 924-1138
E-mail: mmn9y@virginia.edu

Contributors

Karen Brown, MD,
Assistant Professor of Medicine
Yale University School of Medicine and
Associate Director, Yale Primary Care Center
New Haven, CT
E-mail: karen.brown@yale.edu

T. Shawn Caudill, MD, MSPH
Chief, Division of General Internal Medicine
Director, Primary Care Residency Program
University of Kentucky
K504 Kentucky Clinic, UKMC
Lexington, KY 40536
Office: (859) 257-5499
Fax: (859) 257-2506
Email: tscaud1@uky.edu

Mark J. Fagan MD
Director, Medical Primary Care Unit
Rhode Island Hospital
Providence, RI
E-mail: MFagan@Lifespan.org

Chris Goerdt, MD, MPH
Associate Professor
University of Iowa
E-mail: chris-goerdt@uiowa.edu

Contributors, continued

Phyllis Jen, MD
Medical Director, Brigham Internal Medicine Associates
Brigham and Women's Hospital
75 Francis St
Boston, MA 02115
Office: 617-732-6027
E-mail: pjen@partners.org

Caroline S. Rhoads, MD
Assistant Professor of Medicine
Harborview Medical Center
University of Washington
Seattle, WA
E-mail: crhoads@u.washington.edu

Jeffrey Wong, MD
Associate Clinical Professor
Yale University School of Medicine
Director - Henry S. Chase Outpatient Center
Waterbury Hospital, Waterbury, CT
E-mail: JWong@wtbyhosp.chime.org

Contents

Title	Authors	Pages
Overview	David C. Dugdale Mohan Nadkarni	5
Expectations of and for the Medical Director of the Resident's Ambulatory Clinic	David C. Dugdale	6
Accreditation Issues	Mark J. Fagan	7-10
Teaching Physician Documentation	Phyllis Jen	11-25
Improving Efficiency and Productivity in Resident Teaching Clinics	T. Shawn Caudill	26-28
Ambulatory Teaching Ambulatory Teaching Tips: Annotated Bibliography	Chris Goerd Jeff Wong	29-38
Mentorship and Role Modeling	Karen Brown	39
Evaluation	Caroline Rhoads	40

Orientation manual overview

Based on a consensus process, members of the Medical Resident Clinic Directors Interest Group (MRCDIG) of SGIM developed learning objectives that we thought were of greatest importance to faculty and clinic directors practicing in medical residents' continuity clinics. These were presented during a precourse at the SGIM national meeting in May, 2002. Subsequently, we have revised and refined the content to create the first edition of the Medical Resident Clinic Directors Interest Group (MRCDIG) orientation manual. Our primary goal has been to create a document that can serve to guide clinic directors and faculty as they develop programs to meet their local needs and to help orient new faculty to this key learning environment. For more information, check for updated information at <http://www.sgim.org/interestgroup.cfm>.

Expectations of and for the Medical Director of the Resident's Ambulatory Clinic

Excerpted from Wong JG, Fagan M, Pinsker J for the SGIM MRCDIG. Am J Med 2001;111:84-87.

"The medical resident clinic director is a key figure linking the residency training program to the hospital outpatient arena. She or he also functions as a link between the hospital and the patients in the community served. It is important that the medical resident clinic director earn and maintain the respect of the trainees, the clinic staff, the hospital administration, and the residency training program."

Competencies

Essential competencies. "The medical resident clinic director must be able to manage the outpatient practice site with appropriate administrative skill...; approachable by trainees...; skilled in providing feedback to individual learners; able to communicate with clinic staff..., hospital administration..., and program director...."

Productivity

Essential activities. "The medical resident clinic director must be actively involved with the formal evaluation process...; able to identify quality improvement items within the resident practice...; able to articulate the long-range vision of the ambulatory clinic in terms of the overall goals of the training program...; ultimately responsible for overall clinical productivity and the quality of patient care...."

Resources

Essential resources. "An adequate number of high quality teachers is mandatory. Sufficient protected time for dedicated administrative duties...; a well-defined reporting structure that governs the clerical and support staff under the clinic director's supervision and leadership."

Incentives and career development

Essential career development. "The value of the medical resident clinic director to the academic community must be recognized explicitly and formally. The medical resident clinic director's productivity must be recognized as it relates to promotion, retention, and tenure at the academic facility. There should be an explicit statement of how the productivity will be measured and will contribute to the academic mission."

Accreditation Issues

Mark J. Fagan, MD

- I. Revised Program Requirements (effective date July 1, 2003). Available at www.acgme.org. Some highlights:
 - A. “At least one-third of the residency training must be in the ambulatory setting.”

½ day per week for 3 years = 10%

1-month block = 3%

1 day per week for 1 year = 7%

(examples of ambulatory training: general medicine continuity clinics, subspecialty clinics, ambulatory block rotations, physicians’ offices, managed care health systems, emergency medicine, walk-in clinics, neighborhood health clinics, home care)
 - B. In an ambulatory setting, one faculty member must be responsible for no more than 5 residents or other learners (**note:** this ratio does not satisfy CMS requirements under the primary care exception—see section on Teaching Physician Documentation).
 - C. On-site faculty members’ primary responsibilities must include the supervision and teaching of residents. On-site supervision as well as the quality of the educational experience must be documented.
 - D. Residents must be able to obtain appropriate and timely consultation from other specialties for their ambulatory patients.
 - E. There should be services available from other health-care professionals such as nurses, social workers, language interpreters, and dieticians.
 - F. Number of patients seen, when averaged over the year, must be:

PGY 1: not less than 3 or greater than 5 per ½ day session

PGY 2: not less than 4 or greater than 6 per ½ day session

PGY 3: not less than 4 per ½ day session
 - G. “Clinical records that document both inpatient and ambulatory care must be maintained such that prompt accessibility is ensured at all times.”

- H. At the program director's discretion, residents may be excused from attending their continuity clinic when they are assigned to an intensive care unit, to emergency medicine, to an away elective, or to night float.
 - I. Residents must attend a minimum of 108 weekly continuity clinic sessions during the 36 months of training.
 - M. The continuity experience should not be interrupted by more than 1 month, excluding a resident's vacation.
 - N. During the continuity experience, arrangements should be made to minimize interruptions of the experience by residents' duties on inpatient and consultation services.
 - O. Each resident must follow patients with chronic diseases on a long-term basis.
 - P. It is desirable that residents be informed of the status of their continuity patients so the resident can make appropriate arrangements to maintain continuity of care.
- II. ACGME Outcome Project (new) Program must assure that residents achieve and demonstrate satisfactory performance of the six domains of competency. Some highlights:
- A. Patient care
 - B. Medical knowledge
 - C. Practice-based learning and improvement
 - 1. Residents are expected to analyze practice experience and perform practice-based improvement activities using a systematic methodology.
 - 2. Residents are expected to obtain and use information about their own population of patients and the larger population from which their patients are drawn.
 - D. Interpersonal and communication skills

1. Residents are expected to work effectively with others as a member or leader of a health care team or other professional group.

E. Professionalism

F. Systems-based practice

1. Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

III. Resources

1. ACGME web site: www.acgme.org Contains detailed description of program requirements. Extensive bibliography on the competencies of the ACGME Outcomes Project. Of particular relevance to clinic directors are the bibliographies on Practice-based Learning and Improvement and Systems-based Practice. (From the home page, go to “Competencies and Outcomes Assessment” and then go to “References”.)

To view a description of the revised internal medicine program requirements (effective date July 1, 2003), from the home page go to “Review and Comment”, then “Program Requirements”, then “Internal Medicine”.

Teaching Physician Documentation

Phyllis Jen, MD

1. Medicare teaching physician billing rules
 - General
 - Primary Care Exception
 - Billing for procedures/counseling
 - Addendum covering change in documentation rules, effective November 22, 2002—**these are the MOST relevant for most teaching settings.**
 - Medical student documentation rules
2. Sample template (see <http://www.im.org/aaim/> for more examples)
3. Teaching encounter (Auditor's) checklist
4. Appendix: Pre-November 22, 2002 AAMC teaching physician documentation instructions and templates—**these are LESS relevant for most teaching settings.**

I. Medicare's Teaching Physician Rules

Excerpts from Medicare Carriers Manual, 15016: Supervising physicians in teaching settings:

A. Pay for physician services furnished in teaching settings under the physician fee schedule only if:

- The services are personally furnished by a physician who is not a resident; or
- The services are furnished jointly by a teaching physician and resident or by a resident in the presence of a teaching physician with certain exceptions as provided below.

B. Special situations. If a resident participates in a service furnished in a teaching setting, pay for the services of a teaching physician under the physician fee schedule only if the teaching physician is present during the key portion of the service for which payment is sought.

1. Evaluation and Management services (E/M) services. For a given encounter, the selection of the appropriate level of E/M service should be based on "Documentation Guidelines for Evaluation and Management Services" developed by the American Medical Association (AMA) and HCFA and published by the AMA. If a teaching physician documents his or her presence and participation in the E/M service, the level of service may be selected based on the extent of history and/or examination and/or the complexity of the medical decision making required by the patient and documented in his or her personal entry in the medical record which may include references to notes entered by the resident, and **does not require re-documentation by the teaching physician** (note: this was a change based on the addendum covering changes to documentation rules, effective November 22, 2002, see subsection 4 below, [full text available at: http://cms.hhs.gov/manuals/pm_trans/R1780B3.pdf]).

Except as indicated in subsection 2 (shown below, "Exception for E/M services furnished in certain primary care centers"), the teaching physician must be physically present during the portion of the service that determines the level of service billed. In all cases, the teaching physician must personally document his/her presence and participation in the services in the medical records. This documentation by the teaching physician may be either in writing or via a dictated note and expressed in the following ways for these major categories of E/M service.

- a. Initial hospital care, emergency department visits, office visits for new patients, office consultations, and hospital consultation.

A personal notation must be entered by the teaching physician documenting his or her participation in the 3 key components of these services (i.e., history, examination, and medical decision making) as required by CPT and demonstrating the appropriate level of service required by the patient. If the teaching physician is repeating key elements of the service components obtained previously and documented by the resident, e.g., the

patient's complete history and physical examination, the teaching physician need not repeat documentation of these components in detail. Rather, the documentation of the teaching physician may be brief, summary comments that relate to the resident's entry and which confirm or revise the key elements defined for the purpose of this section as:

- Relevant history or present illness and prior diagnostic tests;
- Major finding(s) of the physical examination
- Assessment, clinical impression, or diagnosis; and
- Plan of care

Therefore, the documentation of the key elements above may be satisfied by combining entries into the medical record made by the resident and the teaching physician. The documentation requirements for some common clinical situations for teaching physician are illustrated below.

b. Subsequent hospital care and office visits for established patients.

A personal notation by the teaching physician must be entered highlighting 2 of the 3 key components of these services (i.e., history, examination, and medical decision making). The same guidelines set forth in subsection a are required for follow-up visits for established patients.

2. Exception for E/M services furnished in certain primary care centers.

For the E/M codes listed below, pay teaching physician claims for services furnished by residents without the presence of a teaching physician. When a GME program is granted the primary care exception, it applies to the following lower and mid-level E/M services:

New patient	Established patient
99201	99211
99202	99212
99203	99213

For this exception to apply, a center must attest in writing that all of the following conditions are met for a particular residency program. A center does not have to be approved in advance. Maintain a file of such attestations for later use in the case of questionable future claims for payment.

Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program. If it becomes necessary to verify this information, teaching hospitals are required to maintain such information under the provisions of 42 CFR 413.86(f)(2).

The teaching physician in whose name the payment is sought must not supervise more than 4 resident at any given time and must direct the care from such proximity as to constitute immediate availability.

The teaching physician must:

- Have no other responsibilities (including the supervision of other personnel) at the time of the service for which payment is sought;
- Assume management responsibility for those beneficiaries seen by the residents;
- Ensure that the services furnished are appropriate;
- Review with each resident during or immediately after each visit the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and
- Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.

The patient seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by the residents under the medical direction of teaching physicians. The residents must generally follow the same group of patient throughout the course of their residency program, but there is no requirement that the teaching physicians remain the same over any period of time.

3. Procedures

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

Minor procedures. For procedures that take only a few minutes (5 minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

Teaching encounters (Medicare carrier manual, 15016.B.6). For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician.

4. Addendum covering changes to documentation rules, effective November 22, 2002 (full text available at: http://cms.hhs.gov/manuals/pm_trans/R1780B3.pdf)

On November 22, 2002, CMS issued transmittal 1780, a revision to part 3 of the Medicare Carrier's Manual covering documentation by supervising physicians in teaching settings. These guidelines substantially reduced the requirements for separate documentation by teaching physicians, thereby allowing billing based on the

documentation provided by the resident, and the statement of involvement and concurrence by the teaching physician.

Unless operating under the rules of the primary care exception, teaching physicians must still either perform the service or be physically present during the key or critical portions of the service and participate in the management of the patient. But, teaching physicians no longer need to separately re-document elements of E/M services.

Teaching physicians' notes should include the following:

- Statement that the critical portions of the service were performed (e.g., "I saw and evaluated the patient...")
- Statement confirming involvement in the management of the patient (e.g., "... and I have reviewed Dr. _____'s note and discussed the case with him/her...")
- Statement and concurrence with the findings in the resident's note and the plan as outlined (e.g., "...and I agree with the findings and plan documented in Dr. _____'s note...")
- Correction (if needed) of any additional elements missing or inaccurate in the resident's note (e.g., "...except that the patient has, on ROS, some dyspnea on exertion.")

Sample acceptable teaching physician note:

"I saw and evaluated the patient and I have reviewed Dr. _____'s note and discussed the case with him/her. I agree with the findings and plan documented in Dr. _____'s note, except that the patient has, on ROS, some dyspnea on exertion."

Sample unacceptable teaching physician note:

"Patient seen, agree with above."

5. Medical Student Documentation

The only documentation by medical students that may be used by the teaching physician is their documentation of the review of systems (ROS) and past family social history (PFSH). The teaching physician may NOT refer to a medical student's documentation of physical exam findings or medical decision-making in his/her personal note. The teaching physician must verify and re-document the history of present illness (HPI), as well as perform and re-document the physical exam and medical decision-making activities of the visit service. This rule also applies to the documentation by other kinds of students, e.g., physician assistants and nurse practitioners.

II. Attending Note Template Example (see <http://www.im.org/aaim/> for more examples)

University of Washington (DC Dugdale)

Template developed based on AAMC memo #99-47 (August 6, 1999) and text of revision to Medicare Carrier's Manual of November 22, 2002

General Internal Medicine Center Attending Note

Care **UNDER** the continuity clinic exception rule

I reviewed and discussed the case of patient _____
with resident, Dr. _____, including the resident's findings in history,
physical examination, and the diagnosis and treatment plan at the time at the time of
today's visit on _____. I provided personal direction in the services rendered at this
visit, and agree with findings, diagnoses, and plans as documented in the resident's note.

Care **NOT UNDER** the continuity clinic exception rule

I saw and evaluated patient _____ and I have reviewed the
note by resident Dr. _____ dated _____. I have discussed the case with
him/her. I agree with the findings and plan as documented in Dr. _____'s note.

My corrected or additional findings or plan that supplement the resident's note are:

Signature (name) _____

UWP number _____ **Date signed** _____

III. Teaching Encounter Auditor's Checklist (to date, this has not been updated by CMS to reflect the November 22, 2002 changes in documentation requirements discussed above)

MRN# _____ Date of Service: _____ Total # Criter Met _____

Resident: _____ Visit Note: Yes No

~~Preceptor: _____ Visit Note: Yes No~~

Documentation method of resident and preceptor:

Resident and preceptor notes are on resident's note with both signatures

Resident note and separate preceptor note

Teaching Physician Guidelines

Does the teaching physician document...

1. Yes No his/her participation with the resident/fellow in the patient encounter?
2. Yes No that she/he has interviewed and /or examined the patient?
3. Yes No critical elements of the history of present illness?
4. Yes No a specific comment about the pertinent ROS, Past Family and/or social history?
5. Yes No specific pertinent element(s) of the physical exam, including critical positive and/or negative findings?
6. Yes No document a summary noting tests ordered/reviewed, the assessment and treatment plan?
7. Yes No a reference to the resident's note when summary option is used that tethers the notes?

OR

For Primary Care Exception

8. Yes No the discussion of the patient's condition with the resident?
9. Yes No when the contemporaneous discussion took place?
10. Yes No a reference to the resident's note?
11. Yes No a summary comment about the history?
12. Yes No a summary comment about the physical exam?
13. Yes No a summary comment about diagnostic tests (if any), assessment and plan?

14. Yes No **the preceptor's name/signature at the end of the preceptor note**

IV. Appendix: AAMC teaching physician documentation instructions (AAMC memo #99-47) and sample templates.

AAMC teaching physician documentation instructions (AAMC memo #99-47)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Medicare's Teaching Physician Documentation Instructions

This tutorial describes the personal documentation required of teaching physicians, in addition to the notes of resident and fellows, for services provided to Medicare patients in order to substantiate a bill.

1. Evaluation and Management (EM) Services (Visits and Consultations)

General Rule

Medicare rules permit a teaching physician (TP) to substantiate a bill based on the combination of the resident's and teaching physicians documentation for a specific service. The TP must clearly convey that he/she saw the patient and participated personally in the patient's care up to the level of EM service billed. Participation is defined as either personally performing the key portions of the service or observing the resident perform the key components. For an EM service, the key components are defined in the AMA Current Procedural Terminology (CPT) manual as history, physical examination, and medical decision-making. In accordance, with CPT, for all initial hospital care, emergency department visits, new patient office visits and inpatient or outpatient consultations, all three key components must be performed and documented by the TP. For office visits on established patients, or subsequent hospital care visits, the TP need perform and document only 2 of the 3 key components, selecting which components to perform based on the patients condition or circumstances. A physical exam does NOT need to be one of the components performed by the TP for a subsequent or follow-up visit service on an established patient.

The requirements to bill a particular level of EM service are described in CPT. The TP must perform enough personal work (either independently, or by the resident in the presence of the TP) that satisfies the requirements for the level of service coded and billed.

For example: HCFA clarified in a letter to the AAMC on February 9, 1998, that "in cases where the teaching physician was present during the entire time of the resident's exam, the extent of the exam is based on the exam performed by the resident *in the presence of* the teaching physician. For example, to bill the highest level EM service, the entire

comprehensive exam must be performed by the resident in the presence of the TP. In this situation, the teaching physician does not have to personally perform ALL elements of a comprehensive exam, (as specified in CPT), as is required when the teaching physician examines the patient without the resident present.” Rather, the TP must personally perform only those elements of the exam that he/she considers to be key elements (in order to confirm the findings of the resident).

Documentation Requirements

In all cases, the TP must personally document his/her presence and participation in the EM services in patient specific terms. When a resident is involved in a service, the documentation provided by the TP is intended to supplement the more detailed documentation for the same service provided by the resident, and may be limited to brief, summary comments of the most relevant patient information which revise or confirm the resident’s history, physical exam, and substantiate the level of service required by the patient (i.e., the level of service must be medically necessary) and the service code billed.

The TP must always:

- Write a statement establishing his/her **presence**. Using personal pronouns and phrases -- for example, “my exam” or “reviewed with patient” or “patient seen and/or examined” --will convey presence.
- Select and briefly summarize the most important **patient-specific** elements within **each** of the required key components that he/she either personally obtained or verified if obtained by the resident during the visit service, i.e., **history of present illness, exam, and medical decision-making**. The review of systems and past family social history does NOT need to be re-documented if completed by the resident or medical student. However, the TP must always re-document the relevant facts regarding the history of present illness (HPI).
- Refer to the resident’s note for the detail of the visit service performed.

Templates

See examples later in this document. One example is:

Dr. Resident’s history as documented above reviewed, patient X interviewed and examined. It is noted that _____ (state the history of present illness and add anything else remarkable to the ROS and PFSH). On exam I find _____. Upon review, I agree (revise) with Dr. Resident’s assessment and plan. Diagnosis is _____. Plan is _____. See Dr. Resident's note for complete details of this service.

Any format or method used by the TP for documenting the encounter is acceptable as long as the supportive information pertaining to a level of service can be understood from a review of the medical record. It is acceptable, for example, to write “negative” or place

a check mark in a designated column for an element with normal findings if a template is designed in this manner. Comments on abnormal, unexpected findings and pertinent information must be recorded.

Medical Student Documentation

The only documentation by medical students that may be used by the TP is their documentation of the review of systems (ROS) and past family social history (PFSH). The TP may NOT refer to a medical student's documentation of physical exam findings or medical decision-making in his/her personal note. The TP must verify and re-document the history of present illness (HPI), as well as perform and re-document the physical exam and medical decision-making activities of the visit service. This rule also applies to the documentation by other kinds of students, e.g., physician assistants and nurse practitioners.

2. EM Services Provided in an Outpatient Center Operating Under the Exception to the Physical Presence Rule

See section 15016B.2 of the Medicare Carrier Manual instructions for the complete criteria for operating under the outpatient exception rule and letter of clarification from HCFA to the AAMC, dated October 15.

The physical presence requirement is waived for certain residency programs in designated *primary care* specialties providing comprehensive care in outpatient centers that meet the rule's criteria. Specifically, the exception to the physical presence rule is limited, and states that the TP is not required to see the patient for low level EM services, levels 1, 2, and 3 only (CPT codes 99201 – 99203 and 99211 – 99213). The exception rule does not apply to procedures or any other services. If a patient comes to the center and requires a more comprehensive visit service (level 4 or 5) that is unexpected and unscheduled by the center, the TP may see the patient, but must revert to the physical presence rule. The TP may continue to bill for other level 1, 2 and 3 EM services furnished by up to 4 residents under his/her direct supervision under the exception during the same clinic session.

The exception applies to training programs in general internal medicine, family practice, gerontology, pediatrics, and OB/GYN, as well as certain psychiatric programs that provide comprehensive primary care services to their patients. Further, the services must be performed in an outpatient center or other entity in which time spent by residents in patient care activities is included in determining direct GME payments to the teaching hospital.

Prior to billing under the exception rules, a letter of attestation must be sent by the institution to the local Medicare carrier medical director describing the residency program and stating that the program meets all the criteria specified in the final rule published on December 8, 1995 (*60 Federal Register 63124*).

Documentation of Services Provided Under the Exception Rule

The TP must still write a personal note that indicates he/she:

1. Reviewed patient-specific information from the resident's history, exam and plan of care as well as any labs/tests/records, etc., and that
2. The review occurred with the resident while the patient was in the clinic or immediately after the resident saw the patient. If the review does not occur within these parameters, the service is not billable.

Phrases such as "Discussed and agree with resident's assessment and plan" are NOT adequate, since this language does not tell an auditor when the review occurred and what patient-specific information was reviewed with the resident.

Templates

See examples later in this document.

3. Minor Procedures

General Rule

Minor procedures are not defined within CPT, although the Medicare rule characterizes minor procedures as those taking only a few minutes to complete (5 minutes or less) -- for example, simple suturing -- that involve relatively little decision-making once the need for the procedure is determined. The TP must be present for the entire procedure in order to bill for the service.

Documentation Requirements

In contrast to the requirements for EM services, the documentation may be provided by either the resident, the nurse, or personally by the TP. If the resident provides the documentation, the attestation may be phrased as follows:

Procedure performed by/with Dr. TP

Or: Dr. TP was present during the entire procedure

Or: Dr. TP observed me perform this procedure

Avoid using the word "supervised" or phrase "directly supervised" or "personally supervised" as these statements do not necessarily convey that the TP was present for the entire minor procedure as required.

Sample templates, designed to be compliant with pre-November 22, 2002 regulations.

Brigham & Women's, p. 1 (Phyllis Jen)

1. Primary Care Exception – Levels 1, 2, 3 (residents \geq 6 months)

RESIDENT NOTE

Patient case reviewed and discussed with Dr. Resident at the time of visit. See detailed note above.

Patient presents with

HPI, pertinent ROS and Past/Family/Social History

Exam shows _____
Pertinent positive/negative exam element(s) key to diagnosis plan. Test results.

Impression and Plan reviewed and I agree with the resident's assessment of
_____ and diagnosis of

Diagnosis – be specific

I agree with resident's plan of care as _____
Treatment/care plan

Brigham & Women's, p. 2 (Phyllis Jen)

2. Level 4, 5 or residents < 6 months.

RESIDENT NOTE

Dr. Resident and I interviewed and examined this _____ year old
_____ patient, who presents with _____. See Resident's note for
HPI

complete detail. Review of systems is remarkable for _____ and
Key ROS related to problem

past/family/social history significant for _____. Upon exam,
Key PFSH elements needed

Dr. Resident and I find _____. Of note is _____

(lab, x-ray, EKG)

Test results show _____.

Impression and Plan reviewed and I agree with the resident's assessment of
_____ and diagnosis of _____.
diagnosis – be specific

We have agreed that the plan is _____.
Treatment/care plan

University of Iowa (Chris Goerdt)

RESIDENT NOTE

Teaching Note (primary care exception):

I discussed the care of this patient with the resident providing service, during or immediately after patient's visit, and was directly responsible for the patient's management. I have assured that the services provided are appropriate, and I was immediately available to the patient had the need arisen. See resident's note for further details. (Complete applicable sections below).

Teaching Note (physical presence):

Resident's history/exam reviewed, patient interviewed and examined. See resident's note for further details.
(Complete applicable sections below)

Brief history: _____

Exam findings: _____

Lab/Diagnostic Tests show: _____
Assessment and plan reviewed with resident.

I Confirm/Revise the differential diagnosis: _____

Care plan is: _____

Procedure Teaching Note:
I was present for the key portion of the procedure, defined as _____

Procedure Teaching Note:

I was present for the entire procedure _____ . (See resident's note)

_____ DICTATED _____

University of Kentucky Template (Shawn Caudill)

Attending for this visit: Dr. _____ (print name of attending supervising this visit, if applicable)
TEACHING/SUPERVISING PHYSICIAN NOTE
(Levels 1-3, Exception rule--TIE-IN WITH RESIDENT NOTE REQUIRED--see below)
(Key elements required for all levels 4 and 5, and all visits using GC modifier, and all patient visits with interns, July-December)
Patient seen and examined by me today; I have reviewed with Dr. _____ the patient's medical history, physical exam, diagnoses, and medical decision. Would add key elements:
History: _____ _____ _____
Examination: _____ _____
Decision Making: _____ _____
Teaching Physicians (LEGIBLE) Signature: _____ MD

IMPROVING EFFICIENCY AND PRODUCTIVITY IN RESIDENT TEACHING CLINICS

T. Shawn Caudill, MD, MSPH

I. GOALS OF RESIDENT CONTINUITY CLINICS

- A. Optimal teaching and patient care
- B. Improved image of “resident teaching clinic”
- C. Improved patient satisfaction and continuity with all providers
- D. Improved patient show rate
- E. Improved revenue by improving show rate and payer mix

II. STRATEGIES TO MEET GOALS

A. ESTABLISH RESIDENT/ATTENDING CLINIC TEAMS

- Assign residents to attending teams with 4:1 resident:attending ratio (HCFA exception rule requirement)
- Maintain teams throughout resident training
- Reduce attending documentation requirements (use HCFA-compliant forms)

Helps to: Improve longitudinal patient continuity with the attending

Increase teaching and check-out efficiency

Reduce documentation time

UK Resident Clinic Teams (samples)

MON	WED	TUES	THURS	MON	WED
<u>Caudill</u>	<u>Caudill</u>	<u>Gibson</u>	<u>Gibson</u>	<u>Toney</u>	<u>Toney</u>
3 Hardy	3 Hardy	3 Quarles	3 Quarles	3 Balog	3 Balog
Geile	Geile	2 Collins	Edwards	Fleming	Kahwash
2 Jones	2 Jones	Mini	2 Collins	2 Sargent	2 Sargent
Green	Green	1 Francis	Mini	1 Reichert	1 Coates

D. MAINTAIN PRACTICE INTEGRITY: SET THE BAR HIGH!

- Keep resident patient flow steady (efficient check-out)
- Keep patient waiting times short (target: < 15 minutes)
- Emphasize productivity and patient (customer!) satisfaction
- Require resident and attending accountability

Helps to: Improve patient waiting times

Improve provider sense of responsibility and ownership

Improve productivity and revenue

C. MARKET THE TEACHING CLINIC

- Name the practice – avoid “continuity clinic” et al.
- Develop and circulate a marketing brochure, focusing on the positive aspects
- Target patient populations for marketing

Helps to: Improve image of resident teaching clinic
 Improve patient expectations of resident and attending roles and interactions
 Recruit and retain favorable patient mix

E. EFFICIENT CHECK-OUT AND BILLING TRAINING

- “One-Minute Preceptor” approach
- Group discussions (pre-clinic conference)
- Check out resident coding of each visit
- Optimize RVU with diversity of codes (new vs. established, preventive care, office procedures and modifiers)

B. IMPROVE PATIENT SCHEDULING TO INCREASE PATIENT ACCESS

- Schedule patient visits to resident/attending template for continuity at both levels
- Progressive template scheduling for advancing residents
- Train scheduling staff

Helps to: Improve longitudinal patient continuity with the attending
 Increase capacity for better access for long-term and acute care needs
 Improve show rate

Resident Continuity Clinic Schedule Template

JULY – OCTOBER

NOVEMBER - JUNE

	VISITS	TIME (min)		VISITS	TIME (min)
PGY 1 (4 patients)	1:30 NP	60	PGY 1 (5 patients)	1:30 FU	30
	2:30 CI	30		2:00 CI	30
	3:00 FU	30		2:30 NP	60
	3:30 FU	30		3:30 FU	30
				4:00 FU	30
PGY 2 (5 patients)	1:30 FU	30	PGY 2 (6 patients)	1:30 FU	30
	2:00 CI	30		2:00 FU	30
	2:30 NP	60		2:30 CI	30
	3:30 FU	30		3:00 FU	60
	4:00 FU	30		3:30 FU	30
				4:00 FU	30
PGY 3/4 (6 patients)	1:30 CI	30	PGY 3/4 (6 patients)	1:30 CI	30
	2:00 FU	30		2:00 FU	30
	2:30 CI	30		2:30 CI	30
	3:00 FU	30		3:00 FU	30
	3:30 FU	30		3:30 FU	30
	4:00 FU	30		4:00 FU	30

- **New Patient (NP)** – ANY patient not seen within the past three years in a GENERAL INTERNAL MEDICINE CLINIC (NO NEW uninsured/medicaid patients)
- **Call-in (CI)** - use ONLY FOR CALL-IN appointments (DO NOT USE FOR FOLLOW-UPS!), the day prior to/of the scheduled clinic
- **Follow-up (FU)** – return appointments to RESIDENT ONLY; if not available, to ATTENDING; if not available, to call-in
- convert any unscheduled slots to call-in opening the day prior to scheduled clinic
- combine 2 open 30 min appointments to ANNUAL PHYSICAL EXAM/PREVENTIVE VISIT appointment

III. OUTCOMES AT UK

- Show rate has increased from 65% to 88 – 95%
- RVU/clinic has increase from 9.3 to 16 (resident clinic average)
- Visits/year/FTE have increased from 3126 to 4671
- 1st available acute care appointment is today
- 1st available new patient appointment is tomorrow
- Patient satisfaction in resident clinic = 9.5 (10-point scale, 10 = best score)

Ambulatory Teaching Ambulatory Teaching Tips Annotated Bibliography of Helpful References

Chris Goerdts, MD, MPH
Jeff Wong, MD

1. The One-Minute Preceptor

Neher JO, Gordon KC, Meyer B, Stevens N. A five-step microskills model of clinical teaching, *J Am Board Fam Pract* 5:419-24, 1992.

Describes a clinical teaching model comprised of five “microskills”: getting a commitment, probing for supporting evidence, teaching general rules, reinforcing what was done right and correcting mistakes. This model focuses on the learner’s decision-making process and takes less than five minutes to use. [Note: see overview of this model and examples of how to use it at end of this section.]

2. Teachable Moments

Lesky L, Borkan SC. Strategies to improve teaching in the ambulatory medicine setting. *Arch Intern Med* 150:2133-2137, 1990.

This paper was one of the first ones to purport that ambulatory teaching (much more so than inpatient teaching) must be more learner-focused than topic-focused. The paper relates an example of a “typical” teaching encounter in the outpatient setting. The rest of the paper analyzes this “typical” encounter. Specific points urged of the teacher include promoting gradual independence of the learner, clarifying the learner’s needs and capturing “teachable moments”. Evaluating what the learner knows by careful observation and thoughtful questioning (along with adequate “wait time” after questioning) and then providing feedback on that evaluation is also outlined.

3. Teaching Scripts

Endelberger Marc dante K, Simpson D. How pediatric educators know what to teach: the use of teaching scripts. *Pediatrics* 104:s1-s11, 1999.

Cross sectional survey of 80 academic pediatricians. They were asked to identify errors common to specific learners and critical teaching points for two common clinical vignettes. There was 85% agreement for the common errors and 80% agreement on the critical teaching points. The authors state that this is consistent with previous research and suggests that clinicians use scripts to teach.

4. Aunt Minnie Approach

Cunningham AS, Blatt SD, Fuller PG, Weinberger HL. The art of precepting: socrates or aunt minnie? *Archives of Pediatric and Adolescent Medicine* 153:114-116, 1999.

These authors, writing a commentary in the pediatric literature, advocate for teaching learners the art of pattern recognition in the busy outpatient clinic. The method, called the “Aunt Minnie” method, was borrowed from Sackett and colleagues [Clinical Epidemiology. Boston, MA: Little Brown & Co. Inc., 1985: 3-15.]: “If the lady across the street walks like your aunt Minnie and dresses like your aunt Minnie, she probably is your aunt Minnie, even if you cannot identify her face.” Operationally, in their pediatric clinic, this method requires that the learners present only the chief complaint of the patient and their presumptive diagnosis. While the learner is completing the paper work, the preceptor evaluates the patient. Upon the preceptor’s return, discussion and feedback is immediately provided back to the learner. [Note: *this model seems to work well in a general pediatric clinic. The authors readily admit that most the problems that they see are routine. It is not clear how translatable this experience is to other venues, e.g., an internal medicine resident’s clinic*]

5. *Learning Vector Model*

Stritter FT, Baker RM, Shahady EJ. “Clinical Instruction”, in Handbook for the Academic Physician, MaGaghie and Frey, eds. New York: Springer-Verlag, 1986.

Asserts that professional development occurs in stages (learning vector). Recommends diagnosing the learner’s stage and teaching accordingly, setting learning expectations and matching teaching to these expectations, asking questions in a problem solving sequence to facilitate self-discovery, evaluating learners and providing feedback, evaluating the teaching encounter, providing closure or a summary of what was learned and what remains to be learned. Also provides exercises and instruments that can be used individually or for faculty development to assess and learn clinical teaching methods.

6. *Feedback*

Ende J. Feedback in clinical medical education. *JAMA* 250:777-781, 1983.

An often-quoted review of the importance of feedback. It describes the consequences of poor or no feedback and discusses guidelines on how to give feedback.

Mini-CEX from the ABIM.

Simple tool used to guide evaluations of observed resident-patient interactions. Encourages direct observation of residents and provides a great opportunity to teach.

7. Overview

Heidenreich C, Lye P, Simpson D, Lourich M. The search for effective and efficient ambulatory teaching methods through the literature. *Pediatrics* 105:s231-s237, 2000.

Distills and describes the eleven common ambulatory teaching methods reported in the literature: orienting the learner, prioritizing and assessing learners needs, problem-oriented learning, priming, pattern recognition, i.e. “Aunt Minnie” method, teaching in the patient’s presence, one to two focal teaching points, effective modeling, questioning, feedback, and teacher/learner reflection.

McGee SR, Irby DM. Teaching in the outpatient clinic: practical tips. *JGIM* 12(suppl 2): S34-S40, 1997

The authors’ state that four important points have been made in reviewing educational research: 1) the environmental variables of a particular clinic have little if any impact on the rating of teaching effectiveness, 2) the teacher’s behavior strongly influences the perceived success of the ambulatory experience, 3) the definition of effective teaching tends to be based on the learners’ perception of what is effective, and 4) role modeling clearly influences learners. In light of these points, the authors promote some practical points for making the ambulatory teaching experience enjoyable. The points include preparing for the patient encounter, asking questions to diagnose the learner, select a single teaching point (a general rule), preparing the learner for the patients (called “priming”), role modeling behaviors, seeing the learners’ patients, providing feedback, and teaching after the visit has been completed.

Lesky L, Hershman WY. Practical approaches to a major educational challenge: training students in the ambulatory setting. *Arch Intern Med* 155:897-904, 1995.

This article makes the case for the need to create ambulatory training sites outside of the traditional hospital-based clinic. Some of the obstacles for creating these new sites are listed including recognizing the specific needs for the different types of learners and identifying whom the preceptors will be and how they will be “enticed” to participate. Some of the authors’ specific administrative suggestions include identifying someone in the office dedicated for coordinating for the trainees’ time, having ample office space for the learner and preparing both the office staff as well as the patients for having a learner in the practice. For the teaching aspects, the authors suggest four key steps: 1) understand the student’s starting point, 2) explicitly clarify learner’s expectations, 3) provided graduated independence, and 4) seek opportunities for meaningful contributions to patient care. The paper concludes with some comments of providing feedback effectively, having the learner self-assess, and some thoughts on the future of ambulatory training.

Ferenchick G, Simpson D, Blackman J, DaRosa D, Dunnington G. Strategies for efficient and effective teaching in the ambulatory setting. *Academic Medicine* 72(4): 277-280, 1997.

The authors frame the issue of ambulatory teaching with a challenging dilemma: ambulatory physicians are simultaneously being asked to carry a larger burden of clinical teaching in the office while increasing the number of patients seen in a given amount of time. One way a busy office practitioner might meet this challenge is by carefully planning ahead both the appointment schedules of the patients as well as which patients will be seen by the learner. The concept of “wave scheduling” is introduced and advocated. Briefly preparing the learner before seeing the patient (sometimes called “priming the learner”) is also suggested. Neher and colleagues’ “One minute preceptor” model is also advocated as well as urging the ambulatory teacher reflecting on the process of teaching. [Note: this paper is mostly for a single learner with a single preceptor/teacher simultaneously providing ambulatory care for patients. It also assumes that the patients “belong” to the preceptor.]

Irby DM. What clinical teachers in medicine need to know. *Academic Medicine* 69:333-342, 1994.

Overview of the knowledge domains required to teach clinical medicine in general: knowledge of the subject matter, learners, principles of teaching and content-specific instruction. Observed and interviewed six distinguished clinical teachers. Found the following general teaching principles: question and involve learners, capture attention and have fun, connect to broader concepts, go to the bedside, be practical, relevant, realistic and selective, provide feedback, meet individual needs, use case-based teaching scripts.

Usatine P, Nguyen K, Randall J, Irby DM. Four exemplary preceptors' strategies for efficient teaching in managed care settings. *Academic Medicine* 72:766-769, 1997.

Time and motion observations of four highly rated family practice preceptors teaching students in managed-care settings. Preceptors spent only 1.1 minutes more seeing patients with students compared to without by orienting students, assessing students needs, selecting appropriate patients, teaching with patients, encouraging self-directed learning.

Books on Clinical Teaching

Westberg J, Jason W. Collaborative clinical education. Springer Publishing Company, 1993.

In depth text on the steps, strategies and principles of effective clinical teaching. Part 1 covers the challenges of clinical teaching and the characteristics and capabilities of effective clinical teachers. Part 2 focuses on orienting learners, developing relationships with learners, and helping them set goals, assess their needs and develop learning plans. Part 3 addresses doing clinical teaching and covers role modeling, observing, questioning, listening, responding, encouraging self-reflection and giving feedback. Part 4 explores evaluating clinical teaching. The book contains many indices with checklists that summarize the major points and can be used to support day-to-day teaching.

Alguire PC, DeWitt DE, Pinsky LE, Ferenchick GS. Teaching in your office: a guide to instructing medical students and residents. American College of Physicians, 2001. http://www.acponline.org/catalog/books/teach_office.htm

Concise overview of the pre-requisites for office-based teaching, curriculum goals, preparing the office and learner, teaching skills, case-based learning, efficient teaching, and feedback and evaluation for learners and preceptors. Summarizes the major points and provides data-collection and organizational tools in appendices. Summarizes many of the teaching methods described in the above articles. Probably the best quick reference.

Whitman N, Schwenk TL. The physician as teacher. 2ed. 1997; *Whitman Associates*, Salt Lake City, UT.

This book is organized into two main parts. Part one describes teaching as a form of communication. It provides observations on physicians as communicators, the roles of the teacher and the learner, the teacher-learner relationship in medicine, and attentive silence, negotiation, and challenge. The second part describes teaching responsibilities and their methods. The specific types of teaching analyzed include lectures, small group discussions, teaching rounds and morning reports, bedside teaching, and ambulatory teaching. [*The book is easy to read, a little folksy in its narrative, and is quite well referenced.*]

Whitman N. Creative medical teaching. University of Utah School of Medicine, 1990.

An entertaining collection of thoughts and stories regarding medical teaching based on the author's extensive personal experience as well as published research. The author's aim is to inspire, promote creativity and help teachers show their students how to learn instead of what to think.

Faculty Development Articles for Ambulatory Teaching

Wilkerson L, Armstrong E, Lesky L. Faculty Development for Ambulatory Teaching. *JGIM* 5(suppl): S44-S53, 1990.

This paper, written in 1990, was a part of a larger supplement dedicated to medical education. The authors begin the paper by listing some of the reasons why teaching in the ambulatory setting is far different than teaching in the inpatient setting and, in many ways, is more challenging. Next, they discuss the different ways teachers can maintain clinical competence for ambulatory teaching including continuing medical education courses, regularly scheduled conferences, involvement in developing ambulatory curricula and participating in skill-specific workshops. The third section outlines six basic teaching skills that the authors believe are essential: 1) establishing and monitoring mutual expectations between teacher and learner, 2) setting limited goals for teaching, 3) asking questions, 4) stimulating self-directed learning, 5) giving feedback, and 6) capitalizing on the power of role modeling. The next section lists some strategies for developing and maintaining teaching skills including assessment (via self-assessments, learner assessments and peer assessments), individual consultation, and workshops on teaching skills. They conclude with some observations on the type and amount of institutional support needed to reward teaching contributions.

Skeff KM, Stratos GA, Mygdal W, DeWitt TA, Manfred L, Quirk M, Roberts K, Greenberg L, Bland CJ. Faculty development: a resource for clinical teachers. *JGIM* 12(suppl 2): S56-S63, 1997.

This paper lists a compilation of established regional and national faculty development programs as of 1997. The authors note that while faculty development is necessary and desirable, there are several potential barriers to participating. Those barriers include attitudes and misperceptions of teachers, insufficient institutional support and the relative dearth of research on teaching improvement methods. After listing the different programs, they describe, in general terms, the different types of programs and offer some suggestions for selecting a program to attend. They suggest starting a program that is at least based on empirical studies (if not proven to be effective), and one consistent with known educational theory. They also recommend selecting a program based on one's own teaching role(s), whether or not the program will lead to new personal insights, and whether or not a particular teaching philosophy is espoused.

Skeff KM. Enhancing teaching effectiveness and vitality in the ambulatory setting. *JGIM* 3(suppl) S26-S33, 1988

In this paper, Dr. Skeff articulates many of the challenges that ambulatory teachers must face. They include significant time pressures for seeing the patient efficiently and teaching on the "patient's" time. He then outlines and provides definitions the seven major categories of the Stanford Faculty Development Program model and

applies them specifically to challenges for teaching in the outpatient arena. The seven categories are: 1) creating a positive learning climate, 2) controlling the teaching session, 3) communicating learning goals, 4) promoting understanding and retention, 5) evaluating learners, 6) providing feedback, and 7) promoting self-directed learning. He closes with some thought on strategies that institutions can employ to improve faculty attitudes, faculty knowledge and faculty skills in ambulatory teaching.

Packaged Workshops

Ferenchick G, Langford T. Teaching in the ambulatory setting: a packaged workshop. Available through the Office of Medical Education Research and Development (OMERAD) at Michigan State University.

Complete materials for a teaching workshop including: facilitator guide, overhead transparencies, handouts, laminated aids, evaluation tools, videotape and CD ROM. Workshop participants should learn how to orient learners to the clinic setting, use case-based teaching, use the “One-minute observation”, evaluate and give feedback to learners.

Society for Teachers in Family Medicine. Preceptor Education Project 2. Available through the Society for Teachers of Family Medicine. <http://www.medsch.ucla.edu/som/fammed/pep2.html>

Materials consist of a workbook that provides instruction and advice on how to teach students and residents in your practice; a complete facilitators guide for conducting a teaching workshop including detailed instructions, a videotape of teaching encounters and templates for overheads.

Interactive Website

The expert preceptor interactive curriculum. Office of Educational Development, University of North Carolina School of Medicine. <http://www.med.unc.edu/epic/>

Curriculum targeting community-based preceptors but applicable to all ambulatory teachers. Has ten interactive modules: setting the stage, effective teaching in the community practice, evaluating performance and giving feedback, teamwork in health care, information technology, evidence-based care, clinician-patient relationships, changing environment: managed care, health promotion/disease prevention, working with the community. Each module takes about two hours to complete and qualifies for CME credit.

Resource Website

The Center for Instructional Support. [A resource website for educators in the health professions.](#)

[Center for Instructional Support -- http://www.uchsc.edu/CIS](http://www.uchsc.edu/CIS)

Searchable site that provides annotated lists of books and A/V's for developing educational skills. Also lists other resources regarding educational conferences, educational journals, list serves, evaluation forms and checklists, faculty development workshops, fellowship and graduate degree programs, funding sources, organizations and links to the World Wide Web.

Faculty Development Programs

The Stanford Faculty Development Program in Clinical Teaching.

<http://www.stanford.edu/group/SFDP/>

This faculty development program is a 28-day mini-sabbatical on the campus of Stanford Medical School. The program is a facilitator “train-the-trainer” dissemination model whereby selected faculty, take the SFDP seminars, learn how to present the seminars and then practice giving the seminars. All graduates are expected to return to their home institutions and provide the seminars for their faculty and residents. The seminars consist of seven sequential presentations each about 2 – 2.5 hours in duration. Each seminar covers one of the major categories of clinical teaching (see Skeff’s paper annotated above) and begins with a brief mini-lecture introducing general concepts related to the category and specific teaching behaviors the teacher can use to enhance learning. The seminars then use “trigger tapes” of verbatim re-enacted teaching episodes that help the learners to identify the behaviors from the mini-lecture. Following the trigger tape review, the seminar continues with videotaped role-playing and debriefing sessions which allow the learners practice in demonstrating the desired teaching behaviors. At the end of the seminars, the learners are urged to identify specific personal learning goals for each major category and additional readings from the literature are provided.

University of Southern California Faculty Development Program

<http://www.usc.edu/hsc/medicine/med-ed/program.html>

A nine-month home and away fellowship at the University of Southern California including five weekend teaching workshops (lecture and small group teaching, designing educational experiences, teaching with cases, teaching in a clinical setting, dealing with learners in difficulty), a three-day educational conference, research design and learner evaluation courses, on-line assignments. Participants receive 14 hours of graduate credit. The teaching workshops can be attended without doing the complete fellowship.

National Meetings

1. **SGIM**
2. **American Association of Medical Colleges**
3. **Central Group on Educational Affairs**
4. **Society for Teachers in Family Medicine**

Methods for Evaluating Faculty Teaching

1. **Observation by peers or other local education experts**
2. **Videotaping**
3. **Learner feedback (examples of forms from Collaborative Clinical Education)**
4. **Structured self-reflection (Collaborative Clinical Education)**

Microskills for clinical teaching (from Neher JO, Gordon KC, Meyer B, Stevens N. A five-step microskills model of clinical teaching, J Am Board Fam Pract 5:419-24, 1992.)

What—get a commitment. Ask the learner to make a hypothesis about what might be happening with the patient and explain why that is the most likely diagnosis. This encourages learners to begin the reasoning process that is so essential to clinical medicine and also allows you to assess how the learner has processed information presented.

Examples:

What other information do you think we need?
What do you think is going on with this patient?
What would you like to accomplish in the visit?
What laboratory tests do you feel are indicated?

Why—probe for supporting evidence. Before offering your opinion, ask the learner for evidence to support his or her initial hypothesis. This uncovers the learner's reasoning process for arriving at a conclusion.

Examples:

What were the major findings that led to your diagnosis?

What factors did you take into account when determining a treatment plan for this patient?

What else did you consider? What kept you from the choice?

What facts in this case do not support your conclusion?

When—teach general rules. Learners often remember general principles in the context of a particular patient, so the extent that a given patient is typical or atypical can be an important teaching point.

Examples:

“When this happens, do X”

“Remember that there are about 10-15% of people who are carriers of strep and could lead to false positive strep tests.”

“When a patient only has cellulitis, you have to wait until the infected area becomes fluctuant to drain it.”

Warm fuzzies—tell them what they did right. Be specific and let the learner know the effect his or her actions had on the patient or the treatment plan. Behavior specific positive feedback will promote and encourage desirable clinical behaviors.

Examples:

“Specifically, you did an excellent job of ... which results in this outcome.”

“You didn’t immediately jump into solving her initial problem but kept your mind open until she revealed her real agenda for coming in today. In the long run, you saved yourself and the patient a lot of time and unnecessary expense by getting to the heart of her concerns first.”

Whoops—correct mistakes. As soon after the mistake as possible, but in an appropriate time and place, let the learner know what was wrong and how to avoid or correct the error in the future. Behavior specific constructive feedback discourages behaviors and corrects misconceptions.

Examples:

“Next time this happens, try this.”

“You may be right that this child’s symptoms are probably due to a viral URI, but you can’t be sure it isn’t otitis media unless you’ve examined the ear.”

Mentorship and Role Modeling

Karen Brown, MD

Mentoring- A voluntary relationship in which the mentor is usually an experienced, highly regarded, empathetic individual, often working in the same organization, or field, as the mentee; the mentor, by listening and talking with the mentee in private and in confidence, guides the mentee in the development of his or her own ideas, learning, and personal and professional development. Process should be positive, facilitative and developmental and should not be part of assessment or performance monitoring procedures.

SCOPME (Standing Committee on Postgraduate Medical Education of England)

The mentor is usually considerably older than the protégé and is someone who has acquired much experience and seniority; someone who is more than a didactic teacher or a colleague; someone who is a sponsor, an advisor, and a model; someone who has the time to counsel and support; someone who can communicate direction; and...someone whose high standards of excellence the protégé can emulate

Floyd D. Loop *J Thoracic Surg* 2000;119:S45-8

Mentor serves in many capacities:

Teacher--enhances skills and intellectual development

Sponsor--uses his/her influence to facilitate advancement in the field

Guide--initiates to values, customs, and resources of the medical world

Advisor--provides counsel, moral support, direction

Role model

John Rock, *Am J Obstet Gynecol* 1999;181:1293-5

Role Model- A role model provides an important influence on career choices of trainees and helps trainees acquire the values, attitudes, and behavior associated with professionalism, humanism, and ethical practice. Unlike a mentor, the role model may not be aware that they are being critically observed

Factors predictive of housestaff naming faculty as “excellent role models” included:

Generalist rather than specialist

Greater time assigned to teaching on ward or in clinic (>25%)

Trained in teaching (chief resident/faculty development programs)

Spending > 25 hr/week teaching and conducting rounds when attending on wards

Organizing end of rotation dinner and learning about lives of housestaff but not bringing doughnuts to attending rounds

Teach the psychosocial aspects of medicine

Scott Wright et al *N Engl J Med* 1998;339:1986-93

Evaluation

Caroline Rhoads, MD

Purposes of Learner Evaluation

- Document learner experience
- Provide feedback about educational progress (formative evaluation)
- Reach decisions about competency and fitness for practice (summative evaluation)

ACGME Requirements for Resident Evaluation (see www.acgme.org)

- Regular observation of residents performing specific tasks of patient management.
- Structured clinical evaluation (i.e. mini-CEX) at least 4 times yearly.
- Standardized chart review during each rotation.
- Regular/frequent verbal feedback. Written feedback at the end of each rotation.
- Formal evaluation of knowledge, skills, and professional growth by program director semi-annually.
- System for permanently documenting all of the above.

The Six General Competencies

- Patient care
- Medical knowledge
- Practice-based learning and improvement: Does the resident
 - assess patient compliance to ambulatory regimens and accordingly modify prescribing practices?
 - review topics thoroughly and systematically?
 - freely admit to and seek help in remedying errors?
 - readily seek formative feedback on performance?
 - use self-assessments of knowledge, skills and attitudes to develop plans for addressing areas for improvement?
 - participate actively to improve practice when presented with practice data?
- Interpersonal and communication skills
- Professionalism
- Systems-based practice: Does the resident
 - utilize community and clinic resources for successful patient care?
 - access clinical information systems to enhance patient care?
 - collaborate with payers to ensure that patients receive required care?
 - use practice guidelines when appropriate?

Some Tools for Resident Teaching and Evaluation in Clinic

- Videotape review
- Mini-CEX
- Chart Review/Audit
- 360 degree evaluation (see www.im.msu.edu/eval_form_content.htm for example forms)