

Notes from the workshop

NEEDS FOR FD

- Assessment of Residents – can the experience be not just an assessment but also a learning experience (widely agreed upon)
- Coaching
- Setting expectations at the beginning of rotations, beginning of internship
- Skillset development as medicine evolves (ultrasound-guided procedures, QI, other medical topics)
- How to define FD for individuals – so different for each person
- Career advancement for clinician educators
- Leadership – business of medicine – negotiation – conflict resolution (may not be related specifically to education or clinical medicine)
- Teaching to different levels of learners at the same time
- We need a way to know that faculty are actually using what we teach them – how to help people accept peer observation

CHALLENGES

- Finding the right time (hour of the day, time of the year) – potentially do asynchronous or repeated sessions. Do them at different times
- Protected time
- How to engage the people who really need it (they're the ones who don't show up!)
- Faculty need to decide what they need to improve. Otherwise they show up to the things they already are comfortable doing
- Who sets the expectations for faculty development (Division chief? Residency program? GME office?)
- Are there requirements that must be met in order to continue teaching, be promoted? (very few – 1-2 hands raised). Worried about uproar, we can't scare away faculty since we actually need them!
- Community based programs where academic advancement may not be a clear motivation. Carrots (differential caps for a teaching team) vs. sticks

COMMITMENTS MADE/IDEAS FOR FD PROGRAMS

- Adding something into a meeting that already exists – take 20-30 minutes of an existing meeting to share an FD concept. Could ask the meeting participants, what do they want to learn?
- “Snippets” – existing literature (JGME?)
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ENGAGEMENT

- Faculty development certificate?
- Financial incentives – lectures, grand rounds, etc. – can collective incentive points.
- Importance of having a chair who is on board, setting a culture of expectations – in med peds there is a lot of expectation of teaching already. Take the extra effort to communicate with your chair. This can help with buy-in from subspecialty educators – sharing individual IT scores with each division to motivate higher quality teaching (some people are doing this – does not work for pediatrics side)
- Physicians want to feel like they are good – sharing average scores will motivate those who are below-average. Should that information be shared with higher leadership by residency program directors
- Using “workplace” (a Facebook product) to post about how they used it in real life (after a workshop)
- Video-tape yourselves – then YOU can choose a snippet to share with others and share what you struggled with and ask about it specifically. The videotaped person maintains control and ownership of the process.
- Think about Peer Observation as FOR the observer, not about the observed. No checklists, no medical content. Just about the teaching behaviors and what the observer will consider doing differently.
- Consider doing FD as a pilot with people who are already on-board so they can go on and be champions and help change culture.