

MENTORING TOOLKIT

Doing the APD Shuffle:

Restructuring Roles of
Associate Program Directors
to Improve Mentoring for
the Individual Resident

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YEAR-END SELF-REFLECTION FORM

JENNIFER KOCH, M.D.
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NAME:

PATIENT CARE

Self-Reflection:

Do you provide high quality patient care? What measures do you personally take to ensure that this is the case?

Program Director's Comments (Formative Assessment):

Summative Assessment: unsatisfactory needs attention satisfactory exceeds expectations

MEDICAL KNOWLEDGE

Self-Reflection:

How do you rate your own medical knowledge? What specific steps can you take to improve your medical knowledge?

Program Director's Comments (Formative Assessment):

Summative Assessment: unsatisfactory needs attention satisfactory exceeds expectations

PRACTICE-BASED LEARNING AND IMPROVEMENT

Self-Reflection:

Provide a specific example of how, over the past year, you examined your own practice of medicine and took steps to improve it.

Program Director's Comments (Formative Assessment):

Summative Assessment: unsatisfactory needs attention satisfactory exceeds expectations

NAME:

INTERPERSONAL SKILLS AND COMMUNICATION

Self-Reflection:

Describe a difficult interaction with a colleague, patient, or nurse you have had over the past year. How did you handle this situation? In retrospect, would you handle it differently?

Program Director's Comments (Formative Assessment):

Summative Assessment: **unsatisfactory** **needs attention** **satisfactory** **exceeds expectations**

PROFESSIONALISM

Self-Reflection:

What do you struggle with the most in the area of professionalism? How might you work on overcoming this?

Program Director's Comments (Formative Assessment):

Summative Assessment: **unsatisfactory** **needs attention** **satisfactory** **exceeds expectations**

SYSTEMS-BASED PRACTICE

Self-Reflection:

Provide a specific example of how, over the past year, you took steps to make yourself more aware of the medical system in which you work, and how this enabled you to better provide patient care.

Program Director's Comments (Formative Assessment):

Summative Assessment: **unsatisfactory** **needs attention** **satisfactory** **exceeds expectations**

MEDICAL KNOWLEDGE REMEDIATION: DIAGNOSING THE LEARNER

Nancy Kubiak, MD
University of Louisville • May 25, 2007

- 1. Get basic information about the resident's learning style by having him/her complete the learning style index.** This index is available online, at no cost, and helps the mentor with information about preferred learning styles for information gathering and organization. It is available at <http://www4.ncsu.edu/unity/lockers/users/f/felder/public/ILSdir/ILS-faq.htm>. This link is to the FAQ page which has information about the index as well as a link to the actual index.
- 2. Determine how the resident learns best (cognitive styles: information gathering*)**
 - **Visual:** resident "sees" information he/she has written, does flash cards, can see book pages (rarely)
 - **Verbal:** resident "hears" what someone told him or her, listens to CD's, benefits from lectures

Recommendation: based on style, get resident to study in their preferred manner. Recommend CD's, lectures, podcasts, and discussion groups for verbal learners; flash cards and drawing out mechanisms, algorithms, writing/highlighting buzzwords for visual learners.
- 3. Determine how the resident processes information (cognitive styles: information organizing*)** (I use the Myer's Briggs Type Indicator ideas; don't have them actually take the test but if they know already, it helps.)
 - **Extroverted vs Introverted:** an extroverted individual has to think out loud (even when studying alone) to process information; introverted individuals think through it all and then can verbalize the learned concept.
 - **Sensing vs Intuitive:** a sensing individual cannot see the forest for the trees (gets lost in details) while intuitive individuals get the big picture but have trouble with the details. If the resident doesn't know, ask them a question that would help delineate their preference (for example, "When you learned anemia, did you get it that there was hypoproliferative and hyperproliferative anemia (intuitives), or did you learn all the anemias first and then figured out what they had in common (sensing)?") This area is difficult for most individuals to gauge, as almost everyone has some degree of both intuitive and sensing processing.

Recommendation: Determine if the sensing/intuition issue is part of the problem. In my experience, this generally tends to occur in people at the extreme end of the scale. The goal is not to have the resident abandon their preferred method of learning, but to learn to either fill in the details (intuitives) or get the big picture (sensing) in order to have a better command of their medical knowledge. One way I developed is to have the resident create a chart on his or her own that compares and contrasts the diseases or conditions (see example for vasculitis at the end of this document). For the intuitive individual, have him or her look for the details that differentiate the conditions and highlight those facts; for sensing types, have the resident look for trends and note that on the chart.

 - **Identify clues to learning disabilities:** Mispronunciations, misspellings, written performance on tests much worse than clinical sense of abilities

Recommendation: Send to an educational specialist for testing

 - **For English as a second language individual:** Inquire what language he or she speaks at home, if the resident reads non-medical English books/sources, and what language he or she dreams in. It gives an idea of fluency.

Recommendation: If the resident is communicating in non-English languages in casual settings and are having difficulty with fluency in clinical settings or with time pressures on tests, ask the resident to increase his or her use of English as much as possible.

4. Determine test taking skills.

- **Ask about time to finish tests:** Does the resident languish over one answer, or mark it and move on? Does the resident never finish the test even though he or she is not lingering over a single question, or does the resident get behind early and never catch up? Internal medicine boards allow 2 minutes/question.

Recommendation: If finishing tests on time is an issue, have the resident time him or herself, and allow 2 minutes per question for a set number (like 20 minutes for 10 questions). After doing a set number of questions, have the resident go back and look at the answers, think about why other answers are wrong, etc.

- **Does the resident get test fatigue?** A resident may state he or she gets restless toward the end of the in-training examination. Also probe for ADHD if this issue arises.

Recommendation: Exercise those testing muscles. Have the resident routinely set aside time to take a test, working up to 2 hours. Consecutive MKSAP questions work well for this exercise. If fatigue occurred primarily in the afternoon session of the in-training examination, have the resident periodically set aside a day to just take questions in multiple 2 hour segments with 20 minute breaks in between.

5. Determine how the resident studies

- Many are simply not putting in enough time.
- Many have MedStudy but have not opened it, or do not use the recall questions at the end.
- Many read MKSAP questions, guess at their answer, and then read the explanation.
- Many read about patients on UpToDate but nowhere else.
- A few use too many sources, and never really learn any of them

Recommendation: Ask the resident to estimate how many hours he or she is studying a week, and recommend increasing the amount if that is the issue. If the resident is using Med Study, suggest that he or she read the MedStudy section on specific rotations (the GI section when on a GI rotation, for example) and do questions specific to that rotation. Recall questions at the end of MedStudy firm up knowledge and identify knowledge gaps, and should generally be done before working on application questions such as MKSAP questions. My theory regarding this is that an individual must be able to recall the information before he or she can apply it to the clinical situation. When using MKSAP questions, ask the resident to verbalize why the other choices are wrong, and if he or she does not know, look up the answer and figure it why other answers are wrong before proceeding to the next question (is the treatment for some other diagnosis in the differential, is it an old treatment that has been replaced, is it contraindicated in this situation but often the drug of choice...). If the resident is using too many sources, then help him or her choose the ones that work best for his or her situation. If the resident reviews the board review information on each of the diseases of his or her patients, and notes which symptoms, complications, treatments, etc the patient has or has not experienced, the resident will get an idea of what is important to know for boards, and also develop a way to put a face with the disease.

6. Determine if the resident compares and contrasts when studying

- Many sit down and read but do not apply it to the clinical situation or think how this might look when a patient presents.
- Many do not actively think of differential diagnoses, and how that differs from what they are currently reading.

Recommendation: use charts as described above, write differentiating points in margin of study material. Do not highlight everything, but instead highlight the buzzwords or key differentiating aspects of the disease presentation or therapy.

(* From *The Adult Learner*, 5th edition, Malcolm S. Knowles, Edward F. Holton III and Richard A. Swanson)

VASCULITIS

DISEASE	ARTERY	PATHOLOGY	ORGANS	LABS	DIAGNOSIS	Rx	OTHER
Wegeners		Necrotizing granuloma	Sinus/upper airway, lungs, kidney (fsgn)	anemia, leukocytosis, esr, 90% c-anca	Biopsy	Cyclo-Phosphamide + steroids	90% mortality untreated
Churg Strauss		Necrotizing Vasculitis	Lung, mononeuritis multiplex, allergic rhinitis	Eosinophil > 1000, esr	Biopsy lung; clinical trial of asthma, eosinophil, small vessel vasculitis	Steroids Cyclo-Phosphamide for failure	
PAN	Small & medium arteries	Necrotizing vasculitis	Pulmonary ARTERY, not lungs; renal arteritis NOT GN, abdominal pain, mononeuritis multiplex	Hep B 10-30%	Aneurismal dilation on angio; or biopsy	Steroids + Cyclo-Phosphamide Interferon + ribavirin for Hep B	
Microscopic polyangiitis	Small arteries & veins	Necrotizing vasculitis; no granulomas	Lung; no upper airways or pulm nodules Glomerulonephritis, mononeuritis multiplex			Prednisone; + Cyclo-Phosphamide if life threatening	
Giant cell	Med-large	Panarteritis; giant cells	Eyes, head and neck arteries, aorta; hip and shoulders with PMR	Esr Anemia Normal ck	Biopsy <14 days from start of rx	Prednisone 40-60 mg /d	
Takayasu	Med-large	Panarteritis	Aorta, carotid, subclavian, renal	Esr Anemia	Arteriography	Prednisone	Surgery to Repair aneurysm when not Inflamed
Henoch Schonlein Purpura	Small vessels		Palpable purpura, arthralgias, GI, glomerulonephritis	C' normal IgA ^ (50%)	Signs/symptoms with IgA and C3	Spontaneous remission in children	
Idiopathic cutaneous	Small	Cutaneous Leukocytoclastic	Palpable purpura, vesicles, urticaria		Biopsy		
Essential mixed cryoglobulinemia		Fibrinoid necrosis	Palpable purpura, arthralgias, neuropathy, glomerulonephritis, ear	Hep C associated Low C'; RF +	Rx Hep C interferon, ribavirin		5% of hep C gets this

INTERNAL MEDICINE EDUCATION AND EVALUATION COMMITTEE
POLICY FOR INDIVIDUALIZED EDUCATION AGREEMENT

Jennifer Koch, M.D.
University of Louisville

- DEFINITION:** An Individualized Education Agreement (IEA) is an agreement between a specific resident and the Internal Medicine Training Program wherein the resident agrees to a specific, individualized remediation plan in response to one or more adverse evaluations and/or an adverse consensus evaluation from the Education and Evaluation Committee (EEC).
- PURPOSE:** The IEA is meant to delineate a specific plan for remediation of an area of weakness which the EEC feels may be remediable by taking such steps. It is not a formal probationary status within the School of Medicine, however in most cases it would serve as an informal “pre-probationary” period. Not all areas needing improvement will be considered remediable by such a plan; it will remain within the discretion of the EEC to directly recommend probation, without offering an IEA, in some cases.
- TERMS:** Upon recommendation by the EEC, the IEA will be drafted by the program director, associate program director, or other chosen mentor. It will contain specific behaviors and expectations for the involved resident, the details of which will be approved by the EEC. These may include, but are not limited to, specific reading assignments, study plans, knowledge assessments (which must be completed successfully), minimum expectations regarding scores on evaluations, changes in the rotation schedule (for example, adding an extra month of wards), standardized patient/simulator experiences, and regular meetings with the program director/mentor. There will also be a stated time frame during which the plan will be executed.
- The program director/mentor will provide updates to the EEC (at minimum) every three months.
 - If at any time the resident does not meet the terms of the agreement, the issue will be discussed at the next scheduled EEC meeting, or at an emergency meeting if necessary.
 - If the terms of the agreement are not met, or if any new issues arise during the time frame of the agreement, the EEC will make new recommendations. These may include, but are not limited to, changing the terms of the agreement, recommending extension of residency training, and/or recommending to the Dean that the resident be placed on probation.

INDIVIDUALIZED EDUCATION AGREEMENT EXAMPLE

Jennifer Koch, M.D.
University of Louisville

Date:

Resident:

Mentor: Jennifer Koch

Area(s) for Improvement: Medical Knowledge

Timeframe for plan: Effective immediately, lasting until time of graduation from program.

Terms:

1. Read monthly reading assignments in Harrison's and/or other sources. These will be based on the rotation-specific reading assignments which are utilized program-wide. For any rotation, such as wards, which does not have specific readings assigned, Dr. Koch will assign a list of readings.
2. Pass any quizzes (minimum score 60%) on rotations for which there is a quiz available on Blackboard.
3. For any rotation which does not have an associated quiz, successfully complete a quiz based on boards-style questions as given to you by Dr. Koch.
4. An additional month of wards will be added to your schedule.
5. Must achieve a score of "4" or above on all evaluations in the competency of medical knowledge.
6. Must maintain proficiency (a score of "4" or above) for all other competencies on all evaluations.
7. Monthly meetings with Dr. Koch to discuss progress of study plans.

Please sign below:

I agree to the terms of this education plan and understand that if any of the terms are not met, the Education and Evaluation Committee will discuss further action, including but not limited to a recommendation to be placed on probation.

TIPS FOR WRITING YOUR CV

Jennifer Koch, M.D.
University of Louisville

- Length should be 1-2 pages in most cases (longer is not necessarily better).
- Never make anything up, but do give yourself credit for the things you do – e.g. POD leader, Steering Committee.
- Use reverse chronological order, and account for every year (don't leave gaps).
- Use a font that is easy to read; can choose a slightly different one than Times New Roman, but nothing that stands out or might appear unprofessional. Put your name in a slightly larger font size at the top.
- Choose a format that is easy to read; dates or headings aligned in the left hand margin usually make it look nicer.
- If you have nothing to put under a particular heading (e.g. Honors and Awards, Presentations, Research, Volunteer Experience), leave that section out completely.
- See the attached example CV. Depending on your experiences, a slightly different format may be better for you; alter the format as necessary in order to highlight and give yourself credit for all the things you have done, and to minimize any areas which may be lacking.
- Utilize your team leader (Drs. Houghland/Kubiak/Koch) for help.

Joseph H. Shmoe, M.D.

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Education

2006-present Internal Medicine Training Program
University of Louisville, Kentucky
Anticipated date of completion: June 30, 2009

2001-2005 University of Louisville School of Medicine,
Louisville, Kentucky
Degree earned: Doctor of Medicine

1997-2001 University of Kentucky, Lexington, Kentucky
Degree earned: Bachelor of Science, Biology

Certification and Licensure

2007 Kentucky resident license #R5678, expires January 2008
2006 Advanced Cardiac Life Support certification, expires June 2

Awards and Honors

2007 Golden Apple Teaching Award
Awarded by junior medical students for outstanding teaching

2006 Recognition for achieving the highest in-training exam score among PGY-1
internal medicine residents at the University of Louisville

Professional Affiliations

2006-present American Medical Association, member
2006-present American College of Physicians, associate member
2006-present Greater Louisville Medical Society, member

Academic Involvement and Committees

2007-08 Internal Medicine Training Program Steering Committee
Role: Elected member to an advisory committee which assists program
directors in leadership and establishing policy for the residency program

2007-08 POD Leader
Served as organizer/scheduler for a subgroup of residents to ensure
completion of administrative tasks in a primary care continuity clinic

Presentations

2007 Kentucky Chapter of the American College of Physicians' Shakertown Conference, case-based presentation: "Be Still My Beating Heart"

Research

2007-present Ongoing research participation in a randomized controlled trial investigating the use of razors to wake up faculty, residents, and students who fall asleep in Grand Rounds.
Mentor: Jennifer Koch, M.D.

2006-2007 Chart review comparing patient compliance in the use of metformin and glipizide in the outpatient setting
Mentor: Stephen Houghland, M.D.

Publications

2007 Schmoe, JH, Houghland, SJ. "Patient Compliance and the Use of Diabetic Medications." Diabetes 'R' Us 2007; 75: 100-103.

Professional Work Experience

2007-present Superfast Immediate Care Center
Moonlighting shifts as staff physician, average 10 hours/month

2007-present Annoying Disability Insurance Company
Perform physical exams, average 5 hours/month

Volunteer Experience

2007 Make a Difference Day – volunteered at local homeless shelter clinic

HOW TO LEAD A TEAM ON THE WARDS

Jennifer Koch, M.D.
University of Louisville

Be a leader and educator:

- Model the behaviors you expect from your team members.
- Voice expectations at the beginning of the month, and revise these as the month progresses.
- Give feedback to your team members.
- Begin to recognize teachable moments, and use them.

Logistics:

- On the first day of wards, meet with team to discuss how call will work, expectations for prerounding (meet 15 min early), and develop a days off schedule.
- Anticipate any problems (“we all have clinic on our call day”) and discuss with CMR at beginning of month.
- Obtain and distribute contact numbers for team, including attending.
- Decide how you will make the team list for checkout (OK to use GroupWise if “gwise.louisville.edu” is utilized).

Evaluating patients in ER:

- See tips for efficiency on wards and writing BRANs
- Quickly evaluate patients as a team and write bedslip orders ASAP
- If called on a new admission during rounds, one team member should be sent to evaluate patient in a timely fashion for bedslip orders.

Delegating:

- You have to delegate, or you will never leave the hospital.
- Give specific assignments to team members, then follow-up with them to see if they are completed. This way you see things through without doing them all yourself.

Asking for help:

- Your attendings are available to you.
- Obtain attendings’ numbers. Practice dialing them if necessary.
- Call for any questions on admissions.
- Call on ALL consults from other services.
- Call on any consult from the ER who you do not feel needs to be admitted to your service.