# **Resident as Teacher Workshop (RasT)**

**2020**



Presented by the faculty of

## The Resident as Teacher (RasT) Program

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**Sponsored by**

The Resident-as-Teacher Program

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| Image result for schedule clip art | **Schedule of Activities** |



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| ***1a) Introduction and Workshop Overview*** | | | | |
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| ***1b) Orienting Your Learner & Setting Expectations***  ***Teaching Goals & Objectives***  ***Break***  ***2a) Teacher/Learning Environment Characteristics*** | | | | |
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| ***2b) The Hidden Curriculum***  ***Break*** | | | | |
| ***3a) Clinical Teaching Microskills*** | | | | |
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| ***3b) Session III: Providing Feedback*** | | | | |
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| ***Conclusion/ Post-Test/Workshop Evaluation*** | | |  | |
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| Image result for doctor stick figure introduction clip art | | **Introduction** | |

***He teaches best***

***Who shows his students not what to think,***

***But how to think.***

--Alan Gregg

### RasT Apple Welcome to the Residents as Teachers Workshop

During this workshop, you will explore issues in the education of physicians and learn a set of instructional skills that you can use in residency and in future practice. These skills are easy to learn and efficient to use in practice.

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| Image result for doctor stick figure introduction clip art | Small Group Exercise:  Goals & Objectives |

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| **j0217102** | **Assignment:** Review the rotation’s goals and objectives for medical students (or residents) rotating through your field of medicine.   1. Identify *what* you should be teaching them 2. Discuss how you might teach them two goals and   objectives – one that is easier to teach and one that is  more challenging to teach.    **List your thoughts here to be shared in large group discussion:** |

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| Related image | ***Pair and Share:***  ***Memorable Effective Teaching*** |

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| **j0217102** | **Assignment:** Think back over your years of education (elementary school, high school, college, medical school, and residency (if applicable).  Remember a time when one of your teachers was very effective (where the teaching was exemplary). If possible, try to remember a specific teaching scenario.  “What did the teacher do that made their teaching so effective (teaching/environment characteristics)?”  This activity and the one following it below, (memorable ineffective teaching) should take place during the same session.  **List your thoughts here to be shared in large group discussion:** |  |

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| Related image | ***Pair and Share:***  ***Memorable Ineffective Teaching*** |

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| **j0217102** | **Assignment:** Think back over your years of education (elementary school, high school, college, medical school, and residency (if applicable).  Remember a time when one of your teachers was ineffective, a situation you would prefer not repeat. If possible, try to remember a specific teaching scenario.  “What did the teacher do that made their teaching so ineffective (teaching/environment characteristics)?”  **List your thoughts here to be shared in large group discussion:** |  |

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| Image result for doctor stick figure introduction clip art | ***Small Group Exercise – Role Play:***  ***Clinical Teaching- Microskills*** |

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| j0217102 | **Assignment:**  Use the following five cases to practice your five Microskills. Each scripted case emphasizes one of the five Microskills with more information after the case. However, practice all five Microskills (with impromptu dialogue after the scripted case ends for each case). Use the included guide/pocket card as needed.  Select a role:  One person plays the medical student (or junior resident)  One person plays the resident  One or more people are the observers  The learner and the observer(s) should provide feedback and suggestions at the end of each case.  After each case, rotate roles (clockwise). Every person should play the role of the resident at least once.  **Be ready to discuss your experiences when we return for large group discussion (write down some key impressions):** |

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| RasT Apple | **Case #1** |

Actors: Jan: A third-year medical student.

Pat: A first-year resident on the inpatient service.

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| Pat: | Jan, tell me about the patient you admitted this morning? |
| Jan: | OK... Let’s see... Where are my notes? Oh, yeah. His name is Mr. Holton. He’s in his 60s. He has been short of breath for three days and has a cough with cloudy, yellow sputum. He has smoked two packs per day for forty years. He also has home oxygen. |
| Pat: | Any other medical problems? Heart disease? Stroke? Cancer? |
| Jan: | (Looks at notes) Well, he had a myocardial infarction two years ago. He has high blood pressure and takes Norvasc. He also takes albuterol, atrovent, aspirin, and thyroid supplements. He cannot take ACE inhibitors because they give him a cough. |
| Pat: | What about his exam? |
| Jan: | Well, he was sitting up in bed, propped up on his arms... as if... he was working to breathe. BP was 156/90, HR was 110, and temperature was 98.9. He was using his accessory muscles a little. His chest was hyperinflated. I could barely hear his lung sounds. All I could hear was some rhonchi and some high-pitched expiratory wheezes. I couldn't hear his heart sounds. His abdomen was somewhat distended, but not tender. His legs had some edema, and his feet looked purplish. |
| Pat: | Any jugular venous distension? |
| Jan: | I didn’t check for that. |
| Pat: | Well, how about O2 saturation? |
| Jan: | 86% on room air, but now 96% on oxygen at 5 liters (smiles) |
| Pat: | Did we check a blood gas when he was admitted? |
| Jan: | No, they didn't get one in the E.D. either. |
| Pat: | Let's get one. How about his chest x-ray? |
| Jan: | Oh yeah! He was really hyperinflated. The E.D. physician said he thinks there’s a little infiltrate behind the heart. |
| Pat: | OK. Well, go ahead and write for that blood gas. |
| Jan: | Right. I'll do that right now. |
| Pat: | Great! Anything else? |
| Jan: | No, that’s it. |

What can you say to “**Get a Commitment**?” Continue the dialogue and practice the 5 Microskills…

**Get a Commitment**

***Cue:***

The learner presents the facts of the case and *stops*, waiting for you to offer an interpretation. The learner, in effect, does not present an assessment.

Response:

* *Resist the urge to fill in the verbal blank.*
* Ask the learner what *they* think, instead.
* Use this to observe the learner's problem solving skills.
* Getting a commitment must not be confused with collecting further data about the case.

Rationale:

* Learners must not only learn to collect data, they must also learn to process the data and personally formulate an assessment.
* Learners will feel more responsibility for patient care, and will enjoy a more collaborative role in problem solving.
* Failure to commit to an assessment indicates that the learner has not processed the information, is afraid to expose a weakness, or is dependent on the thinking of others.

Examples:

* "What diagnosis is at the top of your differential?"
* "What laboratory tests do you feel are indicated?"
* "What would you like to accomplish during this visit?"
* "Why do you think the patient has not taken his medication?"

Non-Examples:

* "Sounds like bronchiolitis, don't you think?" (Preceptor has offered own opinion and asked for concurrence.)
* "Anything else?"
* "Did you find out which symptom came first?" (Preceptor is asking for more data, and is taking over the process of problem solving.)

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| RasT Apple | **Case #2** |

Actors: Jerry: A fourth-year medical student

Noel: A resident in the ED

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| Jerry: | Noel, I just saw a 32-year-old woman who has back pain. Yesterday she was in her garden. She did a lot of digging, and she carried some bags of peat moss and some plants out to her back yard. This morning when she woke up, her back was so painful she could hardly get out of bed. She had to crawl on her hands and knees to the bathroom. She took some Motrin, but it didn’t help much. |
| Noel: | Has she ever had anything like this before? |
| Jerry: | No. She has had a few backaches from time to time, but never anything like this before. |
| Noel: | Any underlying illnesses like diabetes, early menopause, hysterectomy, or cancer? |
| Jerry: | No. |
| Noel: | OK. So, tell me about her pain. |
| Jerry: | It's mainly in her lower back. She says she feels the pain down into the gluteal area on the right, but it doesn't radiate into her leg. |
| Noel: | Does the pain change with movement? |
| Jerry: | It hurt when she stood up in the exam room. |
| Noel: | What did her neuro exam show? |
| Jerry: | Her strength testing in her legs was OK. Her DTR’s seemed to be the same on both sides. I checked for sensation and it seemed the same over both feet. |
| Noel: | How far can you raise each leg with the knee extended? |
| Jerry: | I could raise her right leg to about 70 degrees and the left leg a little higher. |
| Noel: | So, what do you think is causing her pain? |
| Jerry: | Well, her pain did go down into the gluteal area on the right. That seems like radiation. It could be muscle spasm... a herniated disk... it could be a compression fracture, but I doubt that.  What bothers me is that her pain is just so severe. It just seems too severe to be musculoskeletal pain. I want to get an MRI of her back and look to see if she has a herniated disk and send her home on oxycontin. |

What can you say to “**Probe for Supporting Evidence**?” Continue the dialogue and practice the rest of the Microskills…

**Probe for Supporting Evidence**

***Cue:***

The learner commits to an assessment or a particular stance, and then looks to you for confirmation. You may or may not agree with the opinion and your instinct is to tell them outright what you think.

Response:

* *Resist the urge to pass judgment on the opinion just stated*.
* Ask the learner, "What evidence supports your assessment?"
* An alternative method is to ask the learner, "What other diagnoses did you consider, and what evidence supported or refuted each of these alternatives?"

Rationale:

* Probing for evidence forces the learner to demonstrate his/her own problem solving skills.
* Probing for evidence reveals what the learner knows and where any gaps in knowledge are. In this way, opportunities for teaching are identified.
* "Thinking out loud" should be a low-risk way for learners to make mistakes.

Examples:

* "What were the major findings that led to your diagnosis?"
* "What else did you consider? What kept you from that choice?"
* "Why did you choose that particular medication?"

Non-Examples:

* "I don't think this is milk intolerance. Do you have any other ideas?" (Preceptor states his/her judgment of the learner's thinking.)
* "Is there any suprapubic tenderness or costovertebral tenderness?" (Preceptor takes over the process of problem solving.)
* "What are the possible causes of abdominal pain?" (Preceptor has started an oral examination about the problem.)

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| RasT Apple | **Case #3** |

Actors: Sidney: A sub-intern who is on call.

Carol: A resident.

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| Carol: | Can you tell me about that new admission yet? |
| Sidney: | Sure. He's a 72-year-old man who lives at home, and cared for by his wife. His problems include hypertension, hyperlipidemia, type II diabetes, obesity, cigarette smoking, chronic bronchitis, coronary artery disease, congestive heart failure, peripheral vascular disease, and chronic renal insufficiency. And he had a stroke, too, but that's pretty much resolved... |
| Carol: | I understand that his wife brought him to the hospital? |
| Sidney: | Yeah. His wife says he's been getting short of breath for the last three days and having trouble sleeping. He hasn’t been up out of bed for the last two days. She also says he looks puffy and his legs are swollen. |
| Carol: | Any cough? Fever? |
| Sidney: | He has been coughing and has a little sputum production. He didn't have any chills, sweats, or chest pain. |
| Carol: | What are his meds at home? |
| Sidney: | Vasotec... aspirin... Zocor... Amaryl... Atrovent and Albuterol... Lasix and potassium. By the way, he's out of Lasix. |
| Carol: | Really! Has his weight gone up? |
| Sidney: | I’m not sure. His wife doesn't check his weights. |
| Carol: | What did you find on exam? |
| Sidney: | Right now, he's sitting up in bed. He looks short of breath. His respiratory rate is 24. Temperature is 98.8. He has distended neck veins. I can hear crackles and a few wheezes in both bases. His heart sounds are distant. He has some pitting edema in his lower extremities. They put a Foley in him in the E.D. but he hasn't made any urine. I went ahead and gave him a saline bolus to get his urine output up. |
| Carol: | I see... (pauses) Does he have a Durable Power of Attorney for Health Care? |
| Sidney: | I didn’t ask. I didn't see one on his chart. We are waiting on blood gases and a CXR. I also gave him some Rocephin. |
| Carol: | So, do you think this is due to an infection? |
| Sidney: | Well, (pauses)... His chest X-ray could be due to anything... An infection *could* cause this... I mean, how would you know? |

What can you say to “**Teach a General Rule**?” Continue the dialogue and practice the rest of the Microskills…

Teach a General Rule

***Cue:***

After observing the learner's problem solving skills, you have identified gaps or mistakes in the learner's knowledge, logic, or connections, or you have determined that you know something about the case, which the learner needs or wants to know.

Response:

* At last, it is time to "teach" (i.e., give information).
* Present information in the form of general rules, principles, or concepts.
* Target the information to the learner's level of understanding of the problem.
* *Don't give a mini-lecture.*
* Avoid anecdotes and idiosyncratic preferences.
* If the learner has performed well and the preceptor has no new information to add, then skip this Microskill.

Rationale:

* Understanding and attributing meaning to information clearly improves the ability to recall and use that information.
* General rules can be applied to other cases with similar attributes.
* If neither the learner nor the preceptor has the necessary information, then teach how to access resources and evaluate the information obtained (Evidence-based Medicine skills).

***Examples:***

* "A severe exacerbation of COPD raises pulmonary vascular resistance which decreases LV filling. This, in turn, decreases renal perfusion and urine output, which leads to edema and hyponatremia."

Non-Examples:

* "I'm convinced that bedrest is still the best treatment for this child. Also, let’s give him some carnitine, and don't give him too much fluid."

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| RasT Apple | **Case #4** |

Actors: Jo: A fourth-year medical student.

Erin: A first-year resident on the inpatient service.

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| Erin: | So, Jo, did you read about deep vein thrombosis? |
| Jo: | Yeah. I found an issue in the journal *Chest* that had all these guidelines for management of deep vein thrombosis. |
| Erin: | What did you find out? |
| Jo: | Well, the guidelines say that uncomplicated DVT can be treated at home with low molecular weight heparin if the patient is at low risk for complications. |
| Erin: | Do you think Mr. Littman could go home on Lovenox? |
| Jo: | Well, his vital signs are normal. He has no prior history of bleeding. His renal function is normal. His wife is an LPN and can give shots. Also, she knows how to monitor for any signs of embolism or bleeding. |
| Erin: | OK. Let's plan to send him home on Lovenox. |
| Jo: | I thought you'd say that, so I already gave the home teaching nurse a call. She is going to drop by his room this afternoon and show his wife how to give the shots. Also, I talked to the discharge planner and we checked with his insurance company. If he goes home, they will cover the cost of the Lovenox. Oh, and I called his outpatient physician, and he can see him in clinic this Friday. |

What can you say to “**Reinforce what was done right**?”  Reinforce what was done right

***Cue:***

The learner has handled a situation in a very effective manner that resulted in helping you, patients, colleagues, or the clinic. The learner may or may not realize that the action was effective and had a positive impact on others.

Response:

* Take the first chance you find to give reinforcing feedback on the specific good work and the effect that it had.
* Focus on the specific behavior.
* Avoid general praise.

Rationale:

* Skills in learners are not well established. Therefore, learners are impressionable and "vulnerable". Unless reinforced, competencies may never be firmly established.
* Recognizing good performance builds a reservoir of respect and trust from which a teacher can draw when it is necessary to give constructive feedback or correct a mistake.

Examples:

* "You considered the patient's nutritional status. That may improve her strength and immunocompetence during the post-operative course."
* "Thanks for volunteering for the selection committee. Now I don't have to appoint someone and wonder about their commitment to the job."

Non-Examples:

* "You are absolutely right. That is a wise decision."
* *"Good job!"* (General praise, not specific to the task performed)
* "You did that skin biopsy very well." (Still not specific to the task performed).

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| RasT Apple | **Case #5** |

Actors: Chris: An intern.

Jean: A senior resident.

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| Jean: | Say, Chris. How about our 82-year-old man in 3450? |
| Chris: | Oh, he’s not doing so well this morning. The on-call team was called to see him twice last night. He was short of breath so they increased his FIO2, gave him two doses of Lasix, and started him on Natrecor. They also gave him two nebulizer treatments, but it didn't seem to help very much. |
| Jean: | I see that his T-max is 102 today, and his oral intake is zero. |
| Chris: | Yeah, I saw that. This morning he looked lethargic, weak, and he remains confused. His lungs sounded really junky, and he wasn't moving air. He was coughing up lots of secretions. So far, all of his cultures are negative. |
| Jean: | I see... Have you talked with his family today? |
| Chris: | His son was in the room this morning and I talked with him. He was really worried. The older daughter will be in later this morning. Would you like to talk with her? |
| Jean: | Yeah. We need to talk with them about how bad the outlook is at this time. Anything else? |
| Chris: | He hasn't eaten anything, so I put down a small-bore feeding tube this morning. I checked a KUB and the tube is in good position. |
| Jean: | A feeding tube… Did you talk to his family about that? |
| Chris: | Well, when I was talking to the son he said that he was worried because he had not eaten anything. So, I thought some nutrition would be a good idea. I think the family would be in favor of nutrition. |
| Jean: | Um hum… I see that he is now on a Bi-PAP mask. |
| Chris: | Yeah, I told the respiratory therapist to start that. |
| Jean: | I guess you didn't talk to the family about that either? |
| Chris: | Well, when I talked with them yesterday, they said that they wanted us to do everything possible for him. I don’t think they would want us to withhold any therapy that might be of benefit. And it might make him more comfortable. |

What can you say to “**Correct Mistakes**?”

**Correct Mistakes**

***Cue:***

The learner's presentation demonstrates a misunderstanding or error that may have an impact on patient care or the learner's own effectiveness. Teachers are typically reluctant to let mistakes go by without comment, and will use these as opportunities to open up discussion and bring home important points.

Response:

* Give constructive feedback by describing specifically what was wrong, and how to avoid or correct the error in the future.
* If the mistake was serious, as soon as possible find an appropriate time and place to talk with the learner.

Rationale:

* Mistakes left unnoted have a good chance of being repeated.
* Learners who are *unaware* of their mistakes obviously have not seen that their action has had an undesirable consequence. In order to see their mistake, the consequence as well as the correction must be pointed out to them.
* Learners who are *aware* of a mistake are in a "teachable" state. They are eager for and appreciative of tips that will help them prevent the mistake from occurring again.

Examples:

* "That dose of gentamicin is too high for a patient with decreased renal function. Check with the clinical pharmacologist first when you do not know the correct dose."
* "You may be right that this child's symptoms are due to a viral URI. But you can't be sure it isn't otitis media unless you've examined the ears.

Non-Examples:

* *"You did what?"*
* "Those lab tests were completely unnecessary."

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| |  |  | | --- | --- | | Image result for doctor stick figure introduction clip art | Small Group Exercise – Role Play:  Giving Feedback | |  |

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| j0217102 | **Assignment:**  Use three to five of the following case scenarios to practice the new feedback sandwich (you will be instructed which five cases your group should use). You should utilize impromptu dialogue to practice, based on the scenarios. Use the included guide/pocket card as needed.  Select a role:  One person is the feedback recipient  One person provides the feedback (using new feedback sandwich)  One or more people are the observers  The feedback recipient and the observer(s) should provide feedback and suggestions at the end of each case.  After each case, rotate roles (clockwise). Every person should provide feedback at least once.  **Be ready to discuss your experiences when we return for large group discussion (write down some key impressions):** |

1. You have received three complaints from patients over the last month about one of your students, Bill. Patients feel that Bill often seems hurried and does not appear to listen to the details of their concerns. In answering patients’ questions, he seems annoyed and evasive.

2. Prior to entering medical school, Marci had extensive work experience as a mental health counselor. She has always developed great rapport with patients, who seem to love her. You are concerned because her medical knowledge is significantly less than the average student’s is. In clinic, you note that Marci often focuses on the social history at the expense of other pertinent information in her interviews with patients and her presentations to you.

3. One of your students, Scott, has logged an average performance about which you are not particularly concerned. However, you have noted that he does not comb his hair, his shirts often have coffee stains on them, and his white coat is badly wrinkled. His body odor, at times, is offensive.

4. Sarah is one of the students on your team. She is quiet and painfully shy. She seems competent with patient care and her patient assessments are very good. She rarely says a word except when she is presenting her own patients. Her presentations are frequently brief, and her eye contact during them is poor. When you ask her a direct question, she answers, however she does not articulate questions independently.

5. Kent has frequently called upon his peers for coverage. The problems have ranged from a true illness to a friend’s wedding and everything in-between. When asked to repay those who cover him, Kent has a list of excuses explaining why he cannot pay back his colleagues.

6. Your colleague, Joe, just finished a difficult month with the students on your rotation. Joe confides in you that it was difficult for him to write detailed evaluations of his students’ performance, and that his evaluations from students included comments about their lack of meaningful involvement in patient care. You have noticed that Joe frequently ignores students and appears aloof. Joe asks how your evaluations were, and when it becomes apparent that your good work with students has been noted, he comments: “I’m not gonna coddle students to get good evaluations.”

7. A colleague with whom you enjoy a good rapport makes a presentation to the department that is received by the audience as boring, too esoteric, and not clinically relevant. Additionally, your friend’s delivery lacks enthusiasm; his eye contact is poor and his voice is monotone. He is perceptive enough to discern the audience members’ disinterested response, and asks you what you thought about it.

8. You are about to give a 3rd year medical student midpoint feedback. He is caring, empathetic and an excellent team member- always willing to chip in and very dedicated to his patients. His primary problem is poor clinical reasoning manifested by an inability to formulate a good DDX and plan. His oral presentations are otherwise accurate, concise and organized. The student is very interested in receiving feedback and eager to improve. (Developed by Eva Aagaard and Charles Rossi, University of Colorado)

9. You are one of two interns on an inpatient team, which also includes a resident, and two third-year medical students. One of the students, Sam, is on your team. Sam is very outgoing, punctual, efficient, and thorough in his assessments/plans. Overall, he is hardworking, intelligent and a positive student. However, you have noticed that as he has gotten to know the resident and other intern (who is female) a little better as the rotation has gone on, he has become flirtatious and inappropriate with them. Although no one has complained, you have seen him putting his arms around them (which appeared to make them uncomfortable) and telling inappropriate jokes on more than one occasion.

Although Sam behaves very appropriately on rounds and in front of the attending, you are a little concerned about these behaviors that you have witnessed. You decide to meet to discuss the behavior with Sam before taking it to a higher level.

(Adapted from a case developed by Alex Duckworth, Class of 2007, UF)

10. Your sub-intern has the day off and you are writing notes on her patients. You discover that she appears to be cutting and pasting notes from day to day, and that there are significant inaccuracies in the notes in regards to meds, PE and plan. Her oral presentations, plans of care and ability to follow through on plans have all been excellent. So you are quite surprised by this. The following day you are scheduled to give her feedback. The sub-intern denies your allegations and is defensive.

(Developed by Eva Aagaard and Charles Rossi, University of Colorado)

\*Above cases developed (except where noted) by Linnea Hauge, PhD, University of Michigan

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| Image result for stethoscope apple clipart | References for workbook (see additional updated references for presentation in PowerPoint i.e. 2011-2016 references) |

1. Personal Presentation, Association of American Medical Colleges, 1998 Annual Conference, New Orleans, Louisiana
2. Koen FA Vivian AS. Learning the Skills of Clinical Pharmacy Teaching. Am J Pharm Educ 1980; 44: 61-5.
3. Jon O. Neher, Katherine C. Gordon, Barbara Meyer, Nancy Stevens, a Five-Step "Microskills" Model of Clinical Teaching, Journal of the American Board of Family Practice, Vol. 5, No. 4, pp. 419- 423. (July-August 1992)
4. Thomas L Schwenk, Neal Whitman, Residents as Teachers: A Guide to Educational Practice, University of Utah press, 1993.
5. Jack Ende, Feedback in Clinical Medical Education, JAMA, Vol. 250, No. 6, pp. 777- 781 (August 12, 1983)
6. Ferenchick G, et al, Strategies for Efficient and Effective Teaching in the Ambulatory Care Setting, Academic Medicine, Vol. 72, No. 4, pp. 277- 280 (April 1997)
7. Smith CS, Irby DM, The Roles of Experience and Reflection in Ambulatory Care Education, Vol. 72, No. 1, pp. 32- 35 (Jan. 1997)
8. Irby, David M, Conference Presentation, Workshop on Faculty Development, Orlando, Florida 1999
9. An excellent on-line bibliography can be found at: <http://aamcinfo.aamc.org/about/gea/sigs/resteach.htm>
10. Bringing Education & Service Together (BEST); Clinical Teaching Skills Curricula; University of California, Irvine: *http://www.ucimc.netouch.com/Content/ContentMenu.asp*

*This workbook has been adapted from the Resident as Teacher’s Workshop Workbook compiled by Dr. Gordon Woods with permission.*