Association of University Professors of Neurology

AUPN Neurology Clerkship and Program Directors Workshop 2014

Back to Basics: Evaluation and Feedback

Sunday, April, 27, 2014 ~ 6:30-8:30 am

Philadelphia Marriott Downtown
1201 Market Street
Philadelphia, PA 19107
Meeting Room: 405

Course Directors:
James M. Stankiewicz MD, Harvard Medical School
Jeffrey C. McClean MD, San Antonio Military Medical Center

Course Description:
Both the novice educator and the seasoned veteran of many years can benefit from revisiting the way they evaluate trainees and provide feedback. It is only fair to our students that we evaluate as accurately as possible given high stakes residency or fellowship placement. It is also requisite that we give the best possible feedback to promote professional development. In this course two experts bring educators up-to-date on current understandings in evaluation and feedback. Educators will also learn from their colleagues about approaches that work. We intend to empower course attendees to do both evaluations and feedback better. Open to both clerkship and program directors.

Agenda

6:30-7:00 **State of the Art Evaluation**
Speaker: C. Jessica Dine, MD, University of Pennsylvania

7:00-7:20 **Small Group Case Exploration**
Facilitator: James M. Stankiewicz, MD, Harvard Medical School
- Challenge 1: The "un-deserved" grade
- Challenge 2: Is it an Honors or a High Pass?

7:20-7:50 **State of the Art Feedback**
Speaker: Judy A. Shea, PhD, University of Pennsylvania

7:50-8:10 **Feedback on Feedback: Dual Practice Session**
Speaker: James M. Stankiewicz, MD, Harvard Medical School

8:10-8:30 **Small Group Case Exploration**
Facilitator: Jeffrey C. McClean, MD, San Antonio Military Medical Center
- Challenge 3: Is it the same student? Discrepancies in evaluation
- Challenge 4: How to motivate unmotivated faculty

Faculty Biographies

Dr. James M. Stankiewicz

Harvard Medical School

Dr. Stankiewicz is an Assistant Professor of Neurology at Harvard Medical School. He is Neurology Clerkship Director at Brigham and Women's Hospital. He also co-directs the multiple sclerosis fellowship program at the Partners MS center.

Dr. Stankiewicz received his AB from the University of Chicago in 1993 in the Biological Sciences with a specialization in Neurosciences, graduating Phi Beta Kappa. He earned his MD at Loyola University Medical School. He completed medical internship at Mt. Auburn hospital and neurology residency at Tufts. He was a post-doctoral research fellow in the neuroimaging of multiple sclerosis under the guidance of Rohit Bakshi, MD.

Dr. Stankiewicz has authored or co-authored over twenty scholarly works. He co-edits Multiple Sclerosis: Principles of Diagnosis and Treatment, currently the best selling textbook in the field.

Dr. Jeffrey C. McClean

San Antonio Military Medical Center

Dr. C. Jessica Dine

University of Pennsylvania

Dr. Dine is an Assistant Professor in the Division of Pulmonary, Allergy and Critical Care at the Perelman School of Medicine at the University of Pennsylvania. She is also an Associate Program Director for the Internal Medicine Residency Program. Dr. Dine's clinical focus is on consultative pulmonary medicine. Her research interests include understanding and measuring the formation of practice patterns and creating measures of supervision, influence and training in medical education.

Judy A. Shea, Ph.D.

University of Pennsylvania

Judy A. Shea, Ph.D. is Professor in the Division of General Internal Medicine, Department of Medicine, University of Pennsylvania. She is Interim Chief, General Internal Medicine, Associate Dean of Medical Education Research and Director of the Office of Evaluation and Assessment in the Academic Programs Office, School of Medicine. She serves duals roles, working with faculty and fellows to design and evaluate research projects, and directing the evaluation of the medical school curriculum and faculty. Much of her work focuses on evaluating the psychometric properties of curriculum evaluation tools and developing measures to assess components of health such

State of the Art Evaluation

Dr. C. Jessica Dine

University of Pennsylvania

Objectives:

1. Define milestones and Entrustable Professional Activities (EPA)
2. Detail a practical example of how to develop a Next Accreditation System (NAS)-ready evaluation system
3. Evaluate potential barriers to implementation

State of the Art Evaluation

AUPN Neurology Clerkship and Program Directors Workshop 2014

April 27th, 2014

C. Jessica Dine, MD MSPHR

Penn Medicine

Three Key Questions

- **Why assess?**
- **What to assess?**
- **How best to assess?**

Why assess?

Assessment vs. Evaluation

- **Assessment**
  - Gather information about level of performance
  - Is learning occurring?

- **Evaluation**
  - Compare achievements with others or with a set of standards
  - Were (learning) objectives met?

Purpose of Assessment

Before	During	After

Purpose of Assessment

Before	During	After
Needs assessment	Motivate learners/drive learning	Quality assurance of program/ trainee (public accountability)
Develop learning strategy	Assure effective teaching	Judge program quality
Necessary to determine how learners change	Identify learning gaps/gauge progress	Redesign programs
	Assess competence	Choosing applicants for advanced training
	Feedback	Accreditation requirement
	Grades	

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During SJ. TLM 2007. Epstein RM. NEJM 2007.

What to assess?

How to Define Success?

“I would be happy about my learner if I knew that. . .”

- External definitions (ACGME, LCME)

- Internal definitions

External Definitions

- Core competencies
- Curricular milestones
- Entrustable professional activities/EPAs
- Reporting milestones/narratives

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ACGME Core Competencies

- Patient care
- Medical knowledge
- Communication
- Professionalism
- Systems based practice
- Practice based learning and improvement

ACGME

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Definitions

Curricular Milestones

- **Provide granular detail for focused assessment and feedback**

- **Observable developmental steps from novice to expert**
  - "intuitively known"

Entrustable Professional Activities

- **Activities the public trusts that all physicians are capable of doing**
- **Address authentic practice in the work place**
- **Provide context for faculty to perform a meaningful assessment**

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Core Professional EPAs for Entering Residency

1) Gather a history and perform a physical exam
2) Develop a prioritized differential diagnosis and select a working diagnosis following a patient encounter
3) Recommend and interpret common diagnostic and screening tests
4) Enter and discuss patient orders/prescriptions
5) Provide written documentation of a patient encounter in written or electronic format
6) Provide an oral presentation/summary of a patient encounter
7) Form clinical questions and retrieve evidence to advance patient care

AAMC

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CEPAER

8) Give or receive a patient handover to transition care responsibility to another healthcare provider or team
9) Participate as a contributing and integrated member of an inter-professional team
10) Recognize a patient needing urgent or emergent care, initiate evaluation, treatment, seek help
11) Obtain informed consent for tests/procedures that the day 1 intern is expected to perform or order without supervision
12) Perform general procedures of a physician
13) Identify system failures and contribute to a culture of safety and improvement

AAMC

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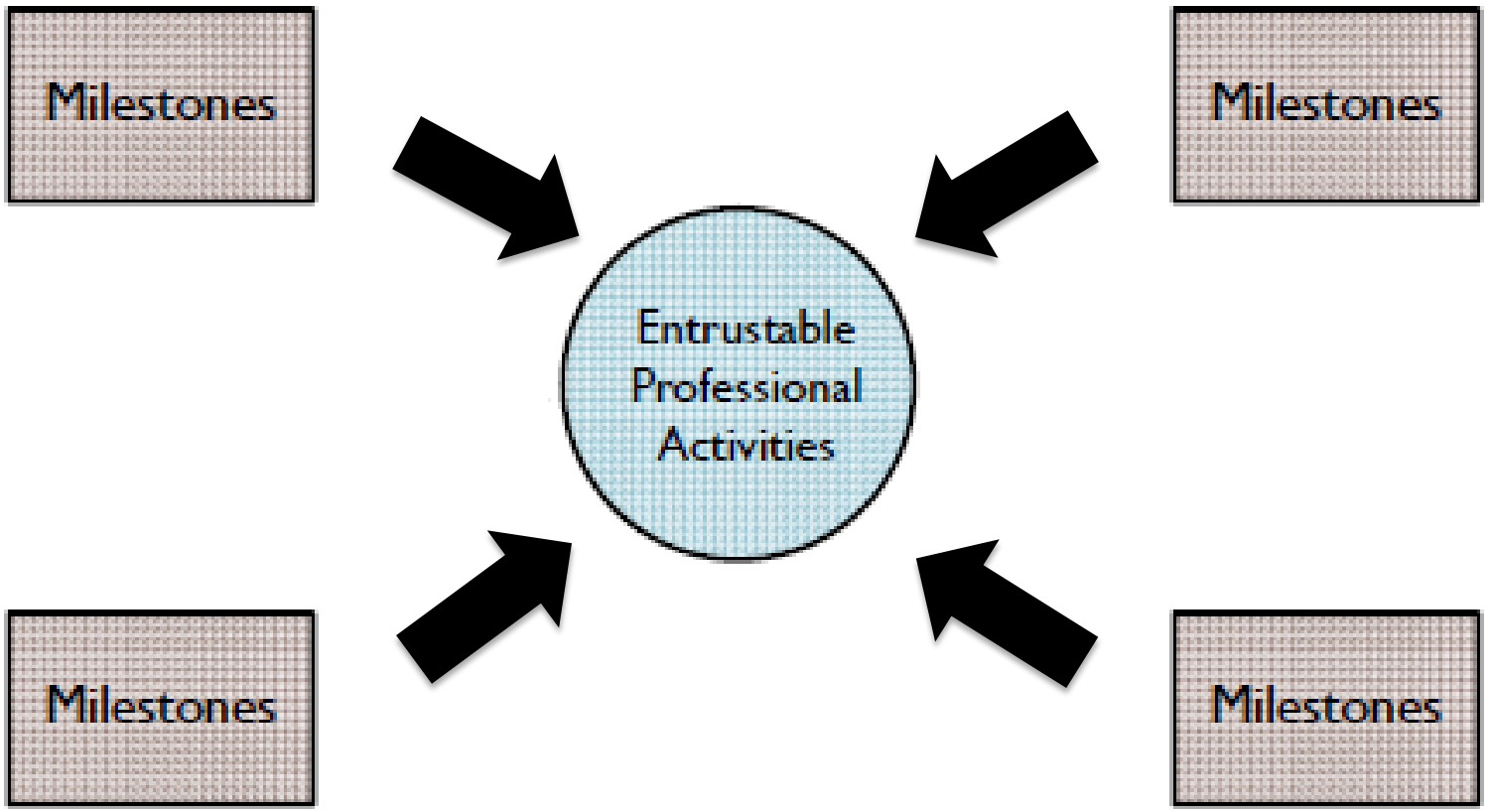
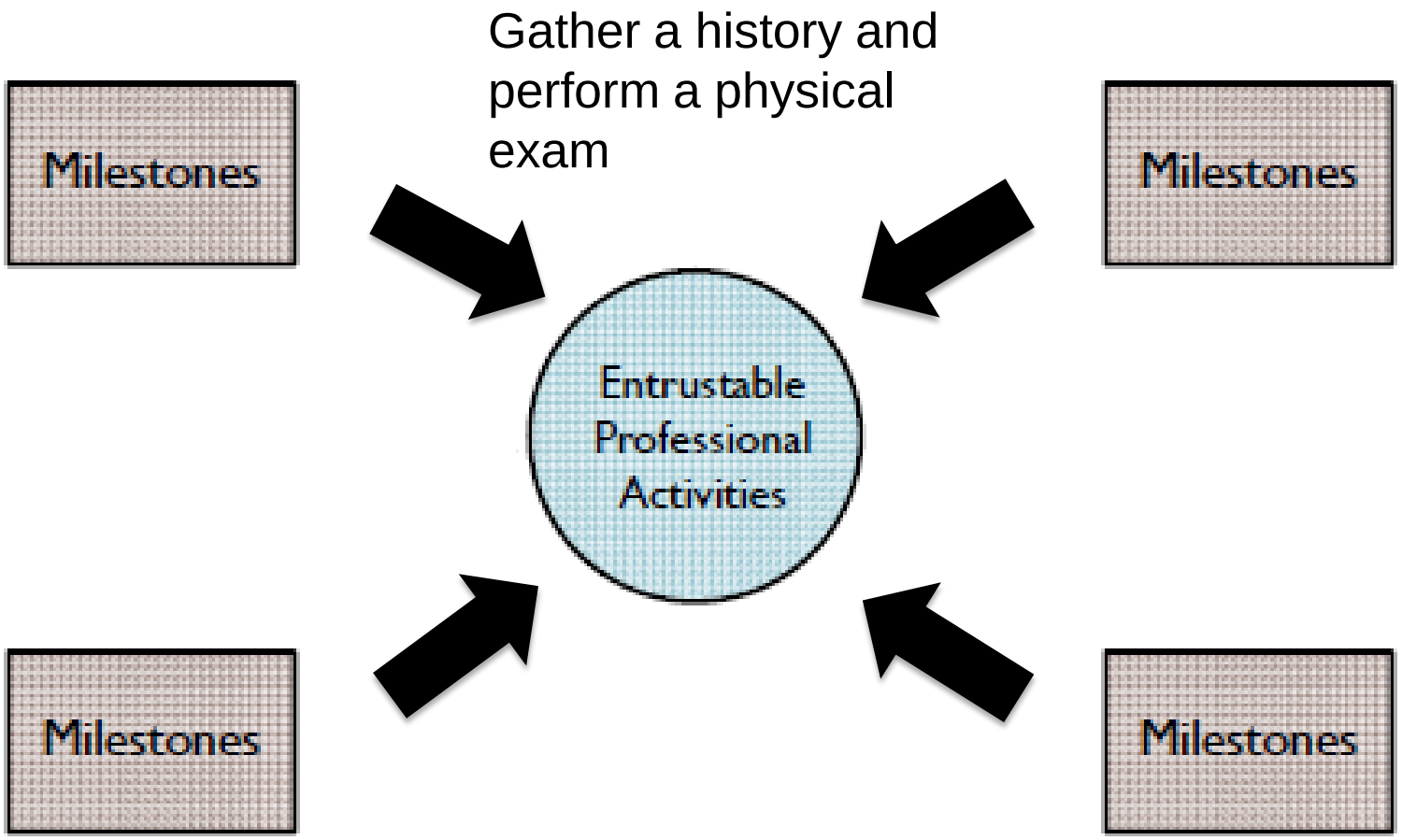
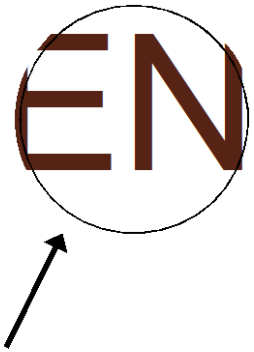
Curricular Milestones and EPAs



Curricular Milestones and EPAs



EPA – Develop a safe discharge plan



Teach patient regarding self-care

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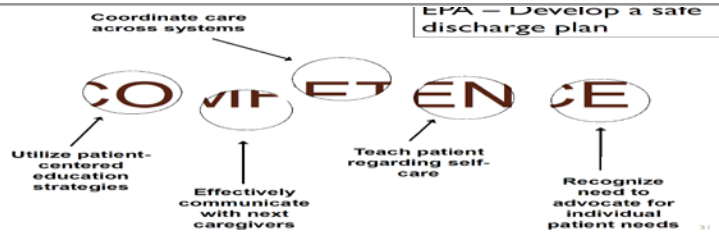

Coordinate care across systems

Utilize patient-centered education strategies

Effectively communicate with next caregivers

Teach patient regarding self-care

Recognize need to advocate for individual patient needs

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Definitions

Reporting Milestones (n=29)

- **Outcomes that document developing competence over the course of training**
- **Should be informed by meaningful assessment data**

Patient Care
1. History
2. Neurological exam
3. Management/treatment
4. Movement disorders
5. Neuromuscular disorders
6. Cerebrovascular disorders
7. Cognitive/behavioral disorders
8. Demyelinating disorders
9. Epilepsy
10. Headache syndromes
11. Neurologic manifestations of systemic disease
12. Child neurology for the adult neurologist

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13. Neuro-Oncology
14. Psychiatry for the adult neurologist
15. Neuroimaging
16. Electroencephalogram (EEG)
17. Nerve conduction studies (NCS)/Electromyography (EMG)
18. Lumbar puncture
Medical Knowledge
19. Localization
20. Formulation
21. Diagnostic investigation
Systems-based Practice
22. Systems thinking, including cost and risk effective practice
23. Work in inter-professional teams to enhance patient safety

Practice-based learning and Improvement
24. Self-directed learning
25. Locate, appraise, and assimilate evidence from scientific studies related to the patient's health problems
Professionalism
26. Compassion, integrity, accountability, and respect for self and others
27. Knowledge about, respect for, and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice
Interpersonal and Communication Skills
28. Relationship development, teamwork, and managing conflict
29. Information sharing, gathering, and technology

Epilepsy — Patient Care				
Level 1	Level 2	Level 3	Level 4	Level 5
• Recognizes when a patient may have had a seizure	• Identifies epilepsy phenomenology, and classification of seizures and epilepsies • Diagnoses convulsive status epilepticus	• Diagnoses and manages common seizure disorders and provides antiepileptic drug treatment • Diagnoses non-convulsive status epilepticus • Manages convulsive and non-convulsive status epilepticus	• Diagnoses uncommon seizure disorders • Appropriately refers an epilepsy patient for surgical evaluation or other interventional therapies	• Manages uncommon seizure disorders • Engages in scholarly activity in epilepsy (e.g., teaching, research)
☐	☐	☐	☐	☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Internal Definitions

- Core competencies
- Curricular milestones
- Entrustable professional activities/EPAs
- Reporting milestones/narratives
- Clerkship objectives

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How to assess?

Common Assessment Methods

- **Descriptive evaluation by teachers**
- **Records of clinical encounters**
- **External/ internal evaluations**
  - MCQ
  - Key features/script concordance
  - Short answer questions/essays
- **Simulations**
- **OSCEs**
- **Checklists**
- **Rating scales**
- **Oral examinations**
- **Chart (record) reviews**
- **Standardized patients**
- **A-V reviews**
- **Educational prescription contracts**
- **Portfolios**
- **360° evaluation**
- **Patient logs**

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How to Choose?

Nothing is Perfect

Reliability and Validity

Not reliable
Not valid

Reliable
Not valid

Reliable
Valid

Utility Index

Utility = educational impact x reliability x validity

x cost effectiveness x acceptability

van der Vleuten CP. Adv Health Sci Educ 1996.

Common Assessment Methods

Assessment method	Advantages	Disadvantages
Descriptive evaluations	In-depth knowledge	Reliability
Formal (external) examinations	High quality	May not match local objectives Monetary cost
Local (internal) examinations	Match local objectives	Faculty time May be lower quality
Checklists	Useful for procedures/ specific events Little guesswork	Simplistic Rater training
Rating scales	Quantify important qualitative factors	"Halo" effect (leniency)
Standardized patients	Realistic Excellent feedback Reliable	SP training/calibration Monetary cost
360° evaluation	Broad array of data	Need raters

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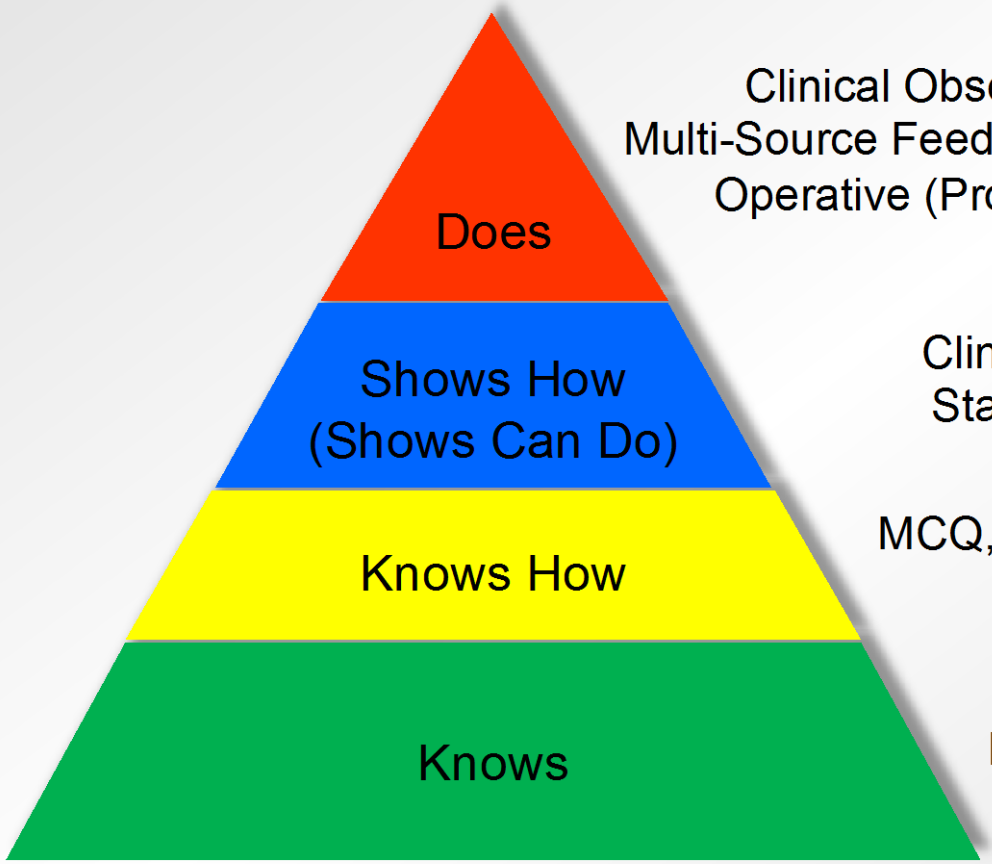
Millers Pyramid



Clinical Observations, Mini CEX,
Multi-Source Feedback, Teamwork Evaluation,
Operative (Procedural) Skill Evaluation

Clinical Observation, Simulation,
Standardized Patients, Mini CEX

MCQ, Oral Examinations, Standardized
Patients

MCQ, Oral Examinations

van der Vleuten, CPM, Schuwirth, LWT. Assessing professional competence: from Methods to Programmes. **Medical Education 2005; 39: 309–317**

ACGME

Recommendation	Example
Broad, Systematic Sampling	Plan multiple observations (may be brief), multiple settings, includes simulations; ideally, 7-10 ratings
Observation by Multiple Raters	Addresses "idiosyncrasies" of single raters
Keep Rating Instruments Short	For progress decisions (grades): 5-10 items plus global rating; when feedback is goal, make form specific to event rated
Separate Appraisal for Teaching, Learning, and Feedback from Appraisal for Promotion	Feedback should be immediate, not saved for written comments on end of rotation rating form
Encourage Prompt Recording	Record observations during the clerkship, as they occur
Supplement Formal Observation with Unobtrusive Observation	Using nurse and patient observations
Consider Making Promotion and Grading Decisions via Group Review	Broadens base of knowledge, perspectives; more likely to make "tough" decisions
Supplement Traditional Clinical Performance Ratings with Standardized Clinical Encounters and Skills Training and Assessment Protocols	Allows all members of group to have clinical skills assessed in standard manner; comparisons to peers and gold standards possible

Recommendation	Example
Educate Raters	Familiarize raters with forms; Provide frame of reference training
Provide Time for Rating	Gather raters together to accomplish ratings (e.g., Evaluation Sessions)
Encourage Raters to Observe and Rate Specific Performances	Use of mini-CEX form (from American Board of Internal Medicine)
Use No More than Seven Quality Rating Categories	Discourage two-level rating (e.g., 1-3 unsatisfactory, 4-6 satisfactory)
Establish the Meaning of Ratings	Use consistent rating form; did forms help identify excellent or poor performers (e.g., those asked to leave program); provide descriptors
Give Raters Feedback about Stringency and Leniency	Let them know how they compare to others
Learn from Other Professions	Aviation, clergy, military; team performance
Acknowledge the Limits of Ratings	Insufficient by themselves to assess clinical competence

Three Key Questions

- **Why assess?**
- **What to assess?**
- **How best to assess?**


TIGER
I TAUGHT STRIPE HOW TO WHISTLE
I DON'T HEAR HIM WHISTLING
I SAID I TAUGHT HIM. I DIDN'T SAY HE LEARNED IT
BUD BLAKE

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QUESTIONS?

AUPN Neurology Clerkship and Program Directors Workshop 2014
Back to Basics: Evaluation and Feedback

Learning objectives

Small Group Case Exploration
1. Develop a consistent approach to challenging evaluation situations
2. Learn strategies to make difficult grading situations less stressful
3. Gain exposure to how others think about grading

Small Group Case Exploration

Challenge 1: The "un-deserved" grade

Your clerkship coordinator sends you the grades for last month's students. You scan the spreadsheet and see that Joe Smith has performed poorly, below the cut-off for passing. Floor evaluation scores are low but written comments collected on the evaluations do not converge on specific behaviors that were concerning. There are a few comments about how Joe's presentations were lackluster but improving. His shelf score is in the lowest 5th percentile nationally.

1. How would you approach this situation? What are the issues here?

2. Is there any more information you would collect? Would you fail the student or take a different approach?

You tell Joe about his substandard performance and your decision about his grade. He tells you that he is surprised to hear this and very upset. He wishes to meet with you to review his performance.

3. Would you prepare for this meeting? If so, how?

Challenge 2: Is it an Honors or a High Pass?

That same month you see on the spreadsheet that Sara Jones is on the borderline between high honors and honors. Your cutoff is 85th percentile for high honors, Sara's overall grade (shelf and evals) falls in the 82nd percentile. Her shelf was in the 90th percentile. You had Sara on service with you, very much liked her, and personally felt like she probably was in the low high honors range. She has told you that she would like to pursue neurology as a career.

1. How would you approach this situation? What are the issues here?

2. Is there any more information you would collect? Would you keep her grade a high pass or give her the honors?

State of the Art Feedback

Judy A. Shea, Ph.D.
University of Pennsylvania

Objectives:

1. Define feedback and its importance
2. Recognize barriers to providing feedback
3. Identify effective characteristics of feedback

Providing Effective Feedback

Judy A. Shea, PhD
Professor of Medicine – Perelman School of Medicine

With attribution to
Jennifer Kogan, M.D.

Objectives

- Define feedback and its importance
- Recognize barriers to providing feedback
- Identify effective characteristics of feedback

What is feedback?

"Specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance."

Van der Ridder MJM, Med Educ 2008;42:189-97.

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"Specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance."

Van der Ridder MJM, Med Educ 2008;42:189-97.

“Feedback is an assessment for learning rather than an assessment of learning.”

Martinez ME, Lipson JI. Educ Leader. 1989;47:73-5

Feedback vs. Evaluation

Feedback

- Conveys information
- Formative
- Current performance
- Foster learning

Evaluation

- Conveys judgment
- Summative
- Past performance
- Certification/grades

Micro vs. Macro Feedback

Micro

- In the moment
- Daily
- Brief (1-3 minutes)
- “Feedback nugget”

Macro

- Mid-rotation
- Less frequent
- More detailed (5-20 minutes)
- More formal/structured

How Do People Become Experts?

- Deliberate practice
  - Working on well defined tasks
  - Informative feedback
  - Repetition
  - Self-reflection (but self assessment is inaccurate)
  - Motivation
  - Endurance

Ericsson KA et al. The role of deliberate practice in the acquisition of expert performance. Psych Rev.1993. 100(3):363-406.

  - Coaching

The Role of the Coach

- "They observe, they judge, and they guide"
- "That one twenty-minute discussion gave me more to consider and work on than I'd had in the past five years"

Atul Gawande, New Yorker 10/3/2011

Implications of Education without Feedback

- Missed learning opportunities
- Performance plateau
- Learner insecurity
- Inaccurate perception of performance
  - Disappointment and surprise with final evaluations

Objectives

- Define feedback and its importance
- Recognize barriers to providing feedback
- Identify effective characteristics

What Are The Barriers To Feedback?

Barriers

- Time constraints
- Limited information about performance
- Unclear standards of competence
- Giving negative feedback
  - Undesirable consequences for learner
  - Undesirable consequences for teacher

Barriers

- Receiver Characteristics
  - Superior
  - Peers
  - Friend/someone you like
  - Someone who is trying
  - Defensive
  - Lack of insight
  - Lack of will
- Repercussions on evaluations

Barriers

- Contextual factors
  - Finding time (post call, end of service)
  - Short time working together
  - Unaware of external circumstances
  - Early year- lack comparisons
- Type of feedback
  - Constructive
  - Not being overly discouraging
  - Making sure taken as useful

Opposing View Points

Faculty

- "*We give a lot of feedback all of the time.*"

Learners

- "*We never get any feedback*"

Explaining the Disconnect

- Learners' self assessment skills may be poor
- Overpowering influence of emotion
- Difficulty recognizing feedback
- Relationships
  - Credibility
  - Trust

Bing-You RG. JAMA 2009; 302(12):1330-1
Watling C et al. Med Educ. 2012;46:593-606

Objectives

- Define feedback and its importance
- Recognize barriers to providing feedback
- Identify effective characteristics

Principles of Effective Feedback

Think of an example when feedback went well. . .

Why did it go well?

Approach

- Set the stage
- Ask
- Tell
- Ask

Approach

- Set the stage
- Ask
- Tell
- Ask

Set the Stage

☑ Establish goals upfront: yours & the learner

☑ Establish expectation of feedback

☑Create the right environment

☑ Signpost

Creating Right Environment

- Place
  - Private, quiet
- Timing
  - Timely vs. Delayed
- Check your intentions

Signpost

- Establish expectation for feedback day 1
- Use the “F word”
- “*I want to give you some feedback*”

Approach

- Set the stage
- Ask
- Tell
- Ask

Ask

- Learner to assess own performance
  - Begins a conversation
  - Assesses learner's insight
  - Promotes reflective practice

Examples

- *"How do you think that went?"*
- *"How do you think things are going?"*
- *"What is going/went well?"*

- *"What are you trying to work on?"*
- *"What didn't go as well as you hoped?"*
- *"What would you do different the next time?"*

- *"What do you want feedback about?"*

Rationale

- Makes feedback interactive conversation
- Assesses learner's level of insight
- Promotes reflective practice

- Be an active listener
- Ask questions
- Reflect back

Approach

- Set the stage
- Ask
- Tell
- Ask

Tell

- What you think of their self-assessment
- What you observed
  - Positive and corrective
- Action plan

** Remember: No more than 2-3 constructive elements

Specific, Positive, Negative

- Be specific
- Reinforce positives and address areas requiring improvement
  - Use "*and*" instead of "*but*"
- Limit quantity

Tone and Content

- Be descriptive not evaluative
  - NOT: "*Your history taking was totally inadequate*"
  - RATHER: "*You omitted a key part of the history*"
- Keep it about the performance not the person
- Use "*I*" instead of "*You*"

Ask (again)

- Receiver what they understand to be areas needing work
  - What do you need to do differently?

- How they are going to work on it
  - Include an action plan

Successful Feedback

“Where am I going?”	“Feed-up”
“How am I going?”	“Feed-back”
“Where to next?”	“Feed-forward”

Hattie and Timperley. Review of Educational Research. 2007;77:81-112

Take Home Messages

- Give micro and macro feedback
- Think of yourself as a coach
- Signpost your feedback
- Ask-Tell-Ask
- It's more about feed-forward than feed-back

Recommended Reading

- Archer JC. State of the science in health professional education: effective feedback. Mewdical Education. 2010; 44:101-8.
- Ende J. Feedback in clinical medical education. JAMA. 1983;250:777-81.
- Hattie J, Timperley H. The power of feedback. Review of Educational Research. 2007;77:81-112.
- Van de Ridder JMM, Stokking KM, McGaghie WC, ten Cate OTJ. What is feedback in clinical education? Medical Education. 2008;42:189-97.

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Learning objectives

Feedback on Feedback: Dual Practice Session
1. Gain experience is delivering feedback effectively
2. Appreciate areas for growth is giving feedback
3. Sharpen strengths in feedback delivery

Feedback on Feedback: Dual Practice Session

Exercise: You will pair with another course participant. One of you will be John, the person receiving feedback, and the other will be the faculty member giving the feedback. Your feedback session should last 5-10 minutes. After the session is completed, "John" should let the faculty member know how the feedback session went from his perspective. "John" should then give feedback on how well the feedback was delivered using the principles of feedback given by Dr. Shea. Then the pair should switch roles and repeat.

The scenario:

You are working with a resident, John, on the floors and have a number of concerns. John has been taking the calls for the consult pager and is often times sharp with those asking for consults. His knowledge base, presentations, and clinical formulations are below what you would expect for his level of training though not markedly so. He seems disengaged from patients. On the other hand, he has kept the service well organized and has helped keep the consulting teams well informed.

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Back to Basics: Evaluation and Feedback

Learning objectives

Small Group Case Exploration
1. Develop a consistent approach to challenging evaluation situations
2. Learn strategies to make difficult grading situations less stressful
3. Gain exposure to how others think about grading
4. Discuss methods to encourage faculty to meaningfully participate in evaluation and feedback

Small Group Case Exploration

Challenge 3: Is it the same student?? Discrepancies in evaluation.

During the course of a four-week rotation, John Smith works primarily with two attendings and several housestaff. From one of the attendings and the housestaff, you receive glowing evaluations that speak of John's dedication, professionalism, and oral presentations. However, the second attending notes that while John is very pleasant, he is consistently late, has frequent errors in his medical documentation, misses key findings on the neurological exam, and is unable to determine a reasonable localization for many patients.

1. How would you approach this situation? What are the issues here?

2. How do you take this divergent information and come up with a single grade? Do you need additional information?

Challenge 4: How to motivate unmotivated faculty

Dr. Thomas is a distinguished and senior member of your department. He is an excellent clinician and students consistently rate him very high in terms of his clinical and didactic teaching. However, he consistently fails to give students feedback or submit evaluations. When he does submit evaluations they are typically very generic without any specific or narrative information. You discuss these issues with him, but he feels he is "too busy with patients and teaching to waste time on more paperwork."

1. How would you approach this situation? What are the issues here?

2. How do you encourage Dr. Thomas to invest time in the evaluation and feedback of students?

EVALUATION

AUPN Neurology Clerkship and Program Directors Workshop 2014

Back to Basics: Evaluation and Feedback

Sunday, April 27, 2014 6:30-8:30AM

Philadelphia Marriott Downtown

1 - State of the Art Evaluation

Speaker: C. Jessica Dine, MD, University of Pennsylvania

Please Circle One

Was presented effectively	Excellent	Good	Fair	Poor
Is relevant to the challenges that I face	Excellent	Good	Fair	Poor
Is likely to enable me to solve some the challenges that I face	Excellent	Good	Fair	Poor

Comments: _____

_____

2 **- Small Group Case Exploration**

Facilitator: James M. Stankiewicz, MD, Harvard Medical School

Challenge 1: The "un-deserved" grade

Challenge 2: Is it an Honors or a High Pass?

Please Circle One

Was presented effectively	Excellent	Good	Fair	Poor
Is relevant to the challenges that I face	Excellent	Good	Fair	Poor
Is likely to enable me to solve some the challenges that I face	Excellent	Good	Fair	Poor

Comments: _____

_____

3 **- State of the Art Feedback**

Speaker: Judy A. Shea, PhD, University of Pennsylvania

Please Circle One

Was presented effectively	Excellent	Good	Fair	Poor
Is relevant to the challenges that I face	Excellent	Good	Fair	Poor
Is likely to enable me to solve some the challenges that I face	Excellent	Good	Fair	Poor

Comments: _____

_____

***4*- Feedback on Feedback: Dual Practice Session**

Speaker: James M. Stankiewicz, MD, Harvard Medical School

Please Circle One

Was presented effectively	Excellent	Good	Fair	Poor
Is relevant to the challenges that I face	Excellent	Good	Fair	Poor
Is likely to enable me to solve some the challenges that I face	Excellent	Good	Fair	Poor

Comments: _____

_____

***5* - Small Group Case Exploration**

Facilitator: Jeffrey C. McClean, MD, San Antonio Military Medical Center

Challenge 3: Is it the same student? Discrepancies in evaluation

Challenge 4: How to motivate unmotivated faculty

Please Circle One

Was presented effectively	Excellent	Good	Fair	Poor
Is relevant to the challenges that I face	Excellent	Good	Fair	Poor
Is likely to enable me to solve some the challenges that I face	Excellent	Good	Fair	Poor

Comments: _____

_____

What portions of the workshop did you find most useful or least useful ?

_____

_____

Please list suggestions for future topics and speakers:

_____

_____

Additional Comments:

_____

_____

Association of University Professors of Neurology

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AUPN Clerkship and Program Directors Workshop Attendees
April 27, 2104

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