

options, ranging from strongly disagree to strongly agree. Residents demonstrated marked increase in their understanding of the various policy and procedure topics, as evidenced by comparison of pre- and posttest responses (FIGURE).

The question-and-answer conclusion to the workshop resulted in a much more robust discussion of topics and further potential application scenarios generated by residents than seen in previous years with the more traditional didactic review of policies and procedures.

Feasibility: presentation of policies and procedures during orientation for new residents can be effectively delivered in a case-based, interactive format. There is minimal cost for supplies and approximately 1 hour of staff time to prepare materials for the workshop. This workshop is easily replicated across programs or sponsoring institutions.

Acceptability: This format leads to greater engagement with the content by residents. Self-evaluation by residents indicates improved understanding of the materials. Further study should measure residents' retention and ability to reference and apply over time.

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Tackling Implicit and Explicit Bias Through Objective Structured Teaching Exercises for Faculty

Setting and Problem

Numerous studies have demonstrated that clinicians' implicit racial bias contributes to health care disparities.

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Furthermore, this “silent curriculum” impacts the medical education provided to our trainees, and likely perpetuates cultural stereotypes. Many physicians and trainees have written essays describing distressing experiences with explicit bias. Unfortunately, despite the important role implicit and explicit bias play in our clinical learning environment, there are few faculty development resources on recognizing and addressing bias. Objective structured teaching exercises (OSTEs) have been used successfully to assess and improve faculty members' teaching abilities in a number of areas.

We utilized an OSTE as a tool to teach faculty how to identify and tackle both explicit and implicit bias. Our objectives were (1) to design a workshop using a 2-station OSTE on recognizing and managing implicit and explicit bias as part of a department-wide faculty development program; (2) to assess feasibility and acceptability of the program; and (3) to assess the effectiveness of the program using a retrospective pre-post survey.

The NYU/Bellevue Hospital Pediatric Residency Program is a multi-site urban program with 58 categorical residents, 32 fellows, and 75 core faculty. All core faculty participate annually in a department-wide faculty development session.

Intervention

We created a 2-station OSTE utilizing actors as standardized learners (SL). At 1 station, faculty helped an SL manage explicit bias against her, expressed by a family requesting a non-Muslim physician. At the second station, faculty precepted an SL on rounds who expressed implicit bias in creating a discharge plan by assuming an immigrant family was not concerned with their child's long-term cognitive development. Both scenarios were derived from true situations faced by our clinicians.

Faculty worked in pairs, each playing a member of the care team, allowing them to address the case and the SL together. This structure allowed faculty to observe and learn from one another. Each station consisted of 10 minutes performing the task, 5 minutes of self-evaluation by faculty, and 5 minutes of verbal and written feedback by the SL using a checklist. A brief didactic on bias was provided prior to the OSTE and a debriefing followed the OSTE. Participants completed an anonymous workshop assessment, using a Likert scale of 1 to 5 (exceeding expectations) to assess the OSTE and a Likert scale of 1 to 10 (effective) for the retrospective pre-post survey. The workshop was conducted twice over 6 months.

Outcomes to Date

Forty-one of 47 (87%) participating faculty completed the workshop assessment. The mean overall OSTE

rating was 4.7 (range 4–5). Participants positively rated the cases and SLs as realistic, and SL feedback, didactics, and debriefing as helpful (all means > 4.5). In the retrospective pre-post survey, participants reported a significant increase in their skills in teaching trainees to recognize and address bias (from 6.0 to 7.9, $P < .001$). Additionally, they reported significant improvement in their own skills in recognizing and addressing bias (6.2 to 8.1, $P < .001$). Through informal verbal feedback, faculty noted that the opportunity to practice these skills in a simulation environment was especially valuable given the charged subject matter. This workshop can be replicated in other specialties by making minor changes in the cases. A limitation of this model is the time and funding required to train actors. (Actors were paid \$25 per hour for a 2-hour training and a 1.5-hour workshop.) However, for departments willing to make a small investment, this innovative faculty development model has the potential to help address bias in the clinical learning environment.

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Feedback on Feedback as a Faculty Development Tool

Setting and Problem

Competency-based medical education requires faculty members to assess clearly defined outcomes of learning

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over time. Unfortunately, assessment of competence is fraught with many difficulties, including the ability of faculty to accurately translate clinical performance into helpful feedback for the learner.

In 2011, we created an assessment system consisting of entrustment ratings of discrete work-based tasks called observable practice activities. Faculty members are asked to provide written comments justifying a given entrustment level, as well as specific suggestions for improvement. Despite multiple faculty development efforts that include e-mails, videos, narrated PowerPoints, and in-person presentations, a significant number of faculty members still use the assessment system incorrectly.

Intervention

We created a feedback tool for the end-of-rotation assessments that faculty members provide for residents. We began by defining behaviors we desired in our faculty and then generating a rating scale for each behavior (FIGURE).

Once a month our education team reviews all assessments submitted by faculty members. Each reviewer assesses 7 to 10 assessments monthly. The feedback tool (FIGURE) consists of 5 columns with numeric values, from 1 (poor) to 5 (excellent), and an average score for each review is calculated. All faculty members receive an e-mail with feedback on their assessments, and those with average scores less than 2 (indicating at least 1 score in the lowest performance column) are invited to an in-person meeting with the program director. All scores are reported to the chair of the department as part of each faculty member's yearly performance review.

Outcomes to Date

We completed 1149 feedback forms for 202 faculty members over 2 years. The average score per faculty assessment episode was 3.28 (median = 3.25). A total of 9% (106 of 1149) of assessments received an average score of less than 2, and 26% (52 of 202) of faculty members received an average score of less than 2 for at least 1 assessment (most faculty had more than 1 assessment).

Typical narrative comments delivered to faculty members included:

“You rated Dr. X's OPAs at a level 4 [entrusted to perform without supervision] throughout the evaluation. In order to justify such a high rating you should specifically note why and how an intern could perform at such a high level.”