bedside resources. The tool will also be introduced during resident orientation and practiced on redesigned, prototypical cases, such as consenting for treatment. Additional data, to include course satisfaction rates from incoming residents, ethics committee utilization, interdepartmental communication regarding ethical dilemmas, program director use of the tool within their programs, and ability to demonstrate resident attainment of Milestones related to professionalism and ethics will be monitored as the tool continues to be deployed. If successful, other departments (nursing) and other military hospitals will be offered training in the use of this innovative new approach.

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New Ideas

Utilization of a Referral-Based Procedure Clinic to Improve Procedure Training and Assessment in a Family Medicine Residency

Kathleen Dor, MD

Setting and Problem

We identified a need to standardize exposure to certain core procedures in family medicine, and to assess competency in these procedures. Our internal medicine department and certain nonfaculty family medicine physicians previously referred patients needing these core procedures to our institution's specialty departments.

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Intervention

We created a referral system for the internal medicine department and nonfaculty family medicine staff physicians to refer certain procedures to our family medicine residency clinic, instead of to the dermatology, gynecology, general surgery, podiatry, or orthopedic departments. These procedures included joint injections, IUDs, EMBs, nexplanon, minor skin procedures, ingrown toenails, and tendon sheath/ligament/aponeurosis (plantar fascia) injections. We created a weekly procedure clinic for these patients that would be

TABLE **Procedures**

Procedure	Percentage of Total Procedures
Sebaceous cysts	29
IUD	10
Knee injection	8
Nexplanon	8
EMB	10
Trigger finger	3
Plantar fasciitis injection	1
Lipoma	3
Ingrown toenail	4
Other skin lesions	24

Abbreviations: IUD, intrauterine device; EMB, endometrial biopsy.

staffed by 1 resident and 1 attending who could directly observe all procedures and assess resident competency.

Outcomes to Date

The procedure clinic is well utilized by both the internal medicine and family medicine departments, and is fully booked each week. The procedures scheduled over a 3-month period are listed in the TABLE.

Conclusions

Benefits for resident education include improving the quality of procedural training through increased and consistent exposure to procedures and evaluation of competency.

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New Ideas

How Bodies Learn: A Brief Intervention Using Dance and Dialogue

Elissa Foster, PhD
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Setting

Although the practice of medicine is inextricably involved with the body, medicine's inherent emphasis on cognition and mental processing means the physician's body is largely ignored as a site of learning. One consequence of this disembodiment is that residents' capacity to monitor their behaviors is compromised. In addition, the adult learning paradigm that dominates current approaches to innovation in medical education expects learners to be self-aware and actively reflect on their learning processes. Many residents have little experience engaging in such reflection. The brief intervention described in this article addresses the problem of "disembodied learning" for physicians in training with the following objectives:

1. Recognize which learning strategies residents are likely to enact in response to new stimuli (eg, new clinical environment, new rotation, or new levels of responsibility).
2. Analyze and articulate how medical education impacts and changes resident bodies as they learn how to perform competently as physicians.
3. Practice leadership and team building through effective communication.

Intervention

The intervention consists of residents choreographing and performing a dance (think Electric Slide, not Swan Lake) as a group, followed by a facilitated dialogue linking the activity to embodied learning. The duration of the exercise is 60 to 90 minutes; with 45 to 60 minutes allocated to the dance portion, and 15 to 30 minutes for the dialogue.

This activity was designed for a cohort of family medicine residents halfway through their internship year and could be run with a cohort from any specialty, with the expectation that the dialogue portion of the activity will differ depending on the residents' experiences. The group should be around 6 to 10 dancers (everyone in the room must dance to the best of their ability—no spectators). Larger groups can be split provided there is sufficient space.

The exercise requires room for the group to move, a stereo, a contemporary song (with a brisk, walking-pace beat),

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