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10. BECOMING A TRAINER

This full chapter can be found online only or as a separate download from our website.

This chapter is designed to help you train clinicians to competence in early abortion care and miscarriage management. It presents techniques for efficiency in training as well as integration of training into the clinical setting.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

• Maintain balance between patient-centered care, safety, clinic flow, and training
• Ask trainees for self-assessment and give effective feedback to trainees
• Assess competence in abortion provision
• Respond appropriately to difficult training situations
• Integrate training seamlessly into a busy clinical setting

READINGS / RESOURCES

• Competency Checklist: Chapter 12 Training Evaluation
• Clinic flow strategies for training clinics and debrief questions
SUMMARY POINTS

SKILL

• Expose each trainee to the process of values clarification prior to, or early in patient contact, and individualize a learning plan for each trainee. Log issues encountered that trainees want help deciphering and revisit their learning plan throughout the training experience.

• Teach opt-out trainees to gain core skills including pregnancy dating, ultrasound, options and contraceptive counseling, referral skills, miscarriage and complication management.

• Make learning expectations clear. Each skill can be broken into distinct steps with observable competencies for learners and for trainers-in-training.

• Distinguish recommendations based on evidence versus those based on provider preference.

• Introduce yourselves as a team to maintain the patient's confidence.

• Learn to manage competing priorities in a busy clinic, including patient support and safety, clinic flow, and training learners with different skills and interest.

• Give the trainee the first opportunity at self-evaluation, and offer positive reinforcement before constructive criticism in a specific and timely fashion.

SAFETY

• Prioritize patient safety (when teaching); review plans for communication that would prompt a trainee to allow you to take over.

• Progressively involve a new trainee in the procedure as they gain more confidence.

• Take every opportunity to discuss the management of potential complications ahead of time, which will help prepare trainees for the challenges they may encounter.

ROLE

• Train new providers as part of a collaborative national effort aimed to normalize abortion within the healthcare system and address the abortion provider shortage.
TRAINING SKILLS

Becoming a trainer can be exciting, challenging, and most of all, rewarding. As you help learners to develop and refine important clinical skills, you also have the opportunity to teach about other critical aspects of reproductive health, such as the public health context of unintended pregnancy, the nuances of patient-centered care, word choice, and cultural humility. As a trainer, you will also build relationships within the reproductive health community and help address stigma associated with abortion provision.

VALUES CLARIFICATION AND PROFESSIONAL RESPONSIBILITIES

It is best to introduce the process of values clarification with each learner before, or soon after having begun patient contact in the abortion care setting.

- Have new trainees read Chapters 1 and 2 before training initiation to clarify their personal values about pregnancy options and abortion in the context of professional judgments they will be called upon to make.
- Remind trainees of their professional responsibility to, and opportunity to support patients by, provide appropriate referrals regardless of their own beliefs.
- Relay how literature recognizes the “conscience” in abortion provision, and not just refusal to participate. Teach how provision can address stigma, as well as impact clinical practice, law and bioethics (Harris 2012).
- Offer each trainee to shadow a patient all the way through the counseling and abortion process, to understand a patient’s perspective before getting into the specifics of clinical care.
- Continue to revisit your own values as you work with patients and trainees, as these interactions may shed new light on your experiences.
- Remember that stigma is an important predictor of satisfaction, burnout and compassion fatigue among abortion care providers (Martin 2014). Therefore, strengthening human resources for abortion care requires stigma reduction efforts. Participants in the Provider Share Workshops show reductions in stigma over time.

OPT-OUT TRAINEES

A thoughtfully implemented opt-out policy is key to the success of an integrated abortion training program. Significantly more trainees receive abortion training when it is incorporated as a routine part of the curriculum with opt-out provisions, compared to when it is elective only. In addition, working with opt-out trainees is likely to help reduce abortion stigma, by providing exposure to the points of view of both patients and providers.

In addition to training future providers, we hope this curriculum broadens the perspective of opt-out trainees to provide unbiased evidence-based care. Gaining skills to provide balanced options counseling, referral and follow-up, miscarriage management, and contraceptive care is critical for all learners. By tailoring the program content to focus on individual interest, trainees ambivalent about abortion still gain critical reproductive health skills.

Studies show that trainees opting-out of some or all abortions valued the ability to partially participate in the family planning training. Many identified specific aspects of their training that impact future patient care, including those addressing core competencies in medical knowledge, exam and procedural skills, counseling skills, appropriate referrals and professionalism. (Steinauer 2014, Freedman 2010, Nothnagle 2008).
For opt-out trainees, we recommend that you:

- Respect varying opinions, which can help defuse polarity.
- Express interest in how a trainee developed their point of view.
- Reinforce that even trainees ambivalent about abortion have important knowledge and patient-care skills to gain from this rotational experience.
- Be explicit about not forcing anyone to perform procedures. There is plenty more to learn.
- Consider sharing part of your own experience, such as the first time you looked at fetal parts or used intra-operative ultrasound.
- Tailor the program using the Opt-Out or Partial Participation Curriculum in Chapter 1.
- Refer to online modules like Physicians for Reproductive Health’s LEARN (Lessons to Enhance Awareness of Reproductive Needs) and ARSH (Adolescent Reproductive and Sexual Health).

As learners realize that choices to provide abortion services are not black and white for providers, opt-out trainees often expand their participation through the rotation.

**PRACTICE WITH SIMULATION MODELS PRIOR TO PATIENT CARE**

A growing body of literature supports the use of simulation models in medical education (Lofaso 2011, Okuda 2009, Ziv 2003). Limited patient encounters, demands on training hours, and heightened focus on safety have all lead to the increasing use of models and simulated complication scenarios. Simulation can help learners with procedural comfort, complication management, and stress-readiness during a crisis.

Existing simulation models for uterine aspiration include low-cost fruit models such as the papaya (Paul 2005) and pitaya (Goodman 2015); both enable trainees to practice cervical anesthesia, aspiration, pelvic exams, or IUD placement. In addition, a number of anatomic models are available to help new learners with pelvic exams and gynecologic procedures.

Programs and trainers should consider require comfort with a model BEFORE a real patient, to set a learner up for success during an actual procedure. The model can be very simple—for example using the trainer’s fisted hand as a pretend cervix if no other model is available—but comfort should be obtained prior to doing the procedure itself.

**MODELING HIGH QUALITY PATIENT-CENTERED CARE**

Remember that in the role of trainer, our own interactions with patients and staff communicate our underlying philosophy. Given the sensitivity of this work, we encourage you to specifically consider the following resources to:

- Incorporate patient-centered counseling techniques and word choices
  - Chapters 2 and 5
- Explore implicit bias
  - Dehlendorf 2010, UCSF Office of Diversity
- Promote inclusiveness and cultural humility
  - Kutob 2013, Loudon 1999
It is helpful to differentiate evidence-based recommendations from provider preference or style.

- Stay current with the growing body of abortion and contraceptive literature
- Expose trainees to the styles of various providers

COMPETENCY-BASED SKILLS

Rather than focus on trainees achieving specific procedural numbers or specialty training, there have been concerted efforts in reproductive health training to help learners attain clinical knowledge and skill-based competencies in line with health professional education standards (e.g. ACGME Family Medicine Milestones, AACN, ACNM, NONPF). Each skill can be delineated into clear steps with observable competencies for learners and for trainers-in-training (Cappiello 2016).

In one clinician training model (Levi 2012), competencies were monitored by both the trainer and the trainee. Both groups used daily and final competency assessments in areas of a) patient comfort, b) procedural completeness, c) speed, and d) ability to identify problems, while review of complications was used to identify concerns about clinician safety.

Abortion safety, efficacy and acceptability are found to be equivalent between most cadres of advanced practice clinicians and physicians (Bernard 2015, Weitz 2013). And the similarity in safety and efficacy is true for both experienced and newly trained providers (Jejeebhoy 2011, Warriner 2006). This supports the adoption of policies allowing more providers to perform early aspiration abortions, and in turn, helps to expand patient access to abortion care.

MEETING INDIVIDUALIZED NEEDS OF YOUR LEARNER

Use a step-wise approach to involving new trainees

- Start slowly on earlier cases, and build involvement with each case. Trainees may progress at differing paces. For some trainees, they may build up to doing most steps of a case in the first session or so. For faster learners, the trainee can do the pelvic exam and observe the first procedure, help aspirate the uterus with the second, help dilate and place the cannula on the third, and be involved in the entire abortion on the fourth.
- To best support learning, stay aware of the trainee’s skill advancement. At first, stand behind a trainee, so you can assist with your hands, and see what they are seeing. As the learner gains competence, move back or to the side.
- Consider agreeing ahead of time on a time limit after which the trainer intervenes (for example, if cases go on longer than 5 minutes). This helps depersonalize the need for the trainer to intervene, and ensures patient comfort and flow maintenance.
- With time, trainees should also take command of communication with the patient.
- Consider having a trainee work independently at the end of the rotation, especially for earlier gestational ages, while you stay within earshot if they need your assistance.
TEACHING DURING THE PROCEDURE

Prioritize patient safety

At the beginning of the training session, ask the trainee what their priorities are for the day, and review plans for communicating during procedures so it is patient-centered. For example:

- Introduce yourselves as a team, and initially lead the patient conversation, allowing a trainee to focus on new procedural skills.
- Don’t hesitate to step in when you are concerned about patient comfort or safety.
- Consider having a signal for “trading places” such as a tap on the shoulder if the situation becomes challenging.
- Encourage trainees to stop for assistance if the procedure does not feel right (i.e. they feel resistance with dilation or instruments pass further than usual).

Play an active role in clinic flow (particularly in a high-volume clinic)

- Set reasonable goals for procedure times with trainees. Emphasize that longer procedures may be uncomfortable for patients and increase waiting for other patients. A first trimester abortion should rarely take longer than 5-10 minutes of speculum time.
- Prior to seeing the first patient, review critical steps of the procedure, such as accurate bimanual exam, efficient speculum placement, the first dilator pass, and the final check for completion.
- Plan special needs for a case before entering the procedure room to minimize trips out.
- Review tray set-up to adhere to the no-touch technique.
- Tell trainees that part of your communication with them will be through speaking with the patient. For example, you may prompt a new learner to inject anesthetic by saying to the patient, “Next is numbing medicine; you may feel a cramp or nothing at all.”
- Rely on a medical assistant or doula to support the patient to distract from the teaching process.
- If a trainee is taking a long time for any one step (e.g.: speculum placement or dilation), assist with your hands or step in, and offer helpful tips before the next patient, when the trainee can try again.
- Communicate early and often with the clinic or flow manager.
- Provide most teaching and feedback between cases, or bookmark them for the end of the day.
- For additional ideas, see Clinic flow strategies.

GIVING EFFECTIVE FEEDBACK

Feedback helps keep an individual on target to achieve learning goals. Data show that learners appreciate feedback early and often (Cantillon 2008). Providing this information can increase a learner’s rate of improvement, and inspire higher levels of performance.

- Provide feedback in private.
- Invite a trainee to take the first shot at self-evaluation. Ask, “How do you think that case went?” or “What else might you try in this situation?”
- Give B.E.S.T. feedback: Behaviorally based (i.e.: not personality-based), Explanatory (“why” it matters), Specific (the more specific, the easier to improve), and Timely.
- Offer feedback that reinforces good clinical skills before constructive criticism, to soften the delivery and avoid discouragement.
- Share observations about non-verbal communication, wording, and tone.
- Give feedback that includes an action plan for what to try next.
Remember that all learners benefit from constructive feedback, even experienced providers.

Consider varying the types of feedback you provide.

- Share your observation: “You used a number of open-ended questions with that client.” “Your pelvic assessment was accurate, as we see from the angle the dilator entered.”
- React at a personal level: “I liked your reassuring tone; it really seemed to calm her down.” “I appreciate how you asked for help with cannula placement.”
- Predict the outcome of a situation and emphasizing the consequences of an incorrect practice: “One risk of continuing to push against resistance is creating a false tract or perforation. You avoided that by stopping to confirm the patient’s uterine position.”

**MASTERING AND TEACHING ULTRASOUND (US)**

As you become more proficient as a provider and trainer, continue to master your own US skills for dating and intra-operative guidance. Where available, try to provide your trainees with US experience at multiple gestational ages. In addition to reviewing basic US principles from Chapter 3, encourage learners to take advantage of interactive online curriculum that may be available in your setting. If you have other staff members proctoring trainees, consider observing a trainee sonogram yourself to assess skill level. Resources include:

- Ultrasound in Abortion Care (Interactive Online Curriculum), ARMS 2007
- Ultrasound Lecture Series – Obstetrics and Gynecology, AUIM
- Early Pregnancy Ultrasound Skills Evaluation (Download editable copy)

**HELPING TO PREPARE FOR TRANSITIONS TO PRACTICE**

It is valuable to ask trainees how they might integrate this material into their future careers, Reinforce the stories and benefits of being able to offer services in one’s own practice.

- Compare a primary care office to a high-volume setting, which has more ancillary staff to provide counseling, lab work, ultrasound, or recovery support.
- Point out areas where different practice standards exist (i.e. routine vs. selective US).
- Encourage trainees to consider how they will adapt to these differences.

Reinforce the expectation that the trainee should be able to provide multiple aspects of care by the end of their training. On the last day of training, consider completing all steps (US, counseling, pre-medication, procedure, recovery) in one room, to simulate a primary care practice experience.
INTEGRATING TRAINING INTO THE CLINIC SETTING

BUILDING STAFF SUPPORT

When establishing a training program, it is invaluable to build and maintain staff support and involvement. The following strategies have been useful:

• Develop and foster multidisciplinary, team-based care
• Discuss how patients benefit (i.e.: public health implications of improved access)
• Cultivate interest in contraceptive advances
• Use appropriately timed staff surveys and values clarification workshops
• Bring speakers (with an outside opinion) to attest and legitimize the value of services.

NEGOTIATING THE TRAINING RELATIONSHIP WITH STAFF AND PATIENTS

There are various ways to present the training arrangement to staff and patients, reminding them that this is part of the broader process of professional education, and improved access.

• Prior to training initiation, discuss ways for your staff to talk about the training with patients and provide a script. They should feel comfortable presenting it.
  ◦ Training can be described as an initiative to address patient access to reproductive health services, extending expertise to more providers.
  ◦ Staff can explain, “You will be seen by two doctors / providers today; one from our clinic and one from the university.”

• Consider posting information explaining the training partnership in waiting rooms. One example is “A partnership has been established with the (university or hospital) to expand access to services by training more clinicians in reproductive health. This is a center of training and excellence.”

• Consider introducing training in a general consent form for care and services.

• Consider introducing yourselves by saying, “We’ll be doing your procedure together today.” Depending on who is undertaking the hands-on role, the trainer could alternatively say, “I’ll be assisting with your procedure today.”

• Emphasize the team approach to care (instead who has more or less experience).

• Allow the trainees to describe the details of their procedural background as needed, focusing on the fact that they do many procedures of this complexity.

PREPARING FOR AND SUPPORTING CHANGE

We all appreciate that change is not easy. Incorporation of new and controversial programs like abortion training is likely to require significant institutional change. Steps might include:

• Building the case for change; identifying and preparing for resistance
• Creating a plan and enrolling others to champion the change
• Recognizing the strengths your setting already has to support the change
• Considering small steps that can be made toward change
• Supporting, recognizing and maintaining the momentum
• Evaluating and openly addressing unanticipated problems
• Redirecting to stay the course
Embracing the concept of ongoing improvement sets a positive tone in a clinic, where trainers, trainees, and staff alike may be part of the learning process. Assure that there an outlet for staff and patient concerns and suggestions regarding the training program.

- Help reinforce the value of staff contribution in training new abortion providers
- Encourage leadership by creating roles for particular staff to be involved with demonstrating counseling, ultrasound, recovery or discharge teaching
- Encourage staff to give feedback to trainees
- Offer periodical updates to staff to broaden their knowledge and buy-in
- Encourage periodic discussion of clinic flow issues, strategies, and patient care with your staff, including huddles, debriefs, and staff meetings
- Share cumulative results of the training program with staff

EVALUATING NEW TRAINERS

Ideally new trainers have the opportunity to work alongside seasoned trainers to gradually obtain the many skills important to quality training. Timing of evaluation and approval to train independently may vary with experience providing and teaching in other environments, as well as needs of the program, but the following will assist in this assessment.

- New Trainer Skills Evaluation: A competency evaluation for new trainers (Download editable copy)

CONTINUING COMMITMENT

We hope that the above suggestions can help you to more seamlessly integrate training into your practice and to make it a fulfilling means to address disparities in access to abortion and reproductive health regionally and throughout the country. Please don’t hesitate to reach out to us and other colleagues with any questions.
**NEW TRAINER SKILLS EVALUATION**

New Trainer being evaluated: __________________________________________________________
Faculty Evaluator: __________________________________________________________________
Number of training sessions observed: _________________________________________________

In addition to meeting the criteria for competency as an abortion provider, a trainer must be able to:

<table>
<thead>
<tr>
<th>Training Skills</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
<th>Did not experience</th>
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</thead>
<tbody>
<tr>
<td>Assesses trainee’s skills and learning needs</td>
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<tr>
<td>Engages trainee in learning experience</td>
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<td>States objectives for each training day</td>
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<tr>
<td>Encourages trainee to ask questions</td>
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<tr>
<td>Answers questions clearly and completely</td>
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<tr>
<td>Demonstrates strong knowledge of subject matter</td>
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<td>Gives appropriate evidence and resources</td>
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<tr>
<td>Uses variety of teaching methods including cases, role plays, “what if” scenarios, didactics</td>
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<tr>
<td>Discusses various approaches to the procedure</td>
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<td>Demonstrates knowledge of site specific protocols</td>
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<tr>
<td>Reviews chart and informed consent</td>
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<tr>
<td>Reviews / interprets US, labs, and medical history with trainee</td>
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<td>Demonstrates establishing rapport with the patient</td>
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<td>Demonstrates non-judgmental attitude towards the patient</td>
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<tr>
<td>Demonstrates clear communication with the patient regarding procedure and management</td>
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<tr>
<td>Allows trainee to solicit and answers patient questions</td>
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<tr>
<td>Confirms physical exam findings</td>
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<tr>
<td>Gives feedback about no touch technique</td>
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<tr>
<td>Gives feedback about trainee’s attention to patient comfort during procedure</td>
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<td>Can take over a case when appropriate without disturbing the patient or undermining the trainee</td>
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<td>Provides feedback to the trainee after each procedure, and at the end of session</td>
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<td>Reviews elements of tissue exam with trainee</td>
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<td>Reviews appropriate post operative orders with the trainee</td>
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<tr>
<td>Reviews patient’s contraceptive needs (including EC) and contraindications with trainee</td>
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<tr>
<td>Models respectful attitude towards staff</td>
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<tr>
<td>Is receptive to feedback from trainee / peers</td>
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<td>Models and teaches trainee attention to clinic flow</td>
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Further Comments:

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Evaluation by Trainer:
[ ] Approved  [ ] Further orientation and observation suggested

SIGNATURE OF EVALUATOR: ___________________________ DATE: __________

TEACH  EARLY ABORTION TRAINING WORKBOOK  11
# EARLY PREGNANCY ULTRASOUND SKILLS EVALUATION

Trainer: ___________________________________________________________ Date: __________

Number of Sonograms Observed: __________________________________________________________________________________

<table>
<thead>
<tr>
<th>TRAINING SKILLS</th>
<th>Beginner</th>
<th>Developing Competence</th>
<th>Competent</th>
<th>Did not experience</th>
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<tr>
<td><strong>INTERPERSONAL SKILLS</strong></td>
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<tr>
<td>Introduces self to patient and establishes rapport</td>
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<td>Explains sonogram procedure to client, and routinely asks about LMP, latex allergy, desire to hear about twins, etc.</td>
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<td>Pays attention to patient comfort</td>
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<td>Uses appropriate language to discuss ultrasound findings in presence of patient</td>
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<td>Solicits and answers patient questions appropriately</td>
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<td><strong>CLINICAL SKILLS</strong></td>
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<tr>
<td>Prepares ultrasound probe properly for use</td>
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<td>Uses keyboard and screen functions properly</td>
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<td>Keeps uterus in center of screen, zooming as needed</td>
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<td>Systematically identifies uterus in longitudinal and transverse views, taking appropriate images</td>
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<td>Systematically scans across pelvis, requesting help as needed.</td>
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<tr>
<td>Measures gestational sac in 3 planes; able to explain how and why</td>
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<td>Identifies yolk sac</td>
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<td>Identifies fetal pole and cardiac activity</td>
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<tr>
<td>Measures CRL in longest view (without limbs or yolk sac)</td>
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<td>Assures location of pregnancy is intrauterine</td>
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<td>Perform post procedural or post medical abortion US to establish no evidence of gestational sac, embryo or fetus</td>
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<td>Ensures transducer(s) cleaned between exams</td>
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<td><strong>MEDICAL KNOWLEDGE</strong></td>
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<tr>
<td>Able to name key US characteristics of pseudo vs. true gestational sac (identify if possible)</td>
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<tr>
<td>Accurately calculates GA with gestational sac measurements</td>
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<tr>
<td>Accurately calculates GA with CRL measurement</td>
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<tr>
<td>Knows when to switch to BPD measurement, and elements of an optimal BPD measurement</td>
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**ADDITIONAL COMMENTS:**
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Evaluation by Trainer:
[ ] Approved       [ ] Further orientation and observation suggested/required

SIGNATURE OF EVALUATOR: ___________________________________________________ DATE: __________
EXERCISE 10.1: Challenging Training Situations

**Purpose:** For each of the cases listed, please consider various ways that you might respond as a trainer. These exercises are meant to build your skill and adaptability to difficult clinical, behavioral, ethical, and clinic flow issues in training.

1. A somewhat new trainee continues to dilate beyond appropriate size, appears overconfident, and demonstrates little “sixth sense” when things don’t feel right. In this moment the trainee suddenly has a look of discomfort, and mentions “I felt some obstruction and a tearing feeling.”

2. A trainee is lacking in enthusiasm, often anxious to leave, and is more interested in gaining procedural skills than providing options counseling or empathic care. They tend to sit back and avoid saying much, making assessment of skill difficult.

3. You start off with the values clarification exercises with a trainee who is shy but friendly. After a brief introduction, they tell you that they are struggling over whether or not to provide abortions. They feel it is hard to “help someone commit a sin.” They would feel better if only they could spend a lot of time with each patient to make sure that they thought abortion was the right decision for that patient. They especially wanted to avoid doing abortions for those who use it as birth control. The trainee states, “Clearly some patients make bad decisions for themselves, so I cannot trust that they are making the right decision about this.”

4. A trainee shows confidence with the procedural aspects of aspiration abortion, but tends to be very formal with clients, using extensive medical jargon, and speaking in a tone you feel is not very empowering to the patients.

5. The last couple days in your training clinic, you’ve noticed the clinic flow seems to be less than optimal, with longer patient waiting times, and your staff becoming mildly inpatient with training. How might you approach this problem?

6. You are assisting a trainee in a procedure on a patient with a very low pain threshold. During the dilation, the patient starts fidgeting and becomes noisier. The patient then becomes more active on the table, withdrawing from each cervical dilation by the trainee, and starts crying loudly in the middle of the dilation. How do you proceed?
**EXERCISE 10.1: Challenging Training Situations**

**Purpose:** For each of the cases listed, please consider various ways that you might respond as a trainer. These exercises are meant to build your skill and adaptability to difficult clinical, behavioral, ethical, and clinic flow issues in training.

1. **A somewhat new trainee continues to dilate beyond appropriate size, appears overconfident, and demonstrates little “sixth sense” when things don’t feel right. In this moment the trainee suddenly has a look of discomfort, and mentions, “I felt some obstruction and a tearing feeling.”**
   - You need to assess what the trainee has done, making the transition as smooth as possible to preserve safety, and not to alarm the patient.
   - Subtly communicate the need to switch places.
   - Help reassure the patient if there is a change in her procedure.
   - Have a low threshold to use ultrasound guidance if available.
   - Consider the following preventative steps:
     - Practice with simulation models like the papaya, an IUD model, or even a trainer’s fisted hand as a pretend cervix if no other model is available.
     - Consider requiring comfort with a model BEFORE a real patient, to set a learner up for success during an actual procedure.
     - Introduce the trainee gradually to the procedure.
     - Prepare the trainee for “moments of caution” including the first dilation.
     - Work very closely next to a trainee, assisting with your hands, until you gradually gain confidence in his/her skill level.
   - Give feedback after the case, starting with the opportunity for self-assessment.
   - Recognize the trainee for having asked for help when feeling resistance, which contributed to the patient’s safety.
   - Give ideas for improvement, and steps to take to either prevent or manage this challenge if it arises again.

2. **A trainee is lacking in enthusiasm, often anxious to leave, and is more interested in gaining procedural skills than providing options counseling or empathic care. They tend to sit back and avoid saying much, making assessment of skill difficult.**
   - Engage the trainee with values clarification work and counseling exercises.
   - Ask the trainee for specific contributions or actions.
   - Ask for their assistance in making this a meaningful experience. “How can I make this training more useful for you?”
   - Consider asking other trainers if they have had a similar experience with this learner.
   - If the behavior continues, ask the trainee about her apparent lack of enthusiasm, and focus on basic expectations of the rotation.
   - Evaluate the trainee honestly.
3. You start off with the values clarification exercises with a trainee who is shy but friendly. After a brief introduction, they tell you that they are struggling over whether or not to provide abortions. They feel it is hard to “help someone commit a sin.” They would feel better if only they could spend a lot of time with each patient to make sure that they thought abortion was the right decision for that patient. They especially wanted to avoid doing abortions for those patients who use it as birth control. The trainee states, “Clearly some women make bad decisions for themselves, so I can not trust that they are making the right decision about this.”

- Consider asking more about how they perceive sin and forgiveness, and how they weigh the relative difficulty of decisions in this realm.
- Consider asking if they believe in broader platform such as the importance of respecting patient autonomy, reduction of stigma, or a clinician’s duty to ensure a patient receives care.
- "Broaden" the approach to explore other scenarios that might evoke physician bias in relation to childbearing or not (e.g. alcoholism, drug-use, HIV, refusal of blood transfusion, or refusal of a C-section).
- Do values clarification, some counseling observations, and then reassess.
- It’s important to give them the space to work it through in a way that doesn’t adversely affect the care of your patients.
- We recommend evaluating trainees on their ability to render non-judgmental care. When trainees are unable to do so, we need to give an honest evaluation and let the residency faculty know what areas still need work.

4. A trainee shows confidence with the procedural aspects of aspiration abortion, but tends to be very formal with clients, using extensive medical jargon, and speaking in a tone you feel is not very empowering to the patients.

- Do counseling exercises and role-play early. Ask the trainee to play the patient at times, and see which tone they prefer as a patient.
- Review alternative ways to say things.
- Ask the trainee to do the procedure while you talk to the patient and see if they can glean from your word-choice.
- Give feedback after every case.
- Reinforce the benefits gained by the things they tried.
- Reinforce their strong procedural skills, and potential to provide support.
5. The last couple days in your training clinic, you've noticed the clinic flow seems less than optimal, with longer patient waiting times, and your staff becoming mildly inpatient with training. How might you approach this?

- Acknowledge that training can slow down the clinic, and remind the staff of the long-term benefits. Enlist their support in its success.
- ‘Bookmark’ topics to finish reviewing at the end of the clinic day.
- Use a debriefing session after clinic to ask staff to share their perspectives and brainstorm strategies for improvement. See Clinic flow strategies.
- Help keep the case moving by helping with that or the next step (for example, if the trainee is struggling to put adequate pressure on the dilator, add the additional pressure on their hands, so they appreciate the appropriate pressure needed).
- Agree ahead of time with trainee/team on a time limit after which the trainer intervenes (for example, if the case is going on longer than 10 minutes). This can helpful depersonalize things when the trainer intervenes if a case is taking too long, and it also ensures that concerns about flow are addressed in an ongoing way.
- Consider having one trainer whose focus is the learner, and another practitioner whose focus is flow and keeping waiting times minimized,
- Consider other options that may work in your own practice setting.

6. You are assisting a trainee in a procedure on a patient with a very low pain threshold. During the dilation, the patient starts fidgeting and becomes noisier. The patient then becomes more active on the table, withdrawing from each cervical dilation by the trainee, and starts crying loudly in the middle of the dilation. How do you proceed?

- Have the trainee pause during the procedure so you can assess the situation clinically and check in with the patient.
- If you feel the procedure is safe, help reinforce the techniques of relaxation including breath, stabilizing her hips into the table, visualization, and talking her through the procedure. Assess whether more local, oral or IV medication might be helpful.
- Ask for a medical assistant to be more active or step into the doula role yourself. Making eye contact with the patient, holding the patient’s hands, walking through a guided meditation as distraction, and breathing with the patient can all make a huge difference.
- Sometimes, just getting the case done as quickly as possible, though, is necessary, and you will have to complete the procedure. Make this transition using a subtle signal so the patient doesn’t become alarmed.
- Discuss the case after you finish, giving the trainee the first opportunity to assess and problem-solve, and explain why it was important if you needed to take over the case. Offer positive and then constructive feedback.
10. REFERENCES


