



**SPECIAL
POINTS OF
INTEREST:**

- **Duke's Life
Curriculum**

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Interspecialty Professionalism at the University of Tennessee

By: James Lewis, M.D.

Over the past nine months, the University of Tennessee Graduate Medical Education office has attempted to improve interspecialty professional behavior among housestaff. For many years the University has seen problems with housestaff consultative behavior – inadequate information supplied to consultants, rude behavior between housestaff, chart battles, occasional delays in consultation, gaps in charting by consultants, general disrespect between specialties observed and experienced by students.

In December 2007, UT GME conducted an 18-question survey of consultative behavior among Memphis housestaff. There were an extraordinary amount of responses. Among the problems observed were rudeness in housestaff interactions, disappearance of consultants from charts without proper sign-off and follow-up, improper consult notification by clerical personnel, improper consultation for outpatient issues, and poor role-modeling by attending physicians. The most frequently noted complaint was inadequate verbal and written communication between housestaff.

The results of the survey were presented at a noon GME conference in January 2008 followed by a panel discussion

featuring Drs. Jim Lewis, Jimmie Mancell, Elizabeth Pritchard, and George Wood.

Based upon the survey and direct housestaff feedback the following “Ten Guidelines of Consultation” were crafted and adopted by UT GME:

1. Always call in consults physician to physician.
2. The primary team should leave their pagers on into the evening to receive information from consultants.
3. The primary team should always ask consultants to answer a specific question.
4. The primary team for hospitalized patients should limit consults to inpatient issues.
5. The primary team should always perform a history and physical examination and order appropriate laboratory before calling the consultant (exception – emergency care).
6. The primary team should always follow consultants' recommendations or verbally communicate disagreements to the consulting service. The team should refer unresolved management issues to the attending physician.
7. The consulting physician should respond politely, see a consult within 24 hours, and involve the attending physician promptly.
8. The consultant should leave notes daily unless otherwise specified and leave a sign-off

note addressing follow-up issues.

9. The consultant should avoid writing unnecessary orders and verbally communicate potential disagreements to the primary team. The consultant should refer unresolved management issues to the attending physician.

10. Consultants should consider establishing service-specific guidelines to facilitate more appropriate consultations.

The survey was repeated in June 2008. Overall behavior had not improved. However, the majority of housestaff were aware of the new guidelines. Another housestaff GME conference with panel discussion was conducted in August to review the latest data, provide case examples of poor consultative behavior, and encourage interspecialty professionalism. There was general agreement that inpatient consults needed to be called physician to physician (if an M4 was used, then the resident must be standing by), that rudeness was unacceptable, and that attendings should role model better behavior. The group also concluded that better interspecialty professionalism resulted in better patient care.

SVMIC Conference 2008

The annual State Volunteer Mutual Insurance Company Risk Management Conference is scheduled to be held on December 4-5, 2008. There are three sessions that will be offered: one evening session from 5:30-8:00pm on Thursday, Dec 4th, a morning session from 8:00-10:30am on Friday, Dec 5th, and an afternoon session from 11:30-2:00pm on Dec 5th. All residents are required to attend one session. Failure to attend the SVMIC Conference will result in the PGY Level increase in pay July 2009. Residents need to see their program coordinator for details.

This year's conference will focus on resident liability coverage and communication issues in risk management. Dan O'Connell a clinical psychologist from Seattle will be the featured speaker.

Are You Competent in the Competencies?: Interpersonal and Communication Skills

According to ACGME all residents are expected to achieve competence in six major areas before they can practice as a physician. These major areas include patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Each of these areas are essential for providing optimal care for patients. ACGME defines Interpersonal and Communication Skills as "skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals." Residents should be able to exhibit skills both verbally and nonverbally. Also, residents must be able to elicit information from patients using verbal answers and body language. Because of the diversity of patients seen within the Medical Center and St. Jude, residents must be familiar with communicating with patients and families across a wide range of socioeconomic backgrounds.

There are many ways in which residents can be taught proper interpersonal and communication skills. Some conventional examples include role modeling and mentoring; presenting at conferences, seminars, and lectures; educating patients and colleagues; grand rounds, and writing scholarly articles. The best evaluation methods include a 360 degree evaluation also known as a multisource

evaluation, patient survey, portfolio, and standardized patients.

In the April 2008 issue of Residency Program Alert published by HCPro, writers discussed reaching outside the realm of traditional GME educators to theater professors and actors from the local universities to educate residents about interpersonal and communication skills. Instrumental techniques in exhibiting proper communication skills include body language of both resident and patient, speech tone, facial expressions, and word choice. Virginia Commonwealth University (VCU) elicited the help of actors to teach residents "active listening, awareness of body language and nonverbal cues, reflective empathy, modifying the clinical environment to improve patient interactions, and communicating in a team situation." Residents participated in several "role playing activities and interactive exercises" to develop these skills.

The results of the course was positive. VCU published results stating that "observers evaluated residents' clinical empathy communication and scored it at 8.56, up from a score of 6.88 prior to the training." Resident participants found themselves to be more aware of the environment and themselves when addressing patients.

Not only does this competency apply to residents but also

to program directors, faculty and coordinators. It is clear that Program Directors and faculty serve as the major role models of appropriate communication skills for the applicants and residents, but the importance of the coordinator's communication skills may not be as evident in teaching residents.

In a recent article by Ruth Nawotniak and Ellie Gray, the Coordinator was described as the "ambassador" between the applicants and the program. The coordinator's professional behavior played a major role in the applicant's decision on coming to an institution. Nawotniak and Gray state that "when a program coordinator was not focused on the interview day, it left a lasting negative impression on that applicant." Applicants surveyed also mentioned that the 2 largest areas of frustration with coordinators included scheduling issues and not communicating event changes. Skills in communication span across all roles within residency programs and are extremely important for accurate and affective interactions between parties.

For more information about ICS visit the ACGME Outcome Project at www.acgme.org.

"Looking Outside of GME to Teach Interpersonal Communication." *Residency Program Alert*. April 2008 Vol6, No4: 1-3.

Nawotniak, Ruth and Gray, Ellie. "General Surgery Resident Applicants Perception of Program Coordinators." *Current Surgery*. Nov/Dec 2006 Vol63 No6: 473-475.

Best Practice: Duke's Life Curriculum

<http://www.lifecurriculum.info/default.aspx>

Phase 3 of the ACGME Outcome Project requires programs to fully integrate and assess resident achievement of the six general competencies including patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and systems based practice. A beneficial tool for teaching interpersonal and communication skills, professionalism, practice-based learning and improvement, and system-based practice is Duke's LIFE Curriculum. The Learning to address Impairment and Fatigue to Enhance patient safety case based curriculum was spearheaded by the joint effort of Kathryn M. Andolsek, MD, MPH (Duke) and Robert C. Cefalo, MD, PhD (UNC). Several hospitals and professional organizations contributed to its development including Duke University Hospital, UNC Hospital, NC AHEC, and NC Physician's Health Program.

The LIFE Curriculum provides program directors, faculty, and residents with the tools and strategies to identify, prevent, and man-

age signs and symptoms of resident fatigue and impairment. The modules also cover disruptive behavior, stress, burnout, boundary violations, depression, and substance abuse. Program Directors, faculty and residents will not only learn how to identify fatigue and impairment in themselves and others but also how this effects their performance. These modules can be utilized in several ways including resident self study, faculty development, and conferences/workshops. At the end of the curriculum, the student should master the following objectives:

- Implement strategies to help prevent impairment in residents
- Identify an impaired resident
- Manage impaired residents
- Develop written policies regarding impairment
- Access appropriate referral resources

Each module provides a scenario that reflects the negative behavior with discussion points

following. The scenario is replayed displaying appropriate behavior and management techniques. The modules not only educate the program director, faculty, and residents but GME as a whole offering strategies to manage the resident's behavior and possible policies for implementation.

In addition to the CDs and teaching guides, the LIFE website offers a large volume of reference and resource materials covering each topic. A self assessment and a post test are also available to assist program directors, faculty, and residents in setting appropriate learning goals for themselves and the program. The LIFE website also offers potential consumers a sneak peak at the vignettes that are included on the discs.

The 3 CD-ROMs and 2 teaching guides are available for purchase from the LIFE website.

From:

Andolsek, MD, MPH, Kathryn and Cefalo, MD, PhD, Robert. [LIFE Teachers Guide 1](http://www.lifecurriculum.info/downloads/teachersguide1.pdf). 8/14/08. <http://www.lifecurriculum.info/downloads/teachersguide1.pdf>

Module Objectives

Fatigue

- Define fatigue and sleep inertia
- Describe how to recognize excessive sleepiness
- Discuss the physical, mental, and social consequences of fatigue
- Understand the link between medical error and fatigue
- Identify strategies for managing fatigue
- Predict times of peak and nadir performance

- Explain the night float system and explore strategies for addressing duty-hour issues
- Understand the shared responsibility of residents, faculty, and programs in managing fatigue
- Select an appropriate evaluation for a fatigued resident

Stress and Depression

- Describe common personal and professional stressors faced by residents
- Predict physiologic and psychological changes and maladaptive behaviors
- Identify the signs, symptoms,

and behaviors associated with chronic stress

- Compare techniques for stress management
 - Implement strategies that can help prevent consequences of stress
 - Recognize signs and symptoms indicative of depression
 - Anticipate suicide risk
 - Outline strategies and resources for responding to the depressed resident
- ### Substance Abuse
- List 5 substances most commonly abused by physicians

- Cite the recovery rate for physicians with substance abuse or dependence who enter treatment
- Recognize common indicators, signs, and symptoms of substance abuse in residents
- Describe the medico-cultural factors relative to substance abuse in physicians
- Anticipate the favorable treatment outcomes of substance abuse in physicians

(Continued on page 4)

Duke's Life Curriculum

Program includes
3 CDs and 2 Teacher
Guides

3 CD's include 12
modules:

Fatigue
Stress and Depression
Substance Abuse
Disruptive Behavior
Burnout
Boundary Violations
Impairment
Instructive Feedback
Legal
Generations
Applicants
Program Directors

Teacher's Guides
I and II

Provides teacher with:
Aim of module
Objectives
Background Information
Scenario Summary
Discussion Questions
Scenario Reruns
Role Playing Exercises
Teaching Points
Discussion Topics
Management Strategies
Review of Topic
Resources
References

Module Objectives (continued from page 3)

- Outline the types of policies and procedures PDs should have in place for prevention, identification, and management of substance abuse

- List resources available for residents with substance abuse problems

- Discuss strategies for creating a non-punitive, collegial culture

Disruptive Behavior

- Define disruptive behavior
- Describe the impact of disruptive behavior on the medical environment and the health care team

- Recognize the signs and symptoms of disruptive behavior

- Outline strategies to identify, intervene, and manage disruptive behavior

- Access resources to develop effective tools and responses

Burnout

- Describe the signs, symptoms, and consequences of burnout

- Identify characteristics in the individual, the work environment, and the family that increase risk

- Select management techniques to help prevent, identify, or alleviate burnout

- Contrast the challenges residents face in life with those they face in residency

- Identify the signs and symptoms of career uncertainty in a resident

- Compare management strate-

gies appropriate for residents with career uncertainty

Boundary Violations

- Outline strategies for prevention, detection, and intervention for boundary violations

- Contrast sexual violation and sexual impropriety

- Describe the inherent power differences that constitute the primary factor in boundary violations

- Analyze the role that the perceptions of both participants play in boundary violations

- Identify cultural diversity issues as they relate to the potential for misunderstanding in the physician patient encounter

- Recognize that boundary violations can occur in same gender as well as mixed gender relationships

- Assist residents in understanding the difference between healthy demonstrations of empathy and actions that might be construed as boundary violations

Impairment

- Identify performance and behavior patterns that warrant an evaluation

- Recognize poor performance as a symptom

- Refer to an entity that can conduct an appropriate and confidential evaluation

- Determine when the program's best option is to terminate

- Explain the principle of

“reasonable accommodation”

- List the “essential job functions” of your residency

- Name effective interventions that can help a resident address deficiencies in performance

- Describe the process of evaluation be an employee health office and a state PHP

- Respond appropriately to candidates with disabilities

Instructive Feedback

- Identify barriers to honest, productive communication

- Describe the common traps of the evaluation process and enumerate ways to avoid them

- Name the 5 stages of a learner's reaction to critical or instructive feedback

- List strategies to deal with these reactions

- Explain the paradoxical statement: If the interaction with the learner went smoothly, then it did not go well

From:

Andolsek, MD, MPH, Kathryn and Cefalo, MD, PhD, Robert. LIFE Teachers Guide I. 8/14/08.

<http://www.lifecurriculum.info/downloads/teachersguideI.pdf>

Policy Spotlight: Academic Appeals Process

“All residents have the right to appeal any disciplinary or adverse academic action taken by the residency program or institution that results in dismissal, non-renewal of agreement, non-promotion, or other action that could threaten intended career development.” The UT GME Academic Appeals Process contains 3 levels of appeals. The first is a departmental review. During this level the department chair or an appointed advisory committee reviews the case. The second level of appeals is the GME review where the Executive Associate Dean of GME reviews the case. Finally,

the third level of appeals is the Institutional Review where the Dean of the COM reviews the case. At each level of appeal, the resident must submit a written request to the appropriate person. After each level of appeal the resident and DIO will be notified of the decision. Also, the first departmental level of appeal may be waived to proceed to the GME level of appeal and review.

For complete details see the Policies and Procedures Handbook at www.utmem.edu/GME

REVISED ACGME PROGRAM REQUIREMENTS

Effective July 1, 2008

- Pediatric Orthopaedics
- Orthopaedics Sports Medicine
- Diagnostic Radiology

Welcome New Program Directors

The Insider would like to send out a warm welcome to the following new Program Directors:

Family Medicine St. Francis:

Steven Schrock, MD

Pediatric Endocrinology:

Robert Ferry, MD

Rheumatology:

Laura Carbone, MD

Hematology/Oncology:

Furhan Yunus, MD

Urology:

Robert Wake, MD

Pediatric Urology:

Mark Williams, MD

Pediatric Orthopaedics:

Jeffrey Sawyer, MD

Orthopaedic Surgery:

David Richardson, MD

Accreditation Status Update

Vascular Neurology Accreditation 3 year cycle

Dermatology Accreditation 3 year cycle

New Programs

Vascular Neurology

Geriatric Psychiatry

Child and Adolescent Psychiatry

UT Trivia

Test your UT Knowledge!!!

Who is the longest serving Program Director?

When was UT founded?

What GME program has been in existence the longest?

Make your concerns known!!!!

Confidential Resident Comments can be made at www.utmem.edu/GME

The GME Insider
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Memphis, TN 38163



Upcoming Events (Oct 08-Jan 09)

Systems Based Lecture Series

North Auditorium, Coleman
Bldg 12-1pm
Oct 3: Anti-Aging Medicine I
Nov 7: Speaker: Steve Cohen
Dec 4-5: SVMIC
Jan 2: TBD

Program Coordinator's Meeting

North Auditorium, Coleman
Bldg 9-11am
Oct 9th
Nov 13th
Dec 11th
Jan 8th

Graduate Medical Education Committee Meeting

A101 Coleman 12-2pm
Oct 24th
Dec 12th
Jan 23rd

Internal Reviews

Neurology: 11/10/08
Pediatric Urology: 11/14/08
Neurosurgery: 11/17/08
Nephrology: 12/2/08
Infectious Disease: 12/3/08
Rheumatology: 12/4/08

SVMIC Conference

December 4-5, 2008

How Do I?

Future issues of the Newsletter will feature questions from program directors, program coordinators, and residents that focus on practical aspects of GME, along with the answer. Please submit questions to ahall32@utmem.edu

Residents are you Concerned? or Have Questions?

DIO Open Door Policy

When: 8am-4:30pm
Where: 920 Madison Suite C50
Who: Mary Ann Watson, DIO

RESIDENT REMINDER

Mark your calendars for the annual SVMIC Conference

Dec 4th: 5:30-8:00
Dec 5th: 8:00-10:30, 11:30-2:00