Chief Resident Orientation

Friday, May 13, 2011
12:00-4:30 PM
Dining Room A, Riverside East
(Parking will be Validated for those Parking in the Red Ramp)

(Lunch will be provided beginning at 11:45 AM)

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
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</table>
| 12:00 - 12:10 | Introductions & Welcome      | Carol Sundberg
               |                              | Director of Operations for GME;                                        |
|             |                              | Dr. Louis Ling                                                          |
|             |                              | Associate Dean for GME                                                  |
| 12:10 - 12:30 | Navigating UMMC, F           | Dr. James Breitenbicher                                                  |
|             |                              | UMMC VP for Medical Affairs & Clinic Operations;                        |
|             |                              | Terri Lloyd                                                             |
|             |                              | GME Director, Fairview Health System                                    |
|             |                              | Lauren Beckstrom                                                        |
|             |                              | Physician Recruitment Specialist, Fairview Health System                 |
| 12:30 - 1:30 | Conflict Resolution          | Carolyn Chalmers                                                        |
|             |                              | Director, Office for Conflict Resolution;                               |
|             |                              | Janet Morse                                                             |
|             |                              | Director, Student Conflict Resolution Center;                           |
|             |                              | Matt Hanson                                                             |
|             |                              | Staff Psychologist & Coordinator for Career & Outreach Services, U Counseling & Consulting Services |
| 1:30 - 1:45 | ~ BREAK ~                    |                                                                         |
| 1:45 - 2:45 | Residents in Difficulty -   | Dr. Phillip Rauk                                                        |
|             | Remediation                  | Director, Obstetrics & Gynecology Residency Program                     |
| 2:45 - 3:00 | ~ BREAK ~                    |                                                                         |
| 3:00 - 3:30 | Knock ‘em Dead Presentations | Dr. Matthew Ambrose                                                      |
|             |                              | Chief Resident, Pediatrics                                              |
| 3:30 - 4:30 | Surviving as Chief Resident  | Dr. Matthew Ambrose                                                      |
|             | (Chief Resident Panel)       | (Pediatrics)                                                            |
|             |                              | Dr. Keith Moench (PM&R)                                                 |
|             |                              | Dr. Roberto Gamez (Lab Med & Path)                                     |
|             |                              | Dr. Ann Coumbe (Internal Medicine)                                     |
|             |                              | Dr. Scott Reule (Internal Medicine)                                     |

Adjourn
Chief Resident Roles
Hospital Perspective

• Supervision of junior trainees
• Assist hospital with policy and procedure compliance – role model appropriate behavior
• Committee participation
• Interface with program directors
• Adverse event/root cause analysis
• Resource to faculty, hospital, administration, trainees, students
Chief Resident
Key Hospital Issues - 2010

• Hand washing
• Immediate BBFE reporting and follow-up
• Site marking for all procedures
• Order authentication within 24 hours
• Timely discharge planning
• Immediate dictated discharge summaries
• Response to documentation queries
Fairview Health Services
Code of Professional Behavior

PROFESSIONALISM
Code of Professional Behavior

• Place the patient at the center of all we do
• Apply the best science we know
• Model the highest degree of professionalism
• Actively engage as a collaborative member of the care team
• Be aware of, and comply with the rules
Patient Centered Care

• Be available and approachable
• Provide all needed information to patients and staff regarding their treatments and their choices
• Advocate for the patient and family
• Respect confidentiality
• Do our best to meet patient needs within the constraints of science, ethics, and available resources
Apply the Best Science

- Maintain professional knowledge by continuing education, reading, learning from colleagues
- Consult appropriately
- Acknowledge that I am an educator for patients, families, and colleagues
- Disclose conflicts of interest
Model Professionalism

- Share knowledge proactively
- Communicate effectively and respectfully
- Challenge others respectfully
- Avoid speaking negatively about other health care providers
- Model appearance and deportment in a manner which instills confidence and provides comfort
- Refrain from sexual contact or romantic relationships with current patients
- Avoid conduct or activities which could impair judgment and ability to act competently
Team Collaboration

• Actively engage in team conversations, meeting, rounds
• Share helpful information
• Listen carefully and well
• Communicate effectively with referring physicians
• Respond to colleagues and staff in a timely manner
• Manage hand-offs
Comply with Rules

• Know and follow pertinent hospital policies
• Monitor my own behavior, and the behavior of others
• Provide honest feedback and coaching
Questions?

For more information:

Jim Breitenbucher, M.D.
VP Medical Affairs & Clinical Operations
612-273-6086, jbreite1@fairview.org

Mira Jurich
Coordinator, Graduate Medical Education
612-273-7482, mjurich1@fairview.org
Active Bystanders

If you SEE something – SAY something

Have you witnessed hostile, intimidating, or threatening behavior? Bystanders have an important role to play in improving the learning and working conditions at the University. If you are able to “speak up,” there can be many benefits from your actions. If you are in a position of leadership or an opinion leader in your group, others may look to you for guidance on how to respond. You have a responsibility to ensure a positive environment for residents.

Toxic Behavior (www.sos.umn.edu/stafffaculty/Toxic Behavior.pdf) can be very destructive and cause harm if allowed to continue unchecked. Active bystanders can participate directly and indirectly to address this problem.

When you observe shouting, belittling, or threatening conversations on campus, please consider taking action. Ask yourself:

- What is my role?
- Who is in a good position to help me address this problem?
- Whom can I trust to advise or help me with this situation?
- How can I take action without making matters worse?
- What do I hope to accomplish?

Direct Intervention

If I observe a conversation that includes shouting, belittling, or threatening comments, what can I do? You might try ignoring the argument, joining the conversation and shifting the focus to a neutral topic, distracting the parties, or diffusing the situation by saying something like:

- Are either of you planning on going to the seminar this afternoon?
- Have either of you seen ______? I’ve been looking for them all morning.
- Could I get your help on __________________?

Or you may choose to acknowledge that you have overheard the conversation by reflecting back to the parties:

- I see that you are having a discussion...
- Excuse me if I am interrupting a private conversation. I overheard...
- What I just heard makes me feel uncomfortable...
Active Bystanders: If you SEE something – SAY something

These statements may alert the parties to your presence in a non-threatening way. Depending on the response, you may wish to add:

- I was just going to grab a coffee. Would either of you like to join me?
- Is there anything I can do to be helpful?

In extreme cases, the discussion may escalate to a level where you (as a bystander) are uncomfortable and believe someone's safety is at risk. In these cases, you may inform the parties you are uncomfortable with what is happening. Consider leaving to get immediate help.

Options for Following Up

Afterwards, you may wish to talk with one or both of the parties. Some of the issues you may focus on are:

- Here is what I observed.
- Here is how it made me feel.
- How can we work together to address this problem?

These examples may help you in a conversation with one of the people in the argument you witnessed:

- I came into the room when you were talking with _________, and the conversation made me feel pretty uncomfortable.
- How did you feel about what happened then?
- Let’s think about the resources and options for us in trying to address the problem.
- Are you interested in taking some action to address these concerns?

Another strategy is to talk with trusted colleagues who may have observed the behavior. Ask about possible resources and options. See the Quick Reference Guide for guidance on how to handle reports of toxic behavior (www.sos.umn.edu/stafffaculty/Responding.pdf).

Consider getting help from an informal, confidential resource about other intervention strategies:

<table>
<thead>
<tr>
<th>Student Conflict Resolution Center (SCRC)</th>
<th>Office for Conflict Resolution (OCR)</th>
<th>Louis J. Ling, M.D. Assoc. Dean for Graduate Medical Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>254 Appleby Hall</td>
<td>662 Heller Hall</td>
<td>B644 Mayo</td>
</tr>
<tr>
<td>Phone: 612-624-7272</td>
<td>Phone: 612-624-1030</td>
<td>Phone: 612-626-4009</td>
</tr>
</tbody>
</table>
1. **ENSURE PRIVACY** when you talk, and choose a time when you are not preoccupied or rushed.

2. **LISTEN** in a sensitive, non-threatening way.

3. **DEMONSTRATE YOUR UNDERSTANDING** by repeating back the essence of what has been said. Try to include both the **content** ("So you are new to this campus...") and the **feelings** ("...and you are feeling overwhelmed") as appropriate.

4. **ASK QUESTIONS** to get a better understanding of the scope and nature of the problem.

5. **EXPRESS CONCERN** in specific, nonjudgmental, behavioral terms. ("I noticed you weren’t in last weekend,” not “Where have you been lately?”)

6. **COMMUNICATE HOPE** by stating that there are always options, and things tend to look different with time.

7. **RECOMMEND RESOURCES** appropriate to the situation. Take the time to consult the resource ahead of time if you are unsure or would like more information on how they might be helpful in a particular situation. Remind the person that using resources is a sign of strength and courage, not weakness or failure.

8. **FOLLOW UP** in a reasonable length of time.

9. **CONSULT** with other professionals, especially if you are concerned about your safety or the safety of others.
<table>
<thead>
<tr>
<th>Guiding Principles</th>
<th>Description</th>
<th>Examples that Violate the Medical School’s Guiding Principles</th>
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</thead>
<tbody>
<tr>
<td><strong>HUMANITY</strong></td>
<td>Act in a humane way. The medical profession is committed to caring for patients, protecting patients’ rights and treating them with compassion, dignity and respect. Likewise, all Medical School students, staff, and faculty have a right to be treated with dignity and respect and are expected to treat one another in the same manner, regardless of their position or title. Mistreatment of any kind is not only inappropriate but is also prohibited by the University and Medical School policies.</td>
<td>❖ A professor berates students in class. ❖ An attending physician asks a student to plug their parking meter. ❖ A resident asks a student to go get their lunch. ❖ An attending physician asks a student to get them coffee. ❖ A professor asks a student to clean his office. ❖ A supervisor expects staff to work unreasonably long hours without any type of compensation or acknowledgment.</td>
</tr>
<tr>
<td><strong>EXCELLENCE</strong></td>
<td>Be committed to excellence. The Medical School wants students, staff and faculty to strive for excellence in all of their endeavors. Hence, the School encourages and supports the academic, professional and personal development of all of its members. Everyone should have equal access to all opportunities and discrimination of any form is prohibited.</td>
<td>❖ Female students are discouraged from pursuing surgery. ❖ Professor tells students of color not to consider applying for a neurology residency. ❖ Only male residents are considered for chief resident. ❖ GLBT students are not allowed to attend a medical conference.</td>
</tr>
<tr>
<td><strong>ACCEPTANCE</strong></td>
<td>Accept and welcome differences. The Medical School is committed to creating a harassment-free environment that does not interfere with students’ ability to learn or staff’s ability to work.</td>
<td>❖ A professor does not call on students of color in class. ❖ During rounds, an attending physician makes disparaging comment about a student’s religion. ❖ An attending physician makes a racial slur. ❖ A professor makes a derogatory comment about a student’s sexual orientation.</td>
</tr>
<tr>
<td><strong>LEADERSHIP</strong></td>
<td>Lead by example. Members of the Medical School community should not only be leaders in their professional and academic fields but also be leaders of integrity, that teach and model high standards of behavior.</td>
<td>❖ An endowed professor makes racial and gender biased comments in class. ❖ An attending physician has an affair with a resident in his department. ❖ An administrator repeatedly uses profanity in meetings.</td>
</tr>
<tr>
<td><strong>TEMPERAMENT</strong></td>
<td>Maintain a respectful temperament. All members of the Medical School community are entitled to be treated with respect. Everyone, irrespective of his or her role, is expected to communicate and behave in a professional and respectful manner. Appropriate boundaries and conduct should always be maintained.</td>
<td>❖ An attending physician yells at a student and makes them cry. ❖ An advisor crosses professional boundaries with an advisee by making sexual innuendos and engaging in inappropriate conduct. ❖ A resident propositions a student. ❖ A senior Medical School official ridicules staff and calls them incompetent.</td>
</tr>
<tr>
<td><strong>HONESTY</strong></td>
<td>Be honest. Members of the Medical School community are expected to conduct all of their affairs in an honest, fair and ethical manner. Intellectual, professional, and financial misconduct are not tolerated.</td>
<td>❖ A student cheats on an exam. ❖ A researcher forges a consent form. ❖ An attending physician, who has been paid by a pharmaceutical company, does not tell a student the potential side effects of a medication the company wants the physician to prescribe. ❖ A resident alters a chart to cover his misdiagnosis. ❖ A faculty member does not give a student credit for their contributions to a journal article.</td>
</tr>
</tbody>
</table>
Medical School Reporting Chart

Dr. Ted Thompson
Director of Clinical Education
626-2841
thomp005@umn.edu
B-329 Mayo

Office of Equal Opportunity & Affirmative Action
612-626-0751
www.coaffact.umn.edu
Kim Boyd, EOAA Director

Dr. Kathleen Watson
Associate Dean of Students & Student Learning
626-5812
drwatson@umn.edu
B-693 Mayo

Mary Tate
Director of Minority Affairs & Diversity
625-1494
tatex001@umn.edu
B-608 Mayo

Graduate Advisor

Course Director
(Yrs. 1 and 2)
Clerkship Director
(Yrs. 3 and 4)

Ethicspoint
1-866-294-8680
www.Ureport.ethicspoint.com

Medical School Students
IT was morning rounds in the hospital and the entire medical team stood in the patient’s room. A test result was late, and the patient, a friendly, middle-aged man, jokingly asked his doctor whom he should yell at.

Turning and pointing at the patient’s nurse, the doctor replied, “If you want to scream at anyone, scream at her.”

This vignette is not a scene from the medical drama “House,” nor did it take place 30 years ago, when nurses were considered subservient to doctors. Rather, it happened just a few months ago, at my hospital, to me.

As we walked out of the patient’s room I asked the doctor if I could quote him in an article. “Sure,” he answered. “It’s a time-honored tradition — blame the nurse whenever anything goes wrong.”

I felt stunned and insulted. But my own feelings are one thing; more important is the problem such attitudes pose to patient health. They reinforce the stereotype of nurses as little more than candy stripers, creating a hostile and even dangerous environment in a setting where close cooperation can make the difference between life and death. And while many hospitals have anti-bullying policies on the books, too few see it as a serious issue.

Today nurses are highly trained professionals, and in the best situations we form a team with the hospital’s doctors. If doctors are generals, nurses are a combination of infantry and aides-de-camp.

After all, patients are admitted to hospitals because they need round-the-clock nursing care. We administer medications, prep patients for tests, interpret medical jargon for family members and double-check treatment decisions with the patient’s primary team. Nurses are also the hospital’s front line: we sound the alert if a patient takes a serious turn for the worse.

But while most doctors clearly respect their colleagues on the nursing staff, every nurse knows at least one, if not many, who don’t.

Indeed, every nurse has a story like mine, and most of us have several. A nurse I know, attempting to clarify an order, was told, “When you have ‘M.D.’ after your name, then you can talk to me.” A doctor dismissed another’s complaint by simply saying, “I’m important.”

When a doctor thoughtlessly dresses down a nurse in front of patients or their families, it’s not just a personal affront, it’s an incredible distraction, taking our minds away from our patients, focusing them instead on how powerless we are.

That said, the most damaging bullying is not flagrant and does not fit the stereotype of a surgeon having a tantrum in the operating room. It is passive, like not answering pages or phone calls, and tends toward the subtle: condescension rather than outright abuse, and aggressive or sarcastic remarks rather than straightforward insults.
And because doctors are at the top of the food chain, the bad behavior of even a few of them can set a corrosive tone for the whole organization. Nurses in turn bully other nurses, attending physicians bully doctors-in-training, and experienced nurses sometimes bully the newest doctors.

Such an uncomfortable workplace can have a chilling effect on communication among staff. A 2004 survey by the Institute for Safe Medication Practices found that workplace bullying posed a critical problem for patient safety: rather than bring their questions about medication orders to a difficult doctor, almost half the health care personnel surveyed said they would rather keep silent. Furthermore, 7 percent of the respondents said that in the past year they had been involved in a medication error in which intimidation was at least partly responsible.

The result, not surprisingly, is a rise in avoidable medical errors, the cause of perhaps 200,000 deaths a year.

Concerned about the role of bullying in medical errors, the Joint Commission, the primary accrediting body for American health care organizations, has warned of a distressing decline in trust among hospital employees and, with it, a decline in the quality of medical outcomes.

What can be done to counter hospital bullying? For one thing, hospitals should adopt standards of professional behavior and apply them uniformly, from the housekeepers to nurses to the president of the hospital. And nurses and other employees need to know they can report incidents confidentially.

Offending parties, whether doctors or nurses, would be required to undergo civility training, and particularly intransigent doctors might even have their hospital privileges — that is, their right to admit patients — revoked.

But to be truly effective, such change can’t be simply imposed bureaucratically. It has to start at the top. Because hospitals tend to be extremely hierarchical, even well-meaning doctors tend to respond much better to suggestions and criticisms from people they consider their equals or superiors. I’ve noticed that doctors otherwise prone to bullying will tend to become models of civility when other doctors are around.

In other words, alongside uniform, well-enforced rules, doctors themselves need to set a new tone in the hospital corridors, policing their colleagues and letting new doctors know what kind of behavior is expected of them.

This shouldn’t be hard: most doctors are kind, well-intentioned professionals, and I rarely have a problem talking openly with them. But unless we can change the overall tone of the workplace, doctors like the one who insulted me in front of my patient will continue to act with impunity.

I wish I could say otherwise, but after being publicly slapped down, I will think twice before speaking up around him again. Whether that was his intention, or whether he was just being thoughtlessly callous, it’s definitely not in my patients’ best interest.

Theresa Brown, an oncology nurse, is a contributor to The Times’s Well blog and the author of “Critical Care: A New Nurse Faces Death, Life and Everything in Between.”
You have a problem with a resident, attending, staff, student, or patient. Perhaps you need to tell an attending that you disagree with a treatment plan. What do you do? Should you have a face-to-face conversation? If so, how do you prepare? How do you conduct this potentially awkward discussion?

**INITIAL CONSIDERATIONS**

Do you want to do something about it? If the situation is temporary, a wise alternative may be to cope with the problem rather than confront it. However, if the problem is serious and difficult to resolve, you may want to have a dialogue with the person.

If you want to do something about it, consider whether a direct conversation is the best approach. Consult with someone who understands the clinical culture. The Student Conflict Resolution Center (academic issues), Medical School Minority Affairs and Diversity, the Office of Equal Opportunity and Affirmative Action, or a trusted faculty/mentor are all good resources. Consider:

- How does a direct conversation contribute to the achievement of your short- and long-term goals? If your goal is to vent, don’t have the conversation.
- If you value the relationship, a direct conversation could enhance the relationship or risk damaging it. If you feel unsafe or threatened in the relationship, don’t have a face-to-face conversation.
- What are the alternatives to a face-to-face conversation? Are there intermediaries who can help?

**SETTING UP THE MEETING**

If you decide a direct conversation is best, don’t do it by email or phone. Meeting face-to-face will provide you the opportunity to judge the reaction of the other person and adjust your approach, if needed.

- Make an appointment, planning for adequate time. The place should be private.
- Consider practicing the conversation with a trusted mentor or friend. Anticipate the range of reactions and practice your response.
THE CONVERSATION

- Use diplomatic, not inflammatory, language to present the issue in the meeting.
  - Give the other person the benefit of the doubt. Don’t assume the worst about intentions. Try to put yourself in his or her shoes and understand the needs and stressors that person is experiencing.
  - Frame the conversation so that you are acknowledging his or her needs and helping to make clear your own needs and concerns.
  - Avoid judgmental language. For example, instead of saying, “You could have told me two months ago, but you didn’t,” try something like, “This assignment comes at a time when I have no real options to change my schedule.”

- Understand and acknowledge your role in the conflict. Maybe you missed a deadline, failed to communicate about obstacles, or have been inaccessible or non-responsive at times. Acknowledge these shortcomings.

- Be an attentive listener.

- Try to have an open and positive attitude.

- Come prepared to share some ideas for resolutions and to listen to others. Be open-minded about possible solutions. If the other person asks, “What do you want me to do about it?” respond by generating several acceptable outcomes rather than limiting yourself to only one.

- Be brief, organized, and to the point.

ENDING THE CONVERSATION

- Have an exit strategy in case the conversation goes badly. If the conversation begins to escalate unpleasantly, bring it to an end. For example, “Rather than talking more now, let’s think this over and talk more after we’ve had a chance to reflect on this.”

- Have realistic expectations. It may be a great achievement for the conversation to go “not badly.” Don’t expect it to provide the ideal resolution or to resolve all of the relationship issues.

- Identify next steps before concluding the conversation. When will you hear back regarding the response? Will you do further problem solving? Acknowledge that you may feel awkward in the days ahead but you want to get over the awkwardness and have a good working relationship.

SUPPORTIVE AND CONFIDENTIAL RESOURCES

Student Conflict Resolution Center
254 Appleby Hall
612.624.7272
sos@umn.edu
www.sos.umn.edu

Medical School Minority Affairs and Diversity
B608 Mayo
612.625.1494
tatex001@umn.edu
www.meded.umn.edu/apps/mistreatment/
or
Equal Opportunity and Affirmative Action
274 McNamara Alumni Center
612.624.9547
www.ecaffact.umn.edu

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Residents in Difficulty and Remediation

Phillip N. Rauk, MD

Associate Professor, Division of Maternal-Fetal Medicine, Department of Obstetrics, Gynecology, and Women’s Health, University of Minnesota Medical School
and
Residency Program Director, Obstetrics and Gynecology
Resident in Trouble

- The troublesome resident
- The problem learner
- The difficult resident
- The disruptive resident
- The incapacitated resident
- The impaired resident
- The burned out resident
Residents in Trouble

- Generate a disproportionate amount of work
- Disrupt and compromise team work, patient safety and patient care
- Decrease program morale
- Cost programs money
Disciplinary Action by Medical Boards and Prior Behavior in Medical School

• Disciplinary action by medial boards was strongly associated with prior unprofessional behavior in medical school – OR 3.0
  – Severe irresponsibility – OR 8.5
  – Diminished capacity for self improvement – OR 3.1
  – Poor medical school grades – OR 1.1 -1.6

• Questions
  – Do we identify and remediate professionalism in residencies?
  – Do we remediate professionalism well in residencies?
  – Can we change behaviors in residency?
Defining the Problem Resident

• Knowledge Problem
  – Deficiencies in the knowledge of the basic and clinical sciences

• Attitude Problem
  – Difficulties in doctor-patient relationship
  – Interpersonal conflicts
  – Problems with responsibility and self-assessment

• Skill Problem
  – Problems with interpretation of information
  – Problems with performance of technical skills
  – Problems with organization of work
• **Patient Care**
Residents must be able to provide patient care that is **compassionate, appropriate, and effective** for the treatment of health problems and the promotion of health.

• **Medical Knowledge**
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the **application of this knowledge to patient care**.
• **Practice-based Learning and Improvement**
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on **constant self-evaluation and life-long learning**. Residents are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one’s knowledge and expertise;
- set learning and improvement goals;
- identify and perform **appropriate learning activities**;
- systematically analyze practice using **quality improvement methods**, and implement changes with the goal of practice improvement;
- incorporate formative evaluation feedback into daily practice;
Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society and the profession; and,
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
• **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

- communicate effectively with physicians, other health professionals, and health related agencies;

- work effectively as a member or leader of a health care team or other professional group;

- act in a consultative role to other physicians and health professionals; and,

- maintain comprehensive, timely, and legible medical records, if applicable
Systems-based Practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- work effectively in various health care delivery settings and systems relevant to their clinical specialty;

- coordinate patient care within the health care system relevant to their clinical specialty;

- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

- advocate for quality patient care and optimal patient care systems;

- work in interprofessional teams to enhance patient safety and improve patient care quality; and

- participate in identifying system errors and implementing potential systems solutions.
Differential Diagnosis of Disruptive Abusive Behavior

- Situation related stress
  - Financial problems
  - Marital problems
  - Increased work hours
  - Decreased leisure time
- Learned behavior
- Substance abuse or dependency
- Personality disorder
- Psychiatric illness
Situation Related Stress

- Financial Problems
- Marital Problems
- Increased Work Hours
- Decreased Leisure Time

- Most common cause for disruptive abusive behavior
Learned Behavior

• A maladaptive behavior pattern based on role modeling, experience, and reinforcement
  – Yelling at patients, other physicians, or nurses
  – Throwing of instruments
  – Tirades at nurses station
  – Striking other members of the health care team

• Used to improve patient care and get attention

• Can be “unlearned” with mentoring
Substance Abuse or Dependency

• Rarely presents as disruptive abusive behavior

• Cocaine or Methamphetamine
  – Aggressiveness
  – Intrusiveness
  – Hyperactivity

• Alcohol withdrawal
  – Irritability
  – Argumentative
Personality Disorder

• Narcissism
  – Overestimates abilities
  – Inflates accomplishments
  – Appears boastful and pretentious
  – Underestimates of the contribution of others
  – Physician = GOD
Psychiatric Illness

- Depression
- Anxiety
- Mania
- Schizophrenia is rare
Recognition of the Problem

- Difficult as these residents are often given more latitude or called eccentric
- The resident will “work it out on their own”
- The problem will go away
Symptoms and Signs of Abusive Behavior

- Insensitivity
- Selfishness
- Irresponsibility
- Competitiveness
- Need for control
- Marked irritability

- Mood swings
- Interpersonal strife
- Abusive behaviors
- Erratic work behaviors
- Inappropriate medical care
Working with the Difficult Resident

• Understand duties and obligations of the Program and the Institution
  – Program is responsible for educational integrity, accreditation, and competency
  – Institution is responsible for the “protection of the patient”

• Knowledge, Skills, and Professional Behavior are of EQUAL importance to performance
Anticipate Reaction of the Resident

- If the interaction went smoothly, then it did NOT go well

1. Denial
   - Normal response
   - Will attribute their behavior to a strong personality

2. Anger
   - Acknowledge the emotion
   - Do not concentrate on the comments

3. Understanding
   - Listen carefully to the individual
Anticipate Reaction of the Resident

4. Bargaining
   • Be very aware what is within your authority and control
   • Do not promise what is not within your authority or control

5. Acceptance and Agreement
   • Written
   • Oral
   • Documented well
Interview Process

- Demonstrate concern and desire to remediate the resident
- Give both positive and negative feedback
- Appeal to experience and wisdom of resident
- Bring in all the data – evaluations, scores, etc.
- Allow the resident to talk but do not focus on specific events/occurrences
- Focus on performance not person
- Be fair, be firm, be positive
At the End of the Interview

• Be very specific about the problem
  – Focus on the competencies
  – Focus on the behavior

• Give instructions for remediation
  – Performance Improvement Plan
    • Guidelines, measures, outcomes

• Be specific about the consequences if improvement is not seen
  – Time frame
  – Regular meetings
Treatment

• Address the underlying pathophysiology
  – Mental health assessment
  – Behavior modification
  – Anger management
  – Rehabilitation
  – Stress management
    • Partner/Marriage counseling
    • Financial counseling
    • Work flow management
Aftercare Program

• Ensure due process
• Monitor the Performance Improvement Plan
• Ensure compliance with outcome objectives
• Regularly meet with Program Director and/or Administrative Chief Residents
Residents In Trouble: An In-depth Assessment of the 25 year Experience of a Single Family Medicine Program
Reamy BV and Harman JH, Fam Med 2006;38:252-7

• Prevalence 9.1% (National ABIM 8-15%)
• Occurrences
  – Fund of Knowledge 27%
  – Attitudinal Problems 22%
  – Interpersonal Conflict 15%
  – Psychiatric Illness 12%
  – Substance Abuse 7%
  – Relationship Disruption 5%
Residents In Trouble: An In-depth Assessment of the 25 year Experience of a Single Family Medicine Program
Reamy BV and Harman JH, Fam Med 2006;38:252-7

• Documentation of Occurrences
  – GMEC minutes 37%
  – Program Director memoranda 31%
  – Resident rotation evaluations 20%
  – Education Committee minutes 11%
  – Summative transcripts of rotations 0%
Residents In Trouble: An In-depth Assessment of the 25 year Experience of a Single Family Medicine Program
Reamy BV and Harman JH, Fam Med 2006;38:252-7

• Remediation Methods
  – Increase faculty advisor meetings 62%
  – Assigned core content review 52%
  – Increased clinic videotaping 43%
  – Change in rotation schedule/extensions 42%
  – Psychiatric counseling 38%
  – Modified clinic schedules 29%
  – Formal rehabilitation program 14%
Residents In Trouble: An In-depth Assessment of the 25 year Experience of a Single Family Medicine Program
Reamy BV and Harman JH, Fam Med 2006;38:252-7

• Suggestions for Management of Remediation
  – Develop a robust faculty advisor program
  – Be persistence as success is 90%
  – Don’t give up on certain occurrences. Everything can be remediated successfully - even substance abuse
  – Use psychiatric counseling liberally
  – Multiple modalities are required for almost all successful remediation plans
A Model for Instituting Comprehensive Program of Remediation for At –Risk Residents


- Blueprint for Developing a Program of Remediation
- Sample Remediation Curriculum
- Effect on Other Trainees
Blueprint for Developing a Program of Remediation

**Identify problem resident**
- Confirm report of deficits
- Documentation—develop resident file

**Decision to remediate**
- Discuss case with Graduate Medical Education committee or Designated Institutional Official
- Discuss in departmental Education Committee
- Seek advice of institution’s legal counsel
- Rule out organic factors—Occupational Health

**Administrative notice**
- Resident at risk
- Department faculty
- Chief Residents
- Other house staff

**Curriculum development**
- Create tailored objectives and appropriate activities
- Identify faculty advisors and tutors
- Determine if participation in other institutional trainings is necessary

**Evaluation**
- Develop evaluation tool
- Evaluate resident at regular intervals
- Periodically share results with resident

**Possible immediate program or department ramifications**
- Culture of fear may develop among residents
- Residents support their colleague during difficult time—or vice versa
- Faculty support for remediation—or vice versa
- Scheduling: other house staff and faculty may be affected by resident’s altered schedule
- Resident’s teaching responsibilities and privileges may be suspended; may not be allowed to participate in rotations

**Possible long-term program or department ramifications**
- Improved skills/training for resident having difficulty
- Review/update department educational goals and objectives
- Department may earn reputation for being supportive and mentoring
- Program may influence institutional policy for remediation (if one doesn’t already exist)
- Opportunity to concentrate on faculty development in feedback and evaluation skills

**Resident involvement (ongoing)**
- Program Director discuss deficits with resident when they are first identified
- Inform resident of department’s escalated involvement via communication with the Program Director and other documentation
<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>ACGME Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve fund of knowledge in obstetrics and</td>
<td>Weekly instruction in obstetrics, using specifically designed curriculum</td>
<td>Medical knowledge</td>
</tr>
<tr>
<td>gynecology</td>
<td>with obstetrics faculty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekly instruction in gynecology, using specifically designed curriculum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with gynecology faculty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reading program/self-study</td>
<td></td>
</tr>
<tr>
<td>Improve surgical skills</td>
<td>Modified operating schedule with an attending physician</td>
<td>Practice-based learning and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>improvement/medical knowledge</td>
</tr>
<tr>
<td>Address concerns about</td>
<td>Medical evaluation by occupational health services</td>
<td>Interpersonal and communication</td>
</tr>
<tr>
<td>interpersonal behavioral issues</td>
<td>Interpersonal skills course</td>
<td>skills/professionalism</td>
</tr>
<tr>
<td></td>
<td>Appointments with psychiatrist/counselor during probationary period</td>
<td></td>
</tr>
</tbody>
</table>

ACGME, Accreditation Council for Graduate Medical Education.
Effect on Other Trainees

- Junior residents working under a resident in remediation may be uncomfortable with supervision and teaching.
- Changes in schedules, duty hours, and leave of absence disrupt others schedules and increase coverage.
- Other residents require emotional support.
- Heightened surveillance of the resident in remediation affects other residents.
- Fear of expulsion of a resident may cause unrest in the residency as a whole.
- Administrative chiefs are often asked to participate in the remediation process – they are peers.
Summary

• Remediation is required in 8-15% of residents - you will encounter remediation in your residency program
• Residents in trouble commonly require remediation in only multiple core competencies
• Remediation requires multiple modalities for effective resolution
• Though the Program Director and Advisor play a major role in the process toward remediation, fellow residents become involved in the process.

• Remediation has a success rate of 90%
Knock ‘em Dead Presentations

Matt Ambrose, MD
Pediatric Chief Resident 2010-2011
5/13/2011
Objectives

• To review the purpose of PowerPoint
• To review the process of crafting a presentation
• To review PowerPoint style
• To review PowerPoint content
• To provide tips for successful presentations
What makes a good PowerPoint presentation?
What makes a bad PowerPoint presentation?
URBAN PIGEONS AND THE CASPER PIGEON PROJECT

FOR INTERNAL COOPERATOR USE

TECHNICAL POINT OF CONTACT:

Pigeon Biology:
Social birds; mate for life
May achieve sexual maturity at 7 months; breed year round
Produce 1-2 eggs per clutch (the incubation period is approximately 18 days); overlap of clutches and broods common in summer
Young fledge within 48 days of hatching
Life expectancy of 2.4 years

Problems associated with feral pigeons:
Carry and transmit diseases that pose risk to human health
Fecal contamination (long-term roosts often characterized by incredible accumulations of pigeon feces)

Methods to resolve problems associated with feral pigeons:
Non lethal techniques: include frightening devices and exclusion
Lethal techniques: include trapping, hand capture, shooting and use of avicides (e.g., pesticides)
Wildlife Services employs shooting, trapping, net capture and pesticides to manage the Casper pigeon population

Barriers to solving the problem:
Prolific nature (high reproductive potential)
Dispersion (widespread occurrence) and inaccessibility (not all private property is accessible)
“Backyard” feeding — 100% of 30 pigeon crops examined contained anthropogenic food sources
A Few Quick Points

• Your title slide makes a BIG first impression

• You don’t want your audience talking about your design or background
  – Ineffective presentations negate excellent content

• You (not your slides) are the star of the show

• Practice
Purpose
Process
Preparing the Presentation

• Map it out first!
• Plan for 1-2 minutes per slide
• Use anecdotes and stories
• Slides should be meaningless without YOU
Style
Choosing a Background

- Use contrast
- Consistent and subtle
- Avoid distractions
- Make it forgettable
Knock ‘em Dead Presentations

Matt Ambrose, MD
Pediatric Chief Resident 2010-2011
University of Minnesota Department of Pediatrics
Chief Resident Orientation
May 13, 2011
Knock ‘em Dead Presentations

Matt Ambrose, MD
Pediatric Chief Resident 2010-2011
University of Minnesota Department of Pediatrics
Chief Resident Orientation
May 13, 2011
Everyone Hates These Templates

- They were cool in 1992
- But like clip-art
- They are tacky and distracting
- So don’t use them
Background – Bad

- Avoid backgrounds that are distracting or difficult to read from
- Always be consistent with the background that you use
You Can Use Pictures
... but be careful
Choosing a Font

• Sans-serif vs. serif?
Choosing a Font

- Sans-serif vs. serif?
- Consistency within a presentation
- Never smaller than 24-point (except references)
- Headers: larger or different color
- *No italics (except references)*
Color Can Be Bad

- Using a font color that does not contrast with the background color is hard to read
- Using color for decoration is distracting and annoying.
- Using a different color for each point is unnecessary
  - Using a different color for secondary points is also unnecessary
- Trying to be creative can also be bad
Slide Design

• Keep it simple and uncluttered
• Phrases, not sentences (6-8 words/line)
• Max of 6 lines per slide
• Leave empty space
• If you can explain it visually, do so
Using Graphics

• Sparing, tasteful clip-art
• Consistent graphic style
• Check graphics on projector
  – Especially video!
Graphs – Bad

January: Blue Balls 20.4, Red Balls 30.6
February: Blue Balls 27.4, Red Balls 38.6
March: Blue Balls 90.0, Red Balls 34.6
April: Blue Balls 20.4, Red Balls 31.6
Graphs – Good

January 20 40 60 80 100
February
March 80
April
Content
Audience-Based

- What do they know?
- What do you need to tell them?
  - What can you teach them?
- What do they expect?
- What will be interesting to them?
  - What will keep them focused?
Repeat Important Points

- Introduce key concepts early
- Highlight them throughout the talk
- End with Take-Home Points
- Repetition, repetition, repetition
Presentation
Tips

• Maintain eye contact
• Be excited
• Speak slowly and clearly
• Have a laser pointer
• Dress to impress
• Practice
NEXT TIEM...

I WEAR HELMET
Take-Home Points

- Choose your background, fonts, colors, and graphics with care
- Slides to supplement YOU
- Proofread and confirm projection
- Get feedback from peers/mentors
- Practice
May I have your attention?
By Jon Hallberg, M.D.

Confessions of a reformed PowerPoint user.

I think I owe several of you an apology. Over the years, I’ve given dozens of presentations to groups large and small on topics ranging from bubonic plague to steroid use in athletes. Perhaps you were present for one of them. If so, it’s to you I owe the apology.

I gave many of those talks using royal blue slides with yellow lettering. (I was told this color scheme would make them especially easy to read.) I loaded the slides with as much information as I possibly could, although I tried to limit the number of bullet points to six per slide. (I was told this was the optimal number.) I made sure my slides would be easy to print. (Six per page.) I often read directly off my slides, as you read along with me—or ahead of me. I wonder now, how in the world did I keep your attention? (I suspect I didn’t.)

As I think back on some of those talks, I cringe. They must have been awful—dull, text rich and image poor. Where was the story? The pull? The hook? What was I thinking? And when did I fall into the trap of giving visually boring presentations? I can tell you. It was 1997, the year I discovered PowerPoint. But this is about to change. I’ve become a reformed PowerPoint user. And here’s why.

I discovered *Presentation Zen: Simple Ideas on Presentation Design and Delivery* by Garr Reynolds. If you give presentations, you need to read this book. For me, a single read-through changed the way I give talks and view them. I’ve been so taken by Reynolds’ message, I’m now on mission to improve the quality of medical presentations. Encouraging you to read his book is the simplest way I can do that.

Japanese comic book form. For a description of the Bunko book, I was directed to a slide show. I navigated through the more than 100 slides in about five minutes. They were simple and stark, mainly black and white with a little red for accent. They contained few words (sometimes only one), and each slide presented no more than a single idea. I wondered who created this thing. I clicked on another link and found out it was a guy named Garr Reynolds.

Reynolds is an expert on presentation design and delivery who lives in Japan. He loves simplicity, elegance, and white space. Reading his book (itself a thing of beauty), you immediately begin to see why most of our presentations are really awful. We cram too many words (and graphs and charts and data) onto our slides, and as speakers, we literally read off of them. (I think this is often the fault of conference organizers who ask for a copy of our slides ahead of time.)

In this slim book, just over 200 pages, Reynolds covers such ideas as creativity, crafting a story, simplicity, being present, and connecting with the audience. He shares several sample presentations, covering everything from sustainable food to aromatic chemistry. (If a presenter can make the properties of tetravalent carbon visually interesting, then those of us in medicine can surely make an update on congestive heart failure more engaging.) Reynolds also recommends a number of other books and websites, including my new favorite, the TED (for Technology, Education, and Design) conference site. (If you want to see how master presenters make superb use of PowerPoint and other visual tools, check out www.ted.com/talks.)

So why should physicians care about improving their PowerPoint presentations? As long as medical schools and medical conferences continue to offer lecture-like teaching, PowerPoint will continue to be the medium through which information is shared. And if that’s going to be the case, we presenters have a responsibility to improve our presentations. I can’t think of a better place to start this sea change than by reading Presentation Zen.

Jon Hallberg is medical director of the new University of Minnesota Physicians’ Mill City Clinic.
Academic Incivility:
Resources for Dealing with Harassment

The University of Minnesota is committed to a working and learning environment that is respectful, collegial, and free of harassment. Harassment can include offensive, intimidating, or hostile behavior that interferes with a student’s ability to work or study, such as, but not limited to, threatening or demeaning language.

If you or someone you know has experienced offensive, intimidating or hostile behavior that interferes with your ability to work or study, you don’t have to face these challenges alone. There are services here to support you.

First Step Contacts for Personal, Academic or Career Concerns

<table>
<thead>
<tr>
<th>Contact: Jan Morse</th>
<th>Contact: Mary Tate</th>
<th>Contact: Marilyn Becker</th>
<th>Contact: (RAP) Resident Assistance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Conflict Resolution Center (SCRC)</td>
<td>Minority Affairs and Diversity and Medical School EOAA Unit Liaison</td>
<td>Learner Development</td>
<td></td>
</tr>
<tr>
<td>Phone: 612-626-0689</td>
<td>Phone: 612-625-1494</td>
<td>Phone: 612-626-7196</td>
<td>Phone: 651-430-3383 (local); 1-800-632-7643 (toll-free)</td>
</tr>
<tr>
<td>Email: <a href="mailto:morse005@umn.edu">morse005@umn.edu</a></td>
<td>Email: <a href="mailto:tatex001@umn.edu">tatex001@umn.edu</a></td>
<td>Email: <a href="mailto:becke024@umn.edu">becke024@umn.edu</a></td>
<td>Web: <a href="http://www.sandcreekeap.com">www.sandcreekeap.com</a></td>
</tr>
<tr>
<td>Web: <a href="http://www.sos.umn.edu">http://www.sos.umn.edu</a></td>
<td></td>
<td>Office: B608 Mayo</td>
<td></td>
</tr>
</tbody>
</table>

Primary sources of assistance include:

- **Your Program Director or Faculty Advisor.** They are your essential partners in a successful educational experience. If you encounter a problem and feel comfortable approaching them, do it and do it early.

- **Student Conflict Resolution Center (SCRC).** If you want to talk to someone outside of your department, you can contact the SCRC. Consultations are confidential - no one will know you contacted SCRC without your permission. SCRC works with hundreds of students and offers information, coaching, and intervention. You can reach them by phone 612-624-SCRC, by email sos@umn.edu or in person (211 Eddy Hall).

- **Mary Tate.** The Director of the Medical School Office of Minority Affairs and Diversity is the Equal Opportunity and Affirmative Action liaison. For questions or concerns regarding matters of allegations of mistreatment, sexual harassment, or discrimination, the Office of Minority Affairs and Diversity may assist in finding solutions. You can reach her by phone 612-625-1494, by email tatex001@umn.edu, or in person B608 Mayo.

- **Marilyn Becker.** The Medical School Director of Learner Development. Dr. Becker assists residents and fellows with learning/performance concerns across the GME competencies and residency/fellowship requirements; provides assessments and referrals for special services [disability evaluation, ESL tutoring, personal/couple counseling, health/wellness assistance]; and is available for consultation on academic/training process difficulties. You can reach her by phone 612-626-7196, by email becke024@umn.edu, or in person B624Mayo.

- **Resident Assistance Program (RAP).** The Resident Assistance Program (RAP) is a confidential counseling service designed to offer residents and their immediate family members a professional, external resource to address a variety of stressors, at no cost to the client. In many cases, these stressors are affecting personal lives and impacting a resident’s ability to meet professional expectations in the workplace. You can reach them by phone 651-430-3383 (local) OR 1-800-632-7643 (toll free); or the web www.sandcreekeap.com.

For more information on campus resources, visit [http://www.sos.umn.edu/stafffaculty/academic_civility.html](http://www.sos.umn.edu/stafffaculty/academic_civility.html)

Delaying or avoiding a situation can make it worse. Don’t put off addressing a problem until you’re falling behind in your coursework or considering leaving your program or job. You don’t have to face it alone.

See also Resident Dispute Resolution Policy at: [http://www.med.umn.edu/gme/residents/instrupolicyman/disciplresdisputeresolpol/home.html](http://www.med.umn.edu/gme/residents/instrupolicyman/disciplresdisputeresolpol/home.html)

As always, if you believe there is imminent danger to a student or others, please call 911.
Support Resources for Residents/Fellows

Learner Development
Resident Educator Development
Disability Services
Resident/Fellow Spouse Group
Resident Assistance Program
GME Advising Guide for Residents and Fellows
GME Dispute Resolution Policy
Learner Development

Marilyn Becker, PhD LP
Director of Learner Development
B-624 Mayo Building
(612) 626-7196
becke024@umn.edu

Programs/Services:

Assistance to residents and fellows on learning/performance across the GME competencies and residency/fellowship requirements.

- Individual resident contacts by self-referral or program referral.
  - Improving test-taking
  - Learning in residency
  - Adapting to training environment
  - Maximizing efficiency
  - Problem solving
  - Time management
  - Organizational skills
  - Communication skills
  - Well-being
  - Assistance with preparing for USMLE Step 3, In-Training Exams
  - Assessment and Referral to other services [i.e. ESL language assistance, Disability Services, RAP, health/wellness services].

- Workshops/presentations and consultation to GME programs [topics such as improving test-taking, resident efficiency, time management, strategies for ITE prep groups, well-being, etc.].

- Program resource development.

Consultation resource for GME program medical trainees and program administration.

Rev 5/2011
Resident Educator Development (RED)

Introduction: An important part of a residents' job is that of educator. Residents teach medical students, patients, and each other. In order to be effective teachers, residents need to be equipped with teaching skills, important skills that may not have been covered in their own medical school training. RED was developed by Dr. Heather Thompson, Associate Program Director of the Internal Medicine Residency Program at the University of Minnesota, as a means to instruct residents on teaching skills.

To Enroll: E-mail RED@umn.edu with your name, program and U of MN email address. Once you receive confirmation from RED@umn.edu that you have been enrolled in the R.E.D. Moodle site, you can log in to the site via http://moodle.umn.edu. You will see the course “Resident Educator Development (R.E.D.)” under the “My Courses” section in the center of the page. If you do NOT see this, you will need to activate your account in Moodle before you can access the page; do so through this link: http://www1.umn.edu/moodle/instructor/guides/activate_account.html. Troubleshooting? E-mail RED@umn.edu.

GME Contact: Erica King via email [king0367@umn.edu] or at 612–624–9641.

Self-Guided Training Materials
There are multiple modules below designated as "Train the Trainer" materials that faculty, chief residents and others may use to train residents in these topic areas. Each module contains a PowerPoint presentation that outlines the module content, role play scenarios or video clips that illustrate the principles discussed and summary handouts for the session participants.

| Course Information |
|---------------------|-------------------------------------------------|
| **Module**          | **Description**                                 |
| Team Leadership     | This module describes tips to help residents effectively supervise a team of learners. Topics addressed include: setting expectations; time management; and providing feedback. |
| Giving Effective Feedback | This module offers tips on understanding the level learners are at and giving effective feedback to learners. |
| How to Give a Ten-Minute Talk | This module provides tips and techniques so students and interns can understand how to give a concise, focused talk. |
| Microskills Module | This module discusses a clinical teaching module called "The One Minute Preceptor". This model describes five steps that clinical teachers can use with students and residents to further learning and clinical skills development. |
| Bedside Teaching | This module provides tips and points for teaching focused skills (such as physical exam) at the bedside while effectively involving the patient. |
| Teaching Evidence-Based Medicine (EBM) | This module provides materials to teach the two main aspects of the practice of EBM: 1) Search Strategies; and 2) Clinical Appraisal of a Journal Article. The module also describes a tool called the "Educational Prescription", which can be used with residents and students on your team(s) to promote EBM activities. |
| Professionalism | This module contains video clips to begin a discussion of professionalism with residents and students. Three types of cases are provided for aspects of professionalism: physician–industry interaction; dissatisfied patient and family; and nursing staff complaints about the intern on the team. |
| Patient Safety and Medical Errors | This module provides a framework to teach residents and medical students about basic system elements that impact patient safety. Residents need to know how to approach medical errors as they are discovered within their teams in everyday patient care. |
RED Interactive Learning Activities

The GME office sponsors a variety of RED activities throughout the academic year:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Upcoming Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED &quot;Train the Trainer&quot;</td>
<td>Review of available RED modules and materials on eight topics. Designed for chief residents, faculty and others that will teach this material to other residents</td>
<td>Please email <a href="mailto:red@umn.edu">red@umn.edu</a> for further information</td>
</tr>
<tr>
<td>&quot;Giving Effective Feedback&quot;</td>
<td>See description above</td>
<td>Available as a self-study module in Moodle.</td>
</tr>
</tbody>
</table>
University of Minnesota Medical School – Disability Services/UReturn

DS/UReturn is the designated Disability Services office that serves residents and fellows with any disability or medical condition requiring accommodation or adjustment. As a neutral and confidential resource, DS/UReturn works with residents and fellows, with a disability or medical condition that, in some way, interfaces with their job/productivity. DS/UReturn provides assistance such as: confidential provision of medical documentation, determining and implementing reasonable accommodation/adjustment, and referral. DS/UReturn also provides consultation with and training for faculty and staff to ensure access to their programs, facilities, and services. All services are confidential and free. For more information or to arrange reasonable accommodations/adjustments, contact the DS/UReturn office, in the McNamara Alumni Center, Suite 170, (612)626–1333 (voice or TTY).

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Twin Cities Resident/Fellow Spouses & S.O.s Group

This group exists to help support those who are married to or in a committed relationship with medical residents or fellows in the Twin Cities area. It is intended to help them get to know others in their unique situation in order to form a social support system during this challenging stage of life. We hope you find it to be a helpful resource during your time as a resident/fellow spouse or significant other!

http://sites.google.com/site/tcrfspouses/

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On-Line Resources:

http://www.mentalhealth.umn.edu/ – Student Mental Health, Twin Cities Campus
http://www.med.umn.edu/gme/residents/wellness/home.html – GME Well-Being Tools

Rev 5/2011
Resident Assistance Program (RAP)

Sand Creek
333 North Main Street, Suite 203
Stillwater, MN 55082
Phone: 651-430-3383 or 1-800-632-7643

A Service for You and Your Family...

At times it's human nature to feel anxiety, frustration, depression, guilt or anger. Feelings such as these could stem from family tensions, financial problems, or career-related stresses. Whatever your situation may be, RAP is available to help.

It is understandable that for some people it takes a great deal of courage to ask for help. With that in mind, the Metro Minnesota Council on Graduate Medical Education has contracted with an agency called the Sand Creek Group to provide your Resident Assistance Program (RAP). It is an employee assistance program designed specifically for residents. Sand Creek's counselors have particular expertise in dealing with the unique needs of individuals in their residency training programs. Now there is a number you can call whenever the need arises. In making that phone call, you will receive help in addressing the issue and finding options for achieving resolution.

RAP is for you and your family members, your faculty, attending physicians; department heads and supervisors who need help in dealing with resident-related concerns.

Your Privacy is Protected... Since privacy is a primary concern, an outside firm provides your RAP services in a strictly confidential manner. Your written consent is required to disclose information.

What is the Cost? There is no charge associated with your assessment and short term counseling services provided through the RAP program. When additional or more specialized services are indicated, you will be referred to outside resources for help. In those cases, your RAP counselor will work with you to locate appropriate, accessible, and affordable resources based on your specific needs and preferences. Health insurance plans most often provide some coverage for a variety of mental health and chemical dependency concerns.

Help is Available Anytime... When the Sand Creek administrative offices are closed, their back-up clinical services answers calls on a 24-hour basis. Licensed mental health professionals staff this service. You can feel comfortable accessing this program at any time of the day.

RAP Designed to be Flexible... RAP is designed to be flexible and to accommodate your busy schedule. You may either talk with a counselor at one of many Sand Creek clinical offices around the metro area or meet at your hospital. Appointments are scheduled throughout the day. Evening hours are available as well.

RAP is Here for You... Counselors at Sand Creek are available to help you address issues and personal concerns such as the examples listed below.

- My debts have become overwhelming. How can I get a handle on them?
- I think the stress of my residency is impacting my health. How do I discreetly find out?
- I worry about my career choice. Who should I talk to?
- My relationship isn't fulfilling but I don't want to be alone. What do I do now?
- My spouse is having difficulty adjusting to my residency. How do we adjust in a way that works for both of us?

Rev 5/2011
Graduate Medical Education
Advising Guide for Residents and Fellows

Developed by a Work Group Promoting Academic Civility at the University of Minnesota

General Guidelines for Taking Action

1. **ENSURE PRIVACY** when you talk and choose a time when you are not preoccupied or rushed.

2. **LISTEN** to the resident/fellow in a sensitive, non-threatening way.

3. **CHECK** with the resident/fellow to ensure that you are understanding the specific concerns from his/her point of view.

4. **ASK QUESTIONS** to get a better understanding of the scope and nature of the resident/fellow concerns regarding this experience and its impact on the work/learning environment.

5. **COMMUNICATE HOPE** by reminding the resident/fellow that there are always options, and things tend to look different with time.

6. **ASSIST** the resident/fellow with developing ideas about how to address the concerns.

7. **RECOMMEND RESOURCES** appropriate to the situation. Take the time to consult the resource ahead of time if you are unsure or would like more information on how they might be helpful in a particular situation. Remind the resident/fellow that using resources is a sign of strength and courage, not weakness or failure.

8. **FOLLOW UP** in a reasonable length of time to assess progress towards resolving the resident/fellow concerns.

9. **CONSULT** with your Program Director or Faculty Advisor and/or with other professionals [by contacting any of the offices listed below], especially if you are concerned about your safety or the safety of others.

<table>
<thead>
<tr>
<th>ACADEMIC CONCERNS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Considerations</strong></td>
</tr>
<tr>
<td>Keep in mind that there are many causes of academic/performance difficulties including:</td>
</tr>
<tr>
<td>• Difficulty with managing learning and/or understanding performance expectations.</td>
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<tr>
<td>• Difficulty balancing resident/fellow roles.</td>
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<tr>
<td>• Diagnosed or undiagnosed disability issues (Attention Deficit Disorder, Learning Disability)</td>
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<tr>
<td>• Mental health concerns (depression, anxiety etc.)</td>
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<tr>
<td>• Cultural, family or personal concerns</td>
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</tbody>
</table>

Many residents/fellows appreciate someone taking the initiative to express concern and provide clear feedback about their academic/clinical performance. Faculty may be able to help a resident/fellow with content-related difficulty, or may wish to refer to the resources below for these and other concerns.

<table>
<thead>
<tr>
<th>PERSONAL CONCERNS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Considerations</strong></td>
</tr>
<tr>
<td>Be <strong>CLEAR</strong> about what you can and cannot do.</td>
</tr>
<tr>
<td><strong>RESPECT</strong> the resident’s/fellow’s value system and culture.</td>
</tr>
</tbody>
</table>

Bear in mind… Resist the temptation to be a hero or savior
Recognize the limits of your role and refer to other professionals when needed.

Refrain from making promises you cannot or may not be able to keep.

If the resident/fellow or others are in danger, you will need to act; so be cautious about promises of confidentiality.

Doing something in response to a resident/fellow’s concern is almost always better than doing nothing.

Residents/fellows may be in a new and potentially disorienting day-to-day cultural context while some also feel disconnected from their normal social supports.

### ADVISING RELATIONSHIP CONCERNS

#### Considerations

The relationship is dynamic and is defined by the expectations, needs and interests of both resident/fellow and advisor.

Conflict may occur in the advising relationship. Engaging constructively in conflict can provide for diverse perspectives and positive outcomes.

Clarifying expectations early in the relationship can minimize misunderstanding.

### RESOURCES

- **Program Director or Faculty Advisor**

  Marilyn Becker, PhD LP. The Medical School Director of Learner Development. Dr. Becker assists residents and fellows with learning/performance concerns across the GME competencies and residency/fellowship requirements; provides assessments and referrals for special services [disability evaluation, ESL tutoring, personal/couple counseling, health/wellness assistance]; and is available for consultation on academic/training process difficulties. You can contact her by phone at 612–626–7196, by email becke024@umn.edu, or in person B624Mayo.

- **Mary Tate**. The Director of the Medical School Office of Minority Affairs and Diversity is the Equal Opportunity and Affirmative Action liaison. For questions or concerns regarding matters of allegations of mistreatment, sexual harassment, or discrimination, the Office of Minority Affairs and Diversity may assist in finding solutions. You can contact her by phone 612–625–1494, by email tatex001@umn.edu, or in person B608 Mayo.

- **Resident Assistance Program (RAP)**. The Resident Assistance Program (RAP) is a confidential counseling service designed to offer residents and their immediate family members a professional, external resource to address a variety of stressors, at no cost to the client. In many cases, these stressors are affecting personal lives and impacting a resident’s ability to meet professional expectations in the workplace. You can contact them by phone 651–430–3383 (local) OR 1–800–632–7643 (toll free); or the web www.sandcreekeap.com.

- **Student Conflict Resolution Center** 254 Appleby Hall, 128 Pleasant St. SE (East Bank) Phone: 624–SCRC (7272) [http://www.sos.umn.edu](http://www.sos.umn.edu).

- **International Student and Scholar Services** 190 HHH Center Phone: 612–626–7100 [http://www.isss.umn.edu](http://www.isss.umn.edu).


See also Resident Dispute Resolution Policy at: [http://www.med.umn.edu/gme/residents/dispute/home.html](http://www.med.umn.edu/gme/residents/dispute/home.html)
GME Dispute Resolution Policy

The University of Minnesota Medical School is committed to providing an educational and work environment in which trainees may raise and resolve issues without fear of intimidation or retaliation and in a confidential and protected manner.

The following contacts are available for the trainee to raise issues or concerns regarding their work and/or education environment.

**Resident/Fellow Ombudsman:**
Marilyn Becker, Ph.D.
Phone: 612–626–7196
Email: becke024@umn.edu

**Associate Dean for GME:**
Louis Ling, M.D.
Phone: 612–626–4009
Email: lingx002@umn.edu

**GMEC Resident Leadership Council:**
Please visit: [https://umcontent.umn.edu/MEDGME/residents/gmecrescouncil/home.html](https://umcontent.umn.edu/MEDGME/residents/gmecrescouncil/home.html)

**Student Conflict Resolution Center:**
Phone: 612–624–7272
Email: sos@umn.edu

**Confidential Graduate Medical Education Email:**
This is a confidential venue for trainees to report any duty hour violations or other concerns they may have with their training program. These emails are read by the DIO and acted upon accordingly.
Email: gmedhv@umn.edu

**Confidential Reporting Service for the University of Minnesota:**
What to Report: You should report any situation or University conduct you believe violates an applicable law, regulation, government contract or grant requirement, or University policy. You do not need to know the exact law or requirement, or be certain a violation has or will occur. If you suspect something is wrong, the better course of action is always to report it. Examples include theft; wage, benefit, or hours abuses; discrimination or sexual harassment; misuse of University property or equipment; violation of safety rules; OSHA or environmental abuse concerns; conflicts of interest; NCAA violations; and intentional misuse of the University’s network or computers.

Select a campus location on the reporting homepage, and then click on the violation categories on the following page for a more complete list.

This reporting service does not include employment concerns that are not legal or policy violations. For these, and other issues, see the topic “Other Reporting Options and Contacts” for a list of University offices to contact about these concerns.


Rev 5/2011
Teaching Resources/Materials for Chief Residents

Academic Internal Medicine (CDIM/APDIM) Residents as Teachers:
http://www.im.org/toolbox/curriculum/residentsasteachers/Pages/default.aspx

American Academy of Pediatrics, Residents as Teachers:
http://www.aap.org/sections/ypn/r/resident/pdfs/resasteachers.pdf

American College of Emergency Physicians:
http://www.acep.org/practres.aspx?id=40272&ekmensel=c580fa7b_90_378_40272_1

American College of Surgeons: Successfully Navigating the First Year of Residency:
http://www.facs.org/education/essentials.doc

Practical Professor (University of Alberta and Alberta Rural Physician Action Plan):
http://www.practicalprof.ab.ca/

Resident Educator Development (RED):
http://www.med.umn.edu/gme/residents/reseducdevel/home.html

Resident Well Being:
http://www.med.umn.edu/gme/residents/wellness/home.html

University of California, Irvine Residents as Teachers:
http://www.residentteachers.com/Content/Curriculum.asp
GMEC meetings are held the fourth Tuesday of every month from 3:30-4:30pm in Room B646 Mayo Memorial Building unless otherwise indicated. Given the nature of work conducted by the group it is important that voting members attend. If you are unable to do so, please designate someone to attend in your absence.

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<td>May 22, 2012</td>
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<tr>
<td>June Meeting CANCELED</td>
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</table>

GMEC Coordinator:
Carla Nelson
612-625-7634
nelso081@umn.edu
DEADLINE FOR SUBMISSION OF GMEC AGENDA ITEMS

To allow committee members adequate time to review the GMEC meeting agenda and supporting documentation, the meeting agenda will be emailed to committee members by 4:30 PM on the third Wednesday of each month. (To review/print supporting documents, go to www.moodle.umn.edu, log-in and go to “Graduate Medical Education Committee [GMEC]” under “My Courses”.)

To this end, agenda topics and their supporting documentation must be submitted by 4:30 PM on the third Tuesday of each month. Submit items to Carla Nelson, GMEC Coordinator, via E-mail at nelso081@umn.edu or via fax at 612-624-0150. Items may also be delivered directly to Carla’s office, Room B-654 Mayo Memorial Building.

*Topics and supporting documentation received after the deadline will be held until the next GMEC meeting. You must plan accordingly.*

Please take the time to familiarize yourself with the agenda and supporting documentation in advance so that we may have a more productive meeting.

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GMEC Coordinator:
Carla Nelson
612-625-7634
nelso081@umn.edu
Graduate Medical Education Committee (GMEC) ~ RESIDENT LEADERSHIP COUNCIL ~
Meeting Schedule

Unless otherwise indicated, GMEC Resident Leadership Council (RLC) meetings are held the 4th Tuesday of every month from 2:30-3:30pm in Room B646 Mayo Memorial Building. Given the nature of work conducted by the group it is important that members attend. If you are unable to do so, please designate someone to attend in your absence.

As voting members of the GMEC, RLC members are strongly encouraged to attend the Graduate Medical Education Committee meeting immediately following the Resident Council meeting (3:30-4:30 PM in Room B646 Mayo Memorial Building).

July 26, 2011
August 23, 2011
September 27, 2011
October 25, 2011
November 22, 2011

December Meeting CANCELED

January 24, 2012
February 28, 2012
March 27, 2012
April 24, 2012
May 22, 2012

June Meeting CANCELED

GMEC Coordinator:
Carla Nelson
612-625-7634
nelso081@umn.edu
DEADLINE FOR SUBMISSION OF GMEC RLC AGENDA ITEMS

To allow committee members adequate time to review the GMEC RLC meeting agenda and supporting documentation, the meeting agenda will be emailed to committee members by 4:30 PM on the third Wednesday of each month. (To review/print supporting documents, go to www.moodle.umn.edu, log-in and go to “GMEC Resident Leadership Council” under “My Courses”.)

To this end, agenda topics and their supporting documentation must be submitted by 4:30 PM on the third Tuesday of each month. Submit items to Carla Nelson, GMEC Coordinator, via E-mail at nelso081@umn.edu or via fax at 612-624-0150. Items may also be delivered directly to Carla’s office, Room B-654 Mayo Memorial Building.

Topics and supporting documentation received after the deadline will be held until the next GMEC RLC meeting. You must plan accordingly.

Please take the time to familiarize yourself with the agenda and supporting documentation in advance so that we may have a more productive meeting.

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