

UNIVERSITY OF MINNESOTA

Medical School

GRADUATE MEDICAL EDUCATION

Chief Resident Orientation

Friday, April 20, 2012

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)

Time	Topic	Presenter
12:00 - 12:10	Introductions & Welcome	Dr. Kaz Nelson Associate Program Director, Psychiatry Residency Dr. John Andrews Associate Dean for GME
12:10 - 12:30	Navigating UMMC, FV	Dr. James Breitenbucher UMMC VP for Medical Affairs & Clinic Operations; Lynne Peterson Manager of Physician Recruitment
12:30 - 1 :30	<i>Veritas vos liberabit:</i> Acknowledging Stress and the Realities of Medicine	Dr. Thomas Mackenzie Program Director, Psychiatry Residency
1:30 - 1:45	~ BREAK ~	
1:45 - 2:45	Surviving as Chief Resident (Chief Resident Panel)	Dr. Tasaduq Mir (UMMC Family Medicine) Dr. Johannah Scheurer (Pediatrics) Dr. Ruth Thomson (Neurology)
2:45 - 3:00	~ BREAK ~	
3:00 - 3:30	Knock 'em Dead Presentations	Dr. Kaz Nelson Program Director, Psychiatry Residency
3:30 - 4:30	Residents in Difficulty - Remediation	Dr. Phillip Rauk Director, Obstetrics & Gynecology Residency Program
Adjourn		

Fairview Health Services

Chief Resident Retreat

4/20/2012

UNIVERSITY OF MINNESOTA
MEDICAL CENTER

 FAIRVIEW

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
- 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

Epic / PI Stabilization Workgroups

Current Top Workgroups:

- Periop
- Transplant
- Discharge
- Medication Reconciliation
- Blood Administration
- Outpatient Intake Processes
- Lab
- Care Coordination
- Outpatient CPOE

For more information, please contact Anne LaFlamme, UMMC Informatics Officer:

Email: alaflam1@fairview.org / Phone: 612-273-4241

EPIC ASSISTANCE

Technology Service Center 612-672-6805	Password resets Security access to Epic Unable to see same view as colleagues Broken computers, hardware
Epic Assistance Line 612-273-4777	Answer “how to” questions Request “at elbow support” M-F 0800-1630
Fairview Intranet www.intranet.fairview.org Learning and Development-> Epic Tip sheets and Education	Tip Sheets E-learning Classes
Physician’s Informatics Committee Dr. Michael Kim, chair kimxx031@umn.edu	Ideas on improving the system Discussion on provider use of system

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

Physician Wellness

Thomas Mackenzie MD

April 20, 2012

Dining Room A

UMMC - Fairview

- Stress
- Burnout
- Depression
- Compassion fatigue

The measurement of experienced burnout*

CHRISTINA MASLACH

University of California, Berkeley

and

SUSAN E. JACKSON

University of California, Berkeley

SUMMARY

A scale designed to assess various aspects of the burnout syndrome was administered to a wide range of human services professionals. Three subscales emerged from the data analysis: emotional exhaustion, depersonalization, and personal accomplishment. Various psychometric analyses showed that the scale has both high reliability and validity as a measure of burnout.

I. Emotional Exhaustion

I feel emotionally drained from my work

I feel used up at the end of the workday

I feel fatigued when I get up in the morning
and have to face another day on the job

Working with people all day is really a strain
for me

I feel burned out from my work

I feel frustrated by my job

I feel I'm working too hard on my job

Working with people directly puts too much
stress on me

I feel like I'm at the end of my rope

III. Depersonalization

I feel I treat some recipients as if they were impersonal 'objects'

I've become more callous toward people since I took this job

I worry that this job is hardening me emotionally

I don't really care what happens to some recipients

I feel recipients blame me for some of their problems

II. Personal Accomplishment

I can easily understand how my recipients
feel about things

I deal very effectively with the problems of
my recipients

I feel I'm positively influencing other
people's lives through my work

I feel very energetic

I can easily create a relaxed atmosphere
with my recipients

I feel exhilarated after working closely
with my recipients

I have accomplished many worthwhile things
in this job

In my work, I deal with emotional problems
very calmly

A Prospective Cohort Study Investigating Factors Associated With Depression During Medical Internship

Srijan Sen, MD, PhD; Henry R. Kranzler, MD; John H. Krystal, MD; Heather Speller, MD; Grace Chan, PhD; Joel Gelernter, MD; Constance Guille, MD

Arch Gen Psychiatry. 2010;67(6):557-565

Table 1. Sample Demographic Characteristics

Characteristic	Subjects, No. (%)
Sex	
M	337 (45.6)
F	403 (54.4)
Age, y	
≤25	101 (13.6)
26-30	533 (72.1)
31-35	84 (11.3)
>35	22 (3.0)
Specialty	
Internal medicine	358 (48.5)
General surgery	98 (13.3)
Obstetrics/gynecology	42 (5.7)
Pediatrics	94 (12.7)
Psychiatry	63 (8.5)
Emergency medicine	47 (6.3)
Internal medicine/pediatrics	19 (2.6)
Family medicine	19 (2.6)
Relationship status	
Single	479 (64.7)
Married	248 (33.5)
Divorced	13 (1.7)

Over the last 2 weeks, how often have you been
bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

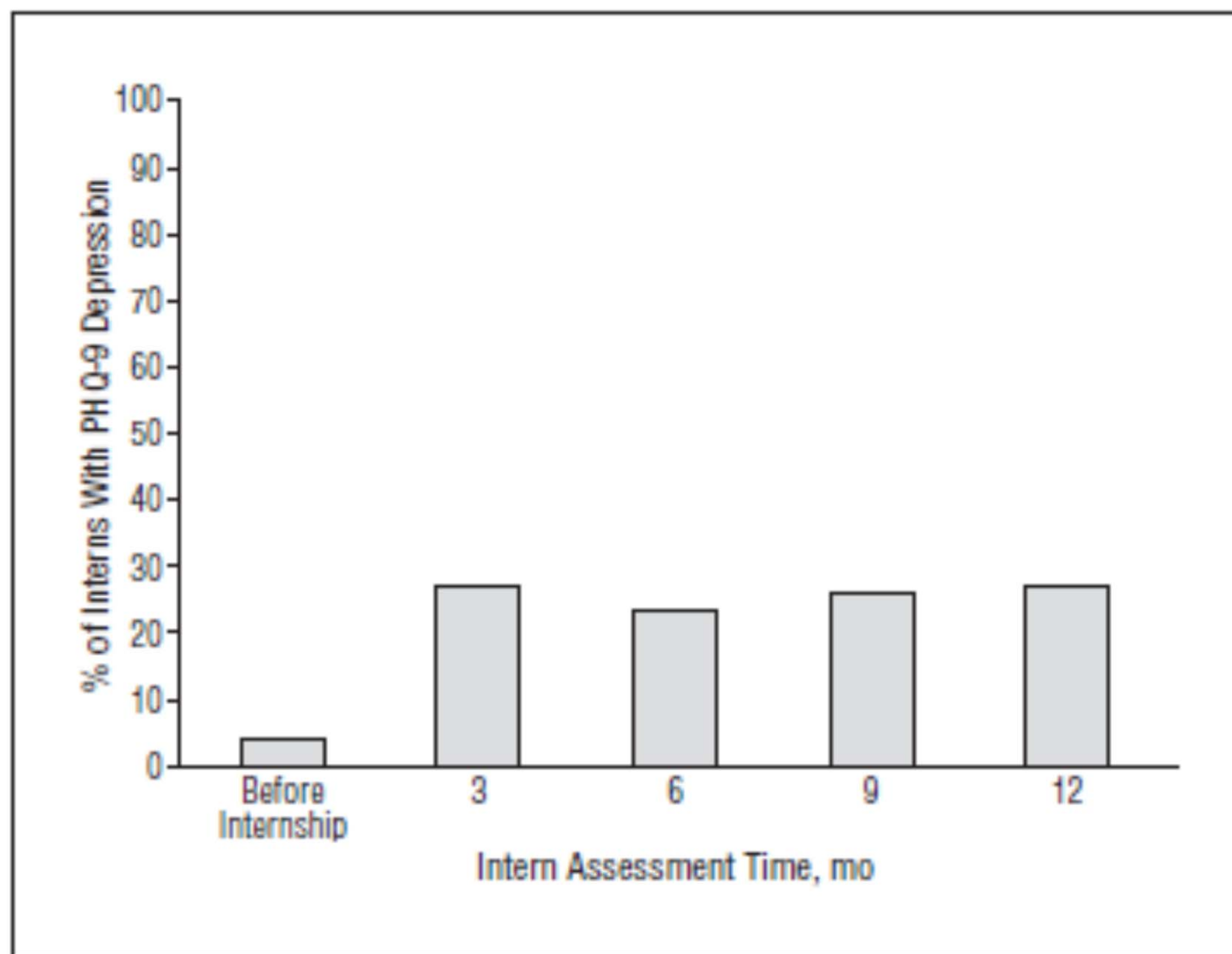


Figure 1. The proportion of interns who met the 9-item Patient Health Questionnaire (PHQ-9) criteria for depression^{s2} prior to internship and at 3-month intervals through the internship year.

Literature (Survey)

- Adapted Maslach Burnout Inventory-type methods
- Hundreds of references – group means – YES RESIDENCY IS STRESSFUL
- Duty hours regulations have helped – implications for patient care less clear
- Program directors know who is stressed, tend to underestimate the magnitude
- Gender, year, program not necessarily predictive

Group Level

- Policy and procedures
 - Clarify ambiguity (which units thrive on)
 - Don't be rule bound and believe there won't be inevitable contradictions
- Duty Hour violations – take seriously
- Critical Incident Debriefing
- You are there for the residents, not to protect the faculty
- Programs tend to underestimate the burnout of their residents

Individual Level

- Listen before talking – understand what you are being told
- Arrange to talk privately, minimize clinical interruption
- Is there a specific incident?
- Are there parallel illnesses in loved ones?
- Be alert for values conflict
 - Want to be perfect – for my patients, colleagues, family
 - Want to be competent, but also a beginner – I am a fraud

Individual Level

- To hear a complaint is not an assertion you can correct it
- Be tolerant (neutral, non-judgmental) of uncharitable personal thoughts
 - Amoral thinking is a prerequisite for moral action
 - To be selfish is to be human
- Isolation is probably inevitable
 - You are not alone
 - Premature
 - Declaration
 - Rejecting and critical
 - Do you feel alone?
- Schedule follow-up

Knock 'em dead Presentations

Kaz Nelson, MD

URBAN PIGEONS AND THE CASPER PIGEON PROJECT

FOR INTERNAL COOPERATOR USE

TECHNICAL POINT OF CONTACT:

Michael Pipas, Wildlife Biologist, USDA Animal and Plant Health Inspection Service, Wildlife Services, Casper, Wyoming

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



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A black and white photograph of a man in a suit and tie, smiling as he uses a shovel to dig a ditch in a field. The man is on the left side of the frame, leaning forward with the shovel. The background is a dark, textured field. A dark rectangular box with white text is overlaid on the right side of the image.

Is it time to
ditch power
point?

presentationzen

Simple Ideas on Presentation Design and Delivery



Garr Reynolds



The Casper Pigeon Project



Can you pass the elevator test?

INTRO ✓

1:30

(243)

PODCAST
SEARCH

COMPARE &
CONTRAST

(NEW)

PRICING (limited)
SEM SERVICES
SMB (NEW)

SEARCH TERM
RESEARCH ✓

1:30

(250)

PODCAST
ENGINEER

POST SEARCH

(NEW)

PRICING
B16 (NEW)

SC
PRICING ✓

1:30

(249)

VIDEO
SEARCH

ADS IN A
QUALITY
SCORE WORLD

(NEW)

SEM & AD
AGENCIES
OR
VS AGENCIES

SEARCH
ADVERTISING
101

VIDEO
ENGINEER

SEARCH
INTERACTION
WITH OTHER
MEDIA

WORKING WITH
CLIENTS

Channel

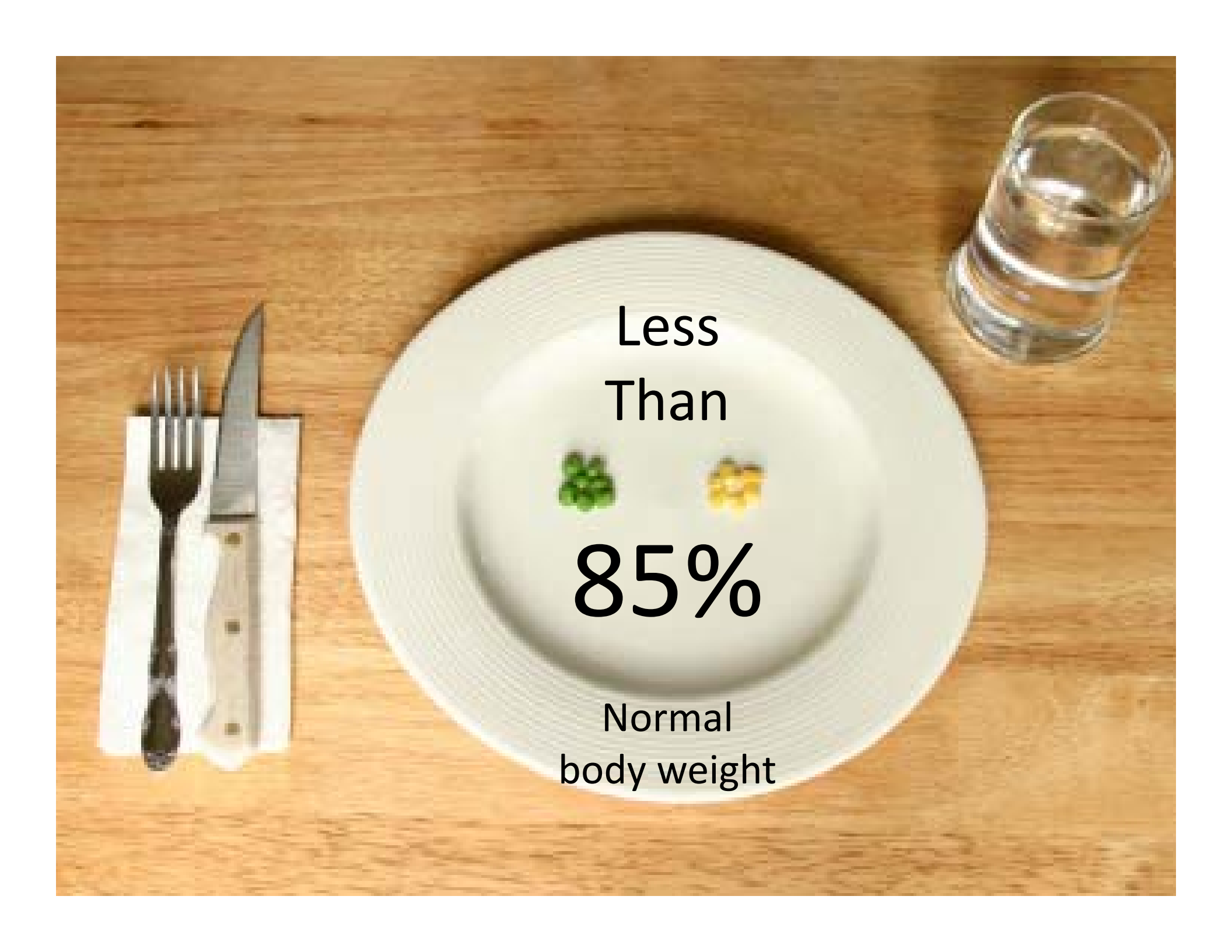
Direct

COMPETITIVE



Anorexia Nervosa

- **Criteria for diagnosis:**
 - Refusal to maintain body weight at or above a minimally expected level (<85% ideal body weight)**
 - Intense fear of gaining weight or becoming fat
 - Disturbance in body image or denial of seriousness of current low body weight
 - Amenorrhea (absence of 3 consecutive periods)



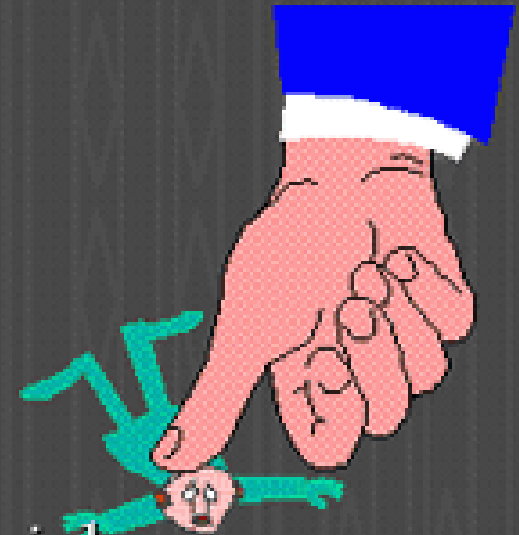
Less
Than

85%

Normal
body weight

Avoid weak verbs (smothered verbs)

- ◆ have sufficient knowledge
- ◆ make a distinction
- ◆ furnish an explanation
- ◆ read a conclusion
- ◆ realize an improvement
- ◆ were able to develop
- ◆ held a meeting
- ◆ know
- ◆ distinguish
- ◆ explain
- ◆ conclude
- ◆ improve
- ◆ developed
- ◆ met





Avoid
Weak
Verbs

Insert Design Animations Slide Show Review View

from
ent Slide
Slide Show

Custom
Slide Show

Set Up
Slide Show

Hide
Slide

Record Narration

Rehearse Timings

Use Rehearsed Timings

Set Up

Resolution: Use Current Resolution

Show Presentation On:

Use Presenter View

Monitors

verbs
(verbs)

- know
- distinguish
- explain
- conclude
- improve
- developed
- met

Avoid
Weak
Verbs

will Soc

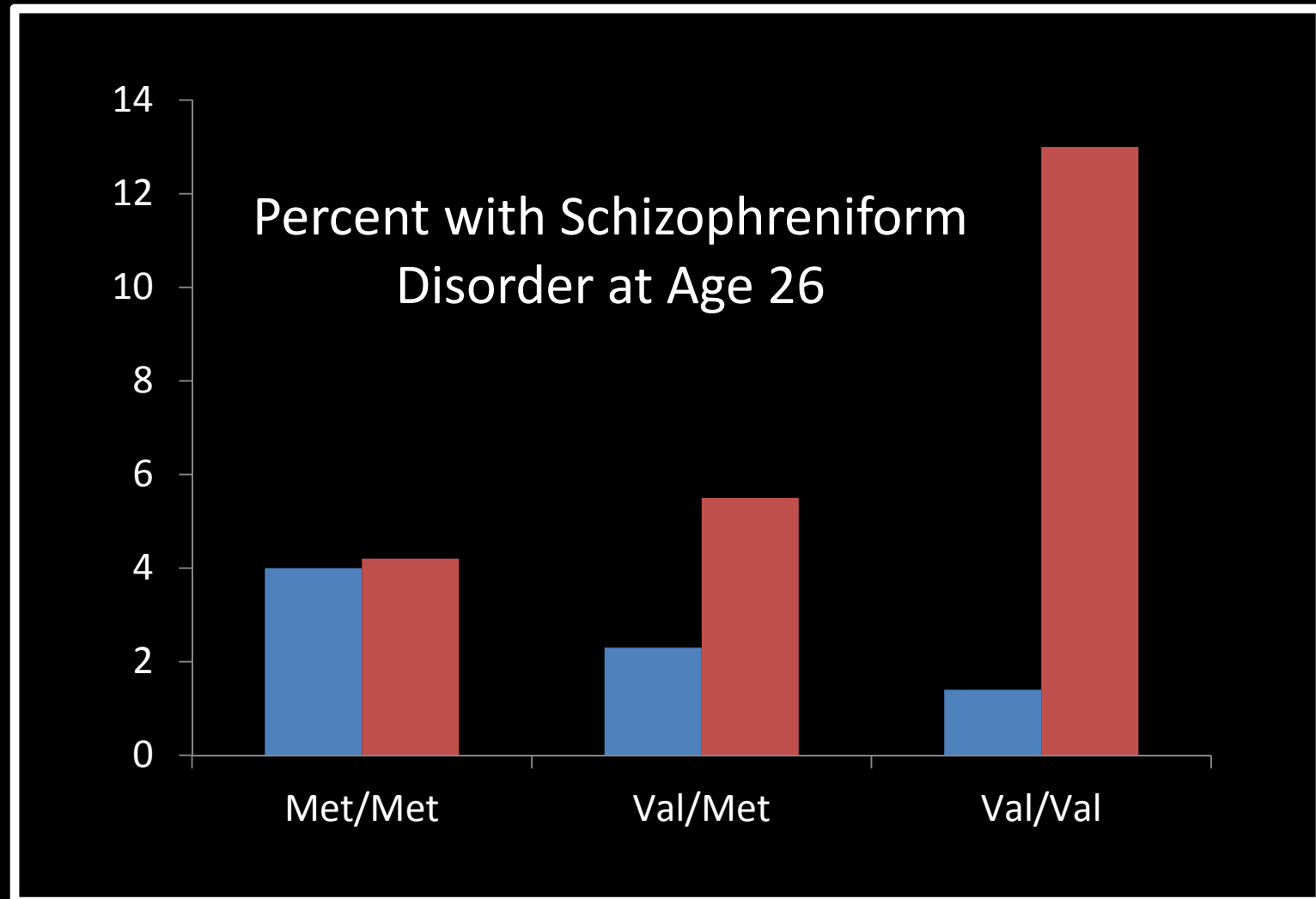
Schizophreniform
at Age 26

Soc



Here is a far more effective image for reinforcing the narration of the speaker.
It's at this point that I started to panic- "But I need all the text on the slides, I can't remember what I'm supposed to text off of slides"
That's when I learned about a feature of powerpoint that is actually very liberating. The "notes" section, that is usual you are designing the presentation, is where you can put all of the text that you want to narrate or the main points tl
After you have made your slides and added notes, you can print out the notes to have for your presentation and no-c

1. Slides the Audience will See



2. Notes Only you will see

Font Paragraph Drawing



Included in this study if they used cannabis before age 15 or if they were monthly cannabis users by the age of 18.

3. Handout to be taken away

1

Psychosis vs. Delirium

(Why are you acting funny and is this my problem or not?)

Kyle Nelson, MD
Chief Resident
University of Minnesota Department of Psychiatry



DSM-IV-TR criteria for delirium include:

1. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, to sustain, or to shift attention
2. A change in cognition (such as memory deficit, disorientation, or language disturbance) that is not better accounted for by a pre-existing, established, or evolving dementia
3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day

Further differentiated into:

1. Delirium due to a general medical condition
2. Substance-induced delirium
3. Delirium due to multiple etiologies
4. Delirium Not Otherwise Specified (NOS)

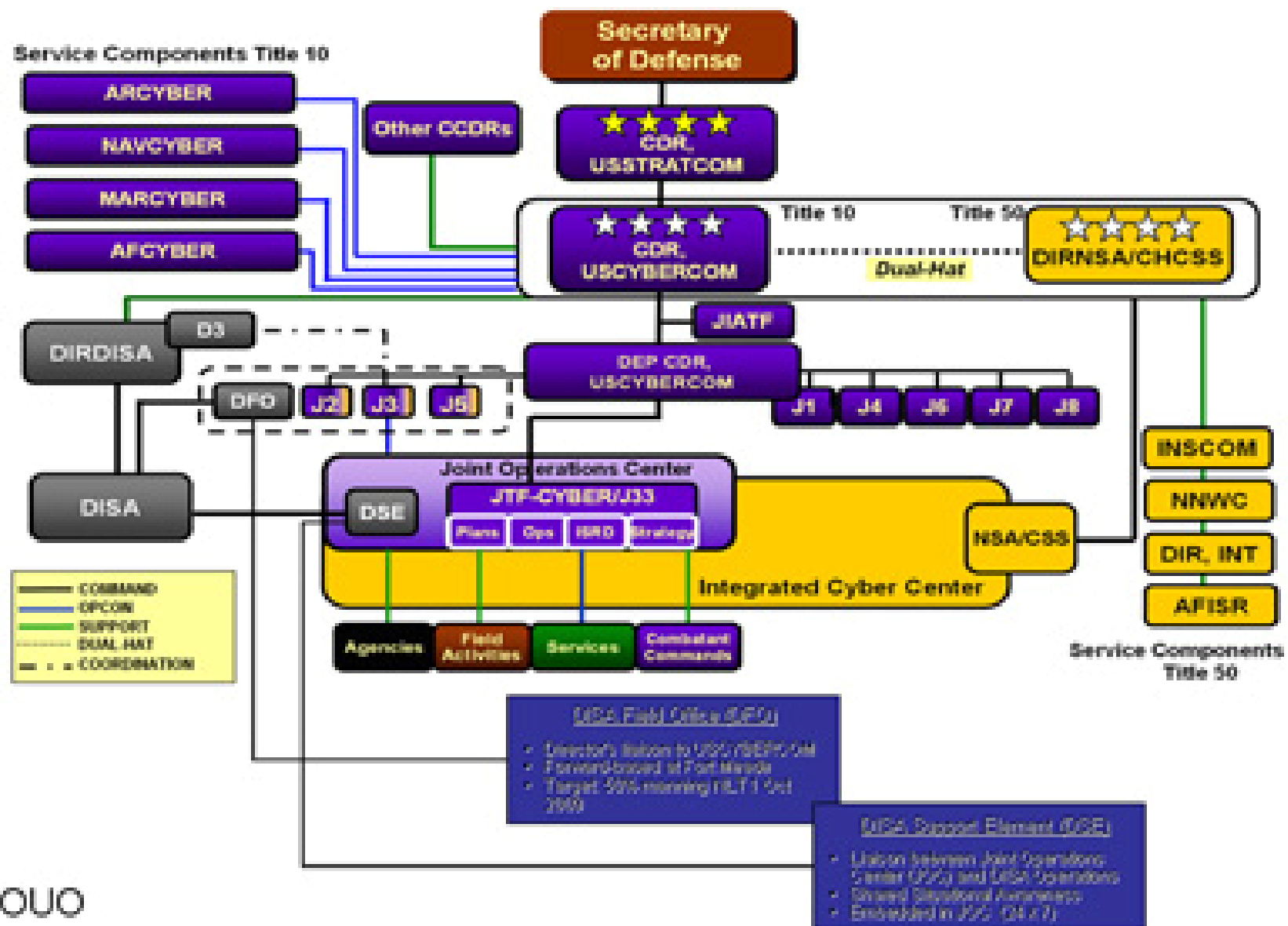
Two clinical subtypes of delirium have been described: hyperactive and hypoactive. The hypoactive form is characterized by confusion and sedation and is less often accompanied by hallucinations, delusions, or illusions. A mixed subtype has also been described. The delirious individual may also exhibit emotional disturbances, such as anxiety, fear, depression, irritability, anger, euphoria, and apathy.

Delirium is estimated to occur in 15 to 25 percent of patients in the ICU, to as much as 75 percent of patients undergoing bone marrow stem cell transplant. In surgical patients, the rates may be even higher than on medical services.

Although the majority of patients recover fully, delirium may progress to stupor, coma, seizures, or death, particularly if untreated and especially in elderly populations.

When delirium is co-morbid with other psychiatric disorders, the underlying causes of the delirium should be treated first, and the treatments for these other disorders should be minimized or not begun until the delirium is resolved.

USCYBERCOM Organization



FOUO

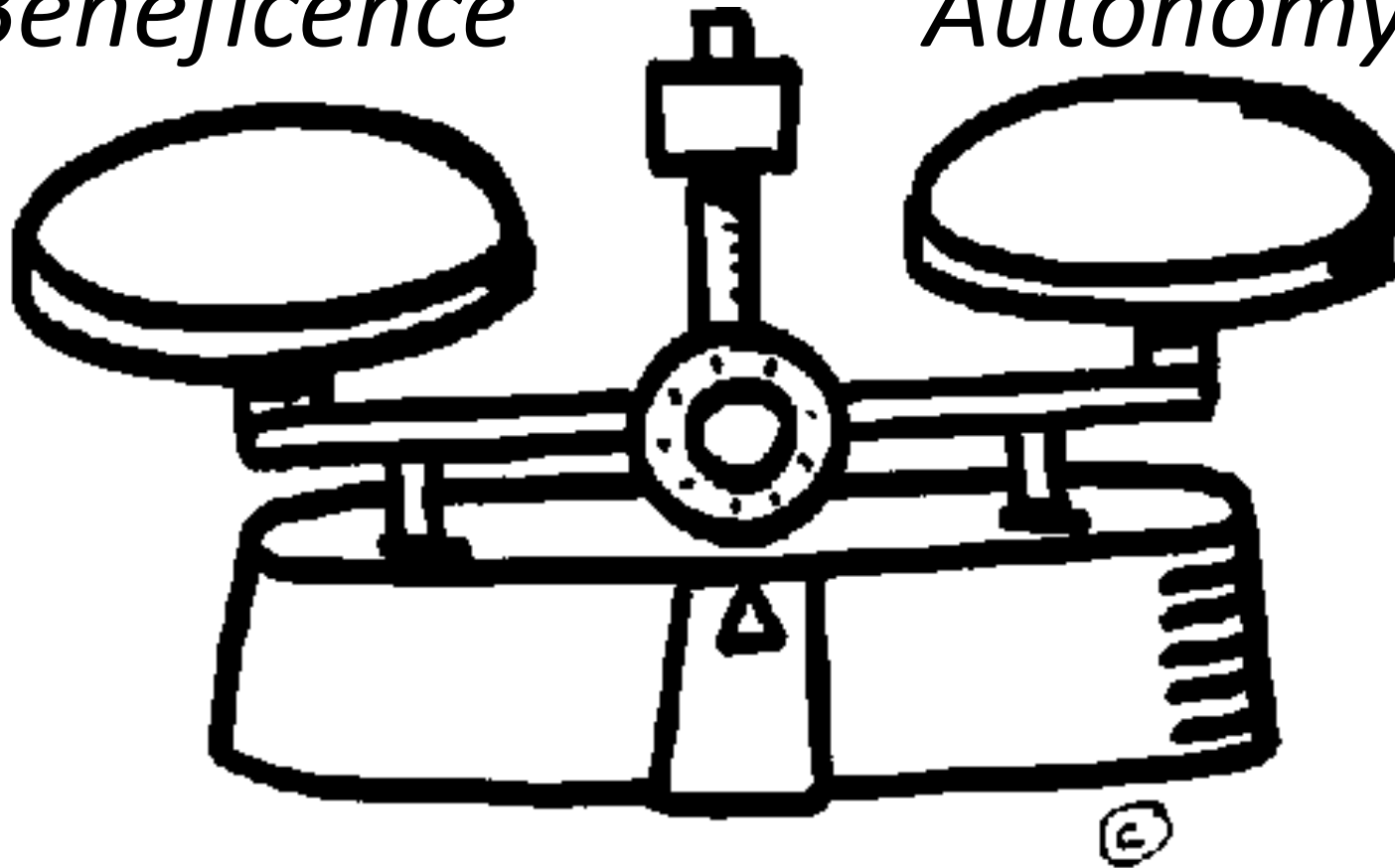


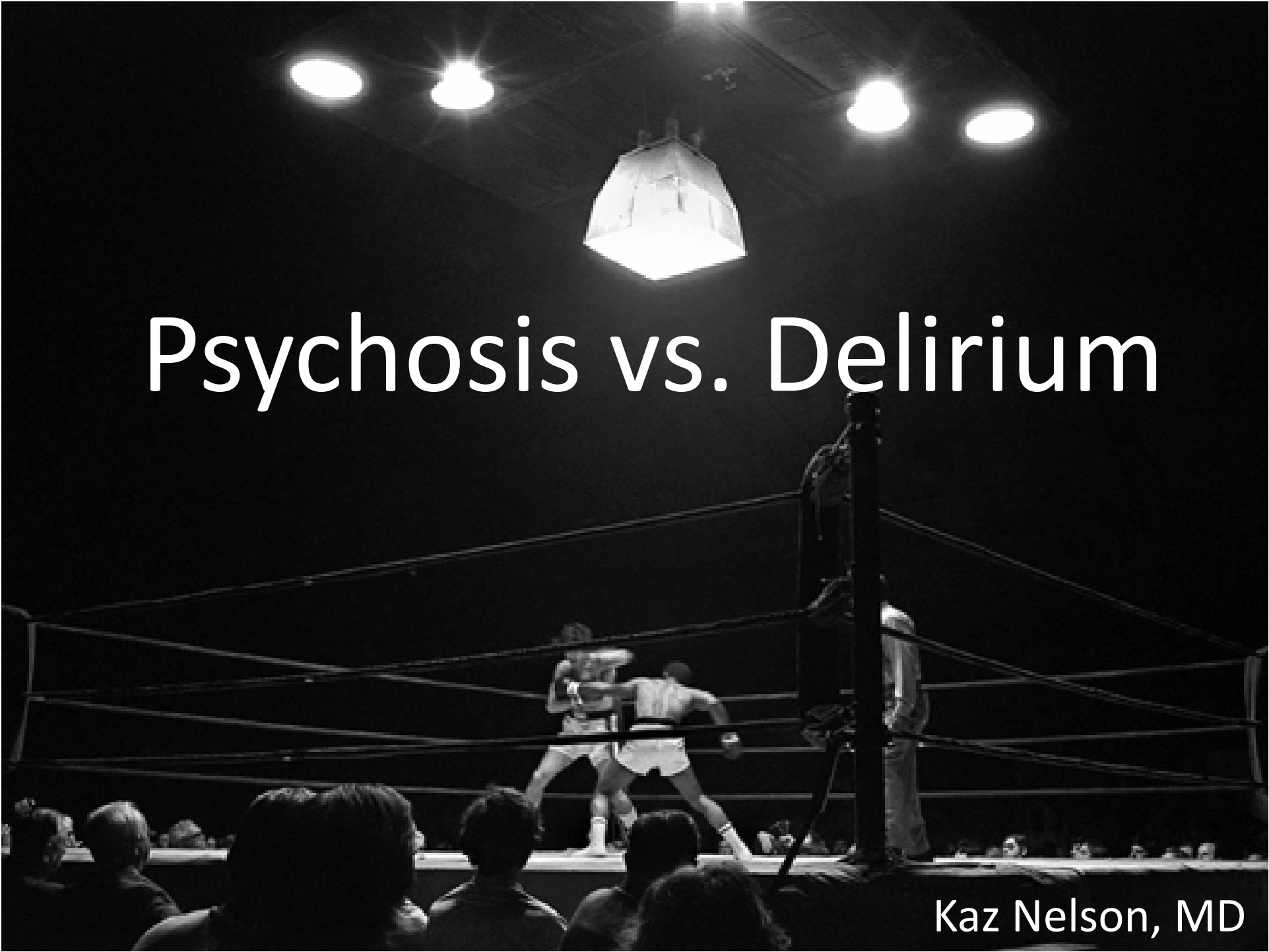
Six values commonly applied to medical ethics discussions

- **Beneficence**
 - a practitioner should act in the best interest of the patient
 - **Non-maleficance**
 - "first, do no harm"
 - **Autonomy**
 - the patient has the right to refuse or choose their treatment
 - **Justice**
 - concerns the distribution of scarce health resources, and the decision of who gets what treatment
 - **Dignity**
 - the patient (and the person treating the patient) have the right to dignity
 - **Truthfulness and honesty**
 - the concept of informed consent
-

Beneficence

Autonomy





Psychosis vs. Delirium

Kaz Nelson, MD

Psychosis vs. Delirium



Kaz Nelson, MD

University of
Minnesota Dept of
Psychiatry

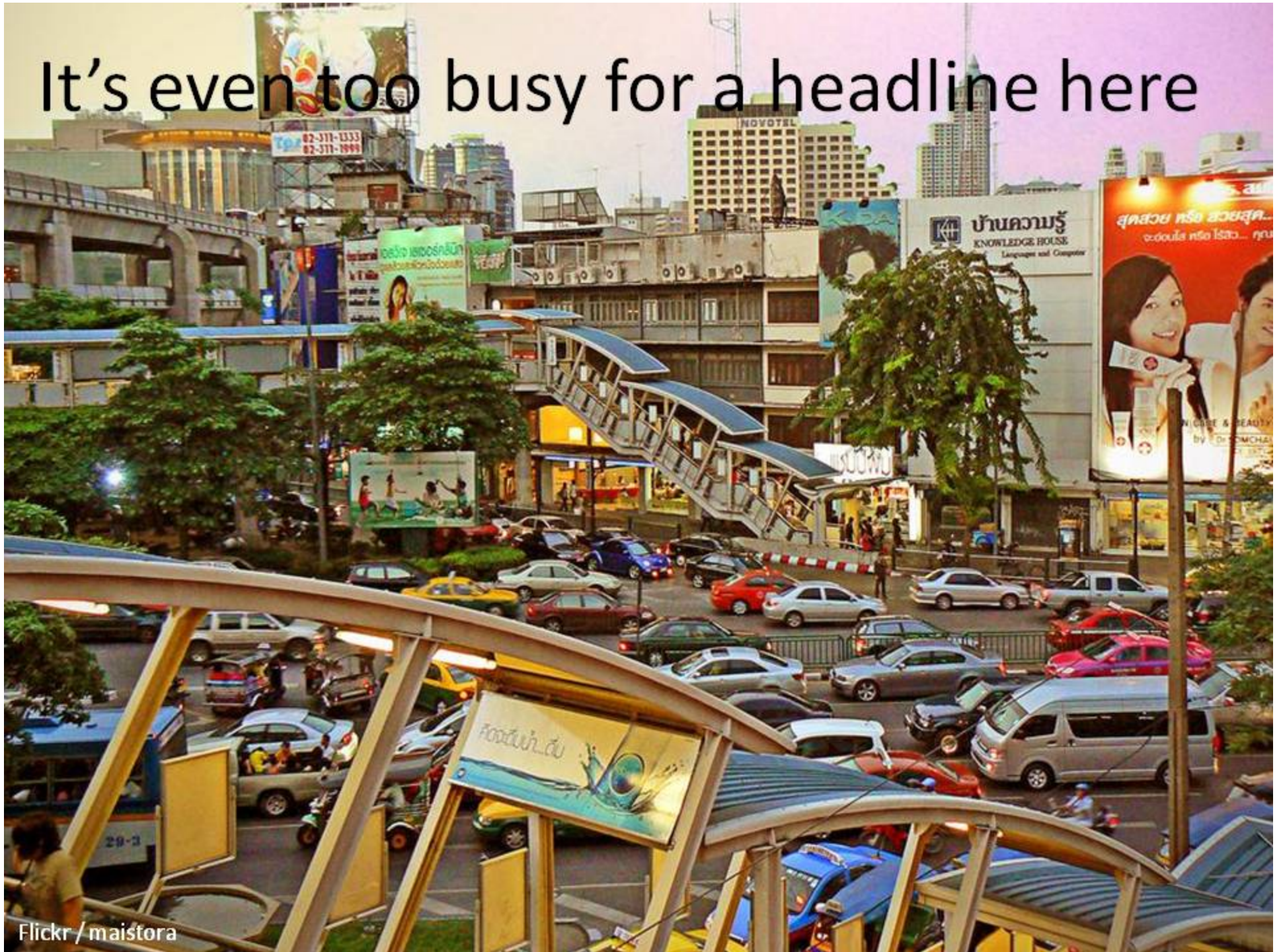
April 30th, 2010



The flour is mixed with yeast, water, salt and oil to make the dough. The dough is left alone for a couple of hours to rise.



It's even too busy for a headline here





US-CERT



Amit Yoran

US-CERT and the Multi-State ISAC are working together on a number of programs, including this webcast series, to help enhance our Nation's cyber security readiness and response. The Multi-State ISAC has recently become a member of the US-CERT portal, which provides a secure mechanism for sharing information between and among partners, improving cyber preparedness, readiness and response capabilities.

US-CERT also hosts a public website, at www.us-cert.gov, which provides a wealth of information regarding cyber security – helpful tips for protecting against cyber security threats; cyber security alerts and bulletins, as well as the ability to sign up to receive free cyber security alerts via email.

National Webcast Initiative



US-CERT



Types of Bipolar disorder

- Bipolar I - mania with and without episodes of hypomania.
- Bipolar II - hypomanic episode(s) without mania, but with at least one episode of Major Depression

Bipolar Type 1

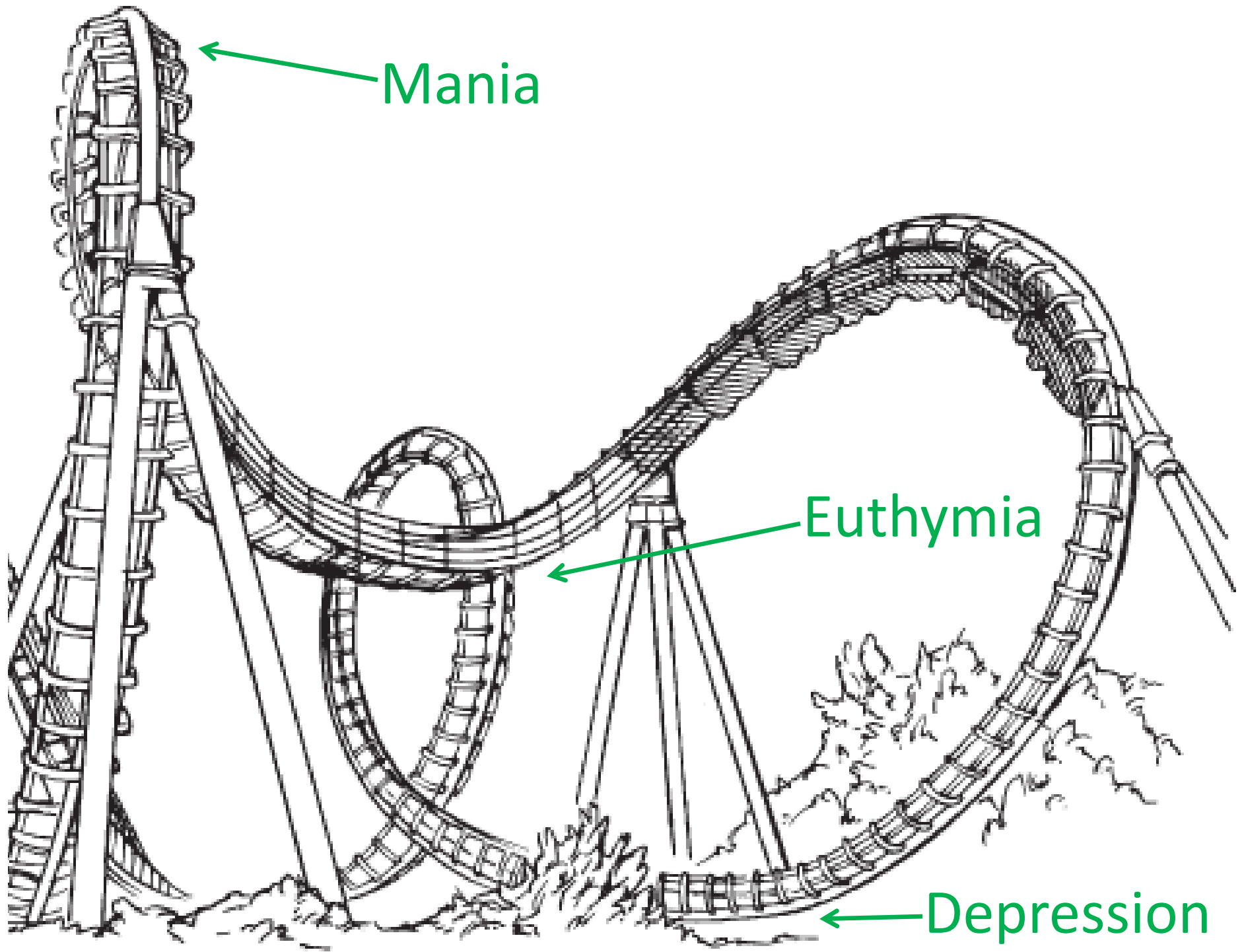
Mania

(with and
without
hypomania)

Bipolar Type 2

Hypomania

(without
mania or
psychosis and
some
depression.)



Mania

Euthymia

Depression

Typical Course

- Affects young people
- May have a depression episode first
- May have a manic episode first



Typical Course



Salmon

High in
Omega-3
fatty acids

Eicosapentaenoic Acid (EPA)
Docosahexaenoic Acid (DHA)

285 calories
(220 g)



presentationzen

Simple Ideas on Presentation Design and Delivery



Garr Reynolds

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.

I stumbled on *Presentation Zen* by accident. Early in 2008, I read another great book, Daniel Pink's *A Whole New Mind: Why Right-Brainers Will Rule the Future*. I was so intrigued, I went to Pink's website. There, I saw a link to his next book, *The Adventures of Johnny Bunko: The Last Career Guide You'll Ever Need*, billed as the first U.S. business book in *manga*, or

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*.
MM

Jon Hallberg is medical director of the new University of Minnesota Physicians' Mill City Clinic.

Presentation Zen

How to Design & Deliver Presentations Like a Pro

By Garr Reynolds
(info@garrreynolds.com)

This brief handout, highlights many of the key points made in my recent presentations and seminars on presentation design. You will also find a bibliography of suggested readings and links to websites referred to in the presentations.

Zen and effective presentations

In the presentation, we discussed the current state of business presentations today which, more often than not, incorporate the use of PowerPoint in ways that actually undermine the speaker's good intentions. Bullet-point filled slides with reams of text become a barrier to good communication. We have become accustomed to a "PowerPoint culture" in which a disconnect exists between the audience and the presenter. Many people, including many top business leaders, are fed up with PowerPoint. But it is not PowerPoint's fault — PowerPoint is just a tool.

"Technical knowledge is not enough. One must transcend techniques so that the art becomes an artless art, growing out of the unconscious."

— Daisetsu Suzuki

If we apply some basic, accessible concepts borrowed from the world of Zen, we can improve our effectiveness and allow our content to connect in more powerful ways. One key concept is simplicity. However, simplicity is not merely a means to more effective communication. Rather, it is a consequence of our "Letting Go" of bad habits and much of what we have learned about multimedia presentations in the era of PowerPoint. Other important concepts include: The beginner's mind; Being fully in the moment; Moderation, or "the middle way;" Minimization of chaos and clutter.

"Making the simple complicated is commonplace; making the complicated simple, awesomely simple, that's creativity."

— Charles Mingus

In a nut shell: PowerPoint culture causes both audiences and presenters to suffer. And content suffers too. The root of the suffering is attachment to old PowerPoint habits and misunderstandings about how best to connect to an audience. Lose your attachment to the "normal" way PowerPoint is used and lose poor presentation habits to move to a higher level of effectiveness.

Effective use of multimedia

When designing our presentations and creating the supporting visual aids, we should keep in mind the way our audience will actually process our presentation. We must design our visuals and use PowerPoint in ways that take advantage of how people process information. Much can be learned, then, from a review of the key findings in the field of cognitive science concerning how people learn best in multimedia presentation settings. Below, cognitive scientist, Dr. Richard Mayer, summarizes the three assumptions of multimedia learning theory.

"Cognitive scientists have discovered three important features of the human information processing system that are particularly relevant for PowerPoint users: **dual-channels**, that is, people have separate information processing channels for visual material and verbal material; **limited capacity**, that is, people can pay attention to only a few pieces of information in each channel at a time; and **active processing**, that is, people understand the presented material when they pay attention to the relevant material, organize it into a coherent mental structure, and integrate it with their prior knowledge."

— Rich Mayer, in an interview with Sociable Media, Inc.

(1) Review of Key Findings

- *Multimedia Effect*. Narration with pictures (visuals) is better than narration alone.
- *Modality Principle*. People learn better when words are presented as narration rather than text.
- *Redundancy Principle*. People learn better from narration & graphics rather than narration, graphics, & text.
- *Coherence Principle*. People learn better when extraneous visual material is excluded.

(2) Practical Implications for better PowerPoint Presentations

- Presentations must be both verbal & visual.
- Too much slide information overloads people's cognitive systems.
- Can your visuals be understood in 3 seconds? If not, redesign them to *support* your talk.
- Slide design & delivery must *help* people organize, integrate information.

Organization & Preparation Tips

PowerPoint is not inherently a bad tool. In fact, if presenters just avoid a few of the most common PowerPoint pitfalls, their presentations will greatly improve. Below, many of the items discussed in the presentation are highlighted in brief.

(1) Start with the end in mind. Before you even open up PowerPoint, sit down and really think about the day of your presentation. What is the real purpose of your talk? What does the audience expect? In your opinion, what are the most important parts of your topic for the audience to take away from your, say, 50-minute presentation? Remember, even if you've been asked to share information, rarely is the mere transfer of information a satisfactory objective from the point of view of the audience. After all, the audience could always just read your book (or article, handout, etc.) if information transfer were the only purpose of the meeting, seminar, or formal presentation.

(2) Plan in “analog mode.” That is, rather than diving right into PowerPoint (or Keynote), the best presenters often scratch out their ideas and objectives with a pen and paper. Personally, I use a large whiteboard in my office to sketch out my ideas (when I was at Apple, I had one entire wall turned into a whiteboard!). The whiteboard works for me as I feel uninhibited and free to be creative. I can also step back (literally) from what I have sketched out and imagine how it might flow logically when PowerPoint is added later. Also, as I write down key points and assemble an outline and structure, I can draw quick ideas for visuals such as charts or photos that will later appear in the PowerPoint. Though you may be using digital technology when you deliver your presentation, the act of speaking and connecting to an audience — to persuade, sell, or inform — is very much analog.

(3) Good presentations include stories. The best presenters illustrate their points with the use of stories, most often personal ones. The easiest way to explain complicated ideas is through examples or by sharing a story that underscores the point. Stories are easy to remember for your audience. If you want your audience to remember your content, then find a way to make it relevant and memorable to them. You should try to come up with good, short, interesting stories or examples to support your major points.

(4) It's all about our audience. There are three components involved in a presentation: the audience, you, and the medium (in our case, PowerPoint). The goal is to create a kind of harmony among the three. But above all, the presentation is for the benefit of the audience. However, boring an audience with bullet point after bullet point is of little benefit to them. Which brings us to point number five, perhaps the most important of all.

**“Respect those who come to you with open ears
and foster a sense of community.”**

— P.T. Sudo

(5) Reduce the text on your slides to an absolute minimum. The best slides may have no text at all. This may sound insane given the dependency of text slides today, but the best PowerPoint slides will be virtually meaningless without the narration (that is you). Remember, the slides are supposed to support/supplement the narration of the speaker, not make the speaker superfluous. Yes, it is true that many people often say something like this: "Sorry I missed your presentation, Steve. I hear it was great. Can you just send me your PowerPoint slides?" Well, you could. But if they are good slides, they may be of little use without you.

(6) Do not read the text word for word off the slide. Audiences can read, so why do presenters insist on reading long lines of text from slides? Also, it is very difficult — if not impossible — to read a slide and listen to someone talk at the same time. So again, why all the text on slides these days? One reason may be that it is convenient for the speaker when organizing the presentation to write out his/her thoughts one bullet point at a time. But as Yale professor and visual communications specialist, Edward Tufte points out in a September Wired Magazine article "...convenience for the speaker can be punishing to both content and audience." Speakers also may be thinking that their wordy slides will make for better handouts, a common "handout" technique. However, the confining, horizontal orientation of a slide (one slide after another) makes for difficult writing and reading. Which brings us to the next point below.

(7) Written documents (research papers, handouts, executive summaries, etc.) are for the expanded details. Audiences will be much better served receiving a detailed, written handout as a takeaway from the presentation, rather than a mere copy of your PowerPoint slides. If you have a detailed handout or publication for the audience to be passed out after your talk, you need not feel compelled to fill your PowerPoint slides with a great deal of text.

Remember: (1) your slides should contain only a minimum of information; (2) your slide notes, which only you see, will contain far more data; and (3) your handout will have still far more data and detail.

Slide (PowerPoint) Tips

(1) Keep it simple. PowerPoint was designed as a convenient way to display graphical information that would support the speaker and supplement the presentation. The slides themselves were never meant to be the "star of the show." People came to hear *you* and be moved or informed (or both) by you and *your message*. Don't let your message and your ability to tell a story get derailed by slides that are unnecessarily complicated, busy, or full of what Edward Tufte calls "chart junk." Nothing in your slide should be superfluous, ever. Your slides should have plenty of "white space" or "negative space." Do not feel compelled to fill empty areas on your slide with your logo or other unnecessary graphics or text boxes that do not contribute to better understanding. The less clutter you have on your slide, the more powerful your visual message will become.

Simplicity is the ultimate sophistication.

— Leonardo da Vinci

(2) Avoid using Microsoft templates. Most of the templates included in PowerPoint have already been seen by your audience countless times (and besides, the templates are not all that great to begin with). You can make your own background templates which will be more tailored to your needs or you can purchase professional templates on-line (for example: www.powerpointtemplatespro.com).

(3) Avoid using PowerPoint Clip Art or other cartoonish line art. Again, if it is included in the software, your audience has seen it a million times before. It may have been interesting in 1992, but today the inclusion of such clip art often undermines the professionalism of the presenter. There are exceptions, of course, and not all PowerPoint art is dreadful, but use carefully and judiciously.

(4) Use high-quality graphics including photographs. You can take your own high-quality photographs with your digital camera, purchase professional stock photography, or use the plethora of high-quality images available on line (be cautious of copyright issues, however). Never simply stretch a small, low resolution photo to make it fit your layout — doing so will degrade the resolution even further.

(5) Use object builds and slide transitions judiciously. Object builds (also called animations), such as bullet points, should **not** be animated on every slide. Some animation is a good thing, but stick to the most subtle and professional (similar to what you might see on the evening TV news broadcast).

(6) Synchronize your speaking with the builds and transitions. In other words, show the next item (new slide or new build) at the same time you begin talking about it. This requires practice, but it takes only a short time to get the hang of it. Watch the evening news on TV and you'll notice that bullet points and graphics appear at the same time or just after the reporter speaks on the particular item.

(7) Use video and audio when appropriate. You can use video clips within PowerPoint without ever leaving the application or turning on a VCR. Using a video clip not only will illustrate your point better, it will also serve as a change of pace thereby increasing the interest of your audience. You can use audio clips (such as interviews) as well. Something to avoid, however, is cheesy sound effects that are included in PowerPoint (such as the sound of a horn or applause when transitioning slides). The use of superfluous sound effects attached to animations is a sure way to lose credibility with your audience.

(8) Limit your ideas to one main idea per slide. If you have a complicated slide with lots of different data, it may be better to break it up into 2-3 different slides (assuming no side-by-side comparisons are needed).

Delivery Tips

(1) Move away from the podium — connect with your audience. If at all possible get closer to your audience by moving away from or in front of the podium.

(2) Remember the “B” key. If you press the “B” key while your PowerPoint slide is showing, the screen will go blank. This is useful if you need to digress or move off the topic presented on the slide. By having the slide blank, all the attention can now be placed back on you. When you are ready to move on, just press the “B” key again and the image reappears. (The “.” key does the same thing).

(3) Use a remote-control device to advance your slides and builds. A handheld remote will allow you to move away from the podium. This is an absolute must. (<http://www.keyspan.com/products/>).

(4) Make good eye contact. Try looking at individuals rather than scanning the group. Since you are using a computer, you never need to look at the screen behind you — just glance down at the computer screen briefly. One sure way to lose an audience is to turn your back on them.

Perfect adequacy (non-attachment) teaches us to transcend ourselves so that we may respond to the inner requirements of those around us.

— Robert Linssen

(5) Take it slowly. When we are nervous we tend to talk too fast. Get a videotape of one of your presentations to see how you did — you may be surprised at the pace of your talk.

(6) Keep the lights on. If you are speaking in a meeting room or a classroom, the temptation is to turn the lights off so that the slides look better. But go for a compromise between a bright screen image and ambient room lighting. Turning the lights off — besides inducing sleep — puts all the focus on the screen. The audience should be looking at you more than the screen. Today's projectors are bright enough to allow you to keep many of the lights on. If you are presenting to a small group, then you can connect your computer to a large TV (via the s-video line-in). With a TV screen, you can keep all or most of the lights on.

Suggested readings

Presentations

Beyond Bullet Points: Using Microsoft PowerPoint to Create Presentations That Inform, Motivate, and Inspire

by Cliff Atkinson

Microsoft press

The Short Road to Great Presentations

by Peter Reimold & Cheryl Reimold

IEEE Press

Looking Good in Presentations, Third Edition

by Molly W. Joss, Roger C. Parker

The Coriolis Group

Presentations That Get Results: 14 Reasons Yours May Not

by Marian K. Woodall

Professional Business Communications

Design/Visual Communication

Multimedia Learning

by Richard Mayer

Cambridge University Press

The Elements of Graphic Design

by Alexander White

Allworth Press

7 Essentials of Graphic Design

by Allison Goodman

HowDesignBooks

ZEN

The Zen of Creativity : Cultivating Your Artistic Life

by JOHN DAIDO LOORI

Ballantine Books

Websites

www.garrreynolds.com

www.sociablemedia.com

www.edwardtufte.com

www.presentersuniversity.com

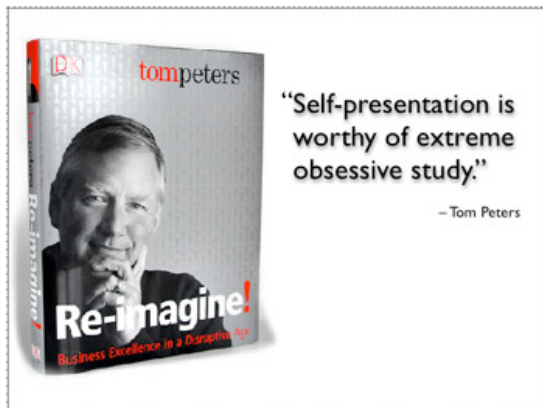
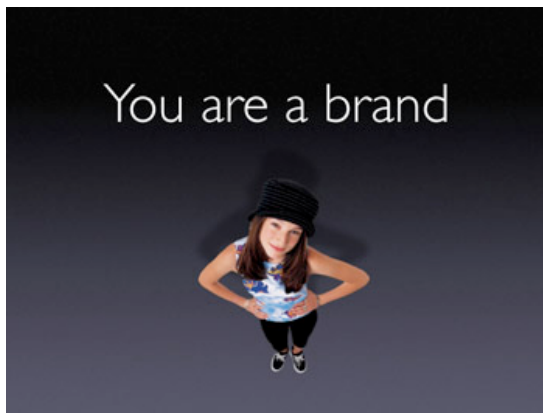
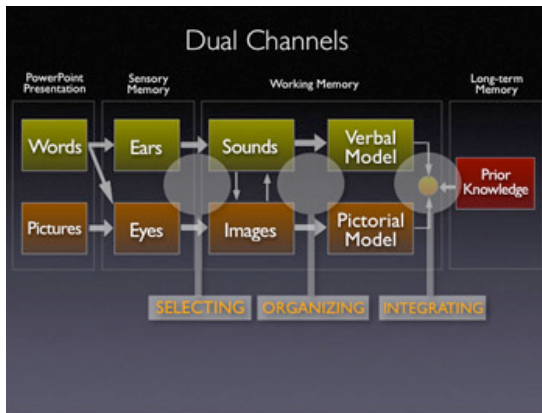
www.presentationcoach.com

Contact Information for Garr Reynolds

Email: info@garrreynolds.com

Web: www.garrreynolds.com

Sample slides on last page.



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



UNIVERSITY OF MINNESOTA
Driven to DiscoverSM

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

Papadakis MA, et al NEJM 2005;353:2673-82

- Disciplinary action by medical 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

Ratan RB, et al Obstet Gynecol 2008;112:1155-9

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



Blueprint for Developing a Program of Remediation

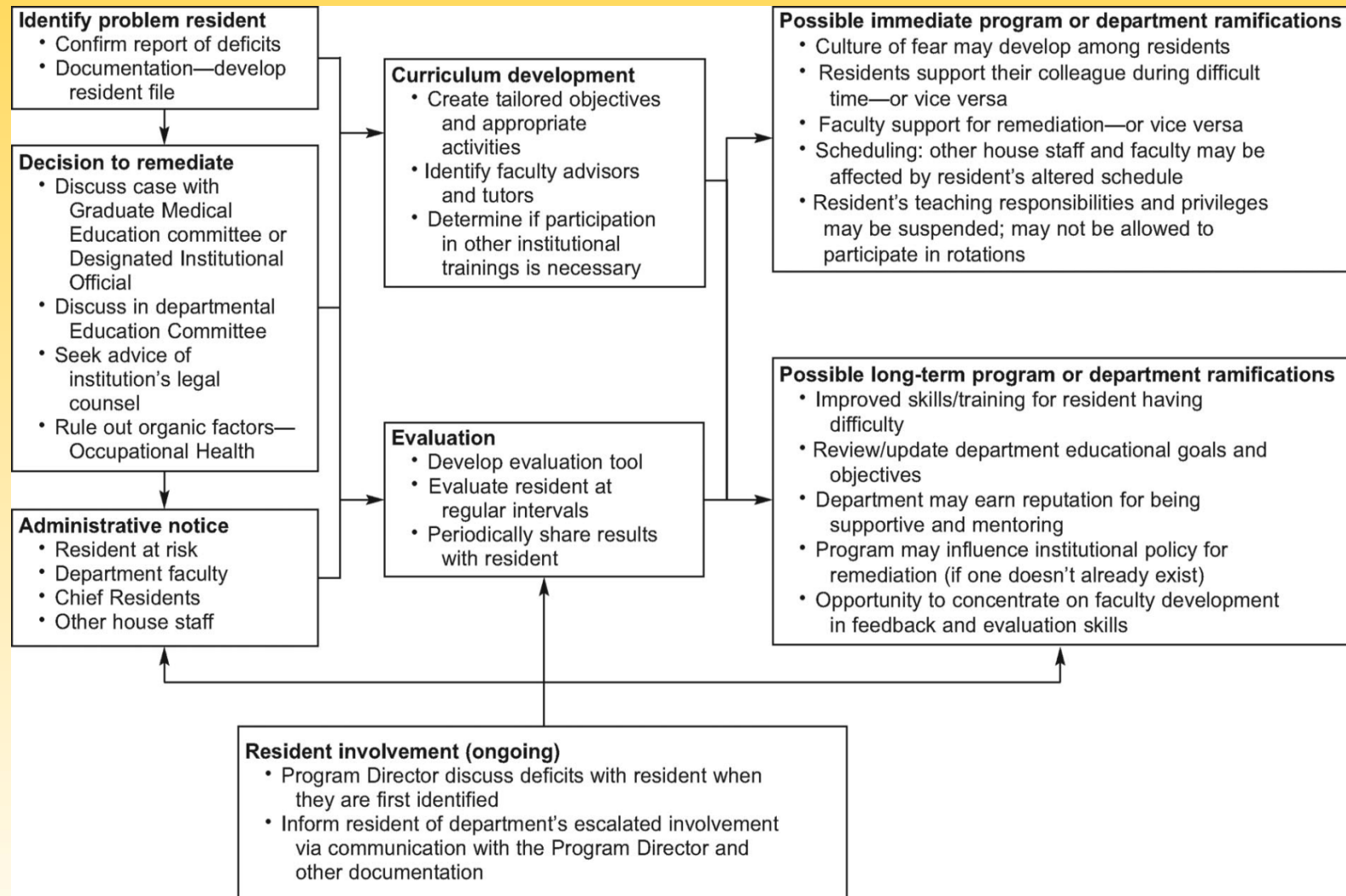


Table 1. Sample Remediation Curriculum

Objective	Activity	ACGME Competency
Improve fund of knowledge in obstetrics and gynecology	Weekly instruction in obstetrics, using specifically designed curriculum with obstetrics faculty Weekly instruction in gynecology, using specifically designed curriculum with gynecology faculty	Medical knowledge
Improve surgical skills	Reading program/self-study Modified operating schedule with an attending physician	Practice-based learning and improvement/ medical knowledge
Address concerns about interpersonal behavioral issues	Medical evaluation by occupational health services Interpersonal skills course Appointments with psychiatrist/counselor during probationary period	Interpersonal and communication skills/professionalism

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%**





UNIVERSITY OF MINNESOTA

Medical School

GRADUATE MEDICAL EDUCATION

2012-2013
Graduate Medical Education Committee (GMEC)
~ RESIDENT LEADERSHIP COUNCIL (RLC) ~
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 24, 2012

August 28, 2012

September 25, 2012

October 23, 2012

November 27, 2012

December Meeting CANCELED

January 22, 2013

February 26, 2013

March 26, 2013

April 23, 2013

May 28, 2013

June Meeting CANCELED

GMEC Coordinator:

Carla Nelson

612-625-7634

nelso081@umn.edu



UNIVERSITY OF MINNESOTA

Medical School

GRADUATE MEDICAL EDUCATION

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 Friday 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.

2012-2013 Submission Deadlines	
Meeting Date	Submission Deadline
Tuesday, July 24, 2012	Tuesday, July 17, 2012
Tuesday, August 28, 2012	Tuesday, August 21, 2012
Tuesday, September 25, 2012	Tuesday, September 18, 2012
Tuesday, October 23, 2012	Tuesday, October 16, 2012
Tuesday, November 27, 2012	Tuesday, November 20, 2012
* December Meeting Canceled *	---
Tuesday, January 22, 2013	Tuesday, January 15, 2013
Tuesday, February 26, 2013	Tuesday, February 19, 2013
Tuesday, March 26, 2013	Tuesday, March 19, 2013
Tuesday, April 23, 2013	Tuesday, April 16, 2013
Tuesday, May 28, 2013	Tuesday, May 21, 2013
* June Meeting Canceled *	---

GMEC Coordinator:

Carla Nelson

612-625-7634

nelso081@umn.edu



UNIVERSITY OF MINNESOTA

Medical School

GRADUATE MEDICAL EDUCATION

**2012-2013
GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)
Meeting Schedule**

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.

July 24, 2012

August 28, 2012

September 25, 2012

October 23, 2012

November 27, 2012

December Meeting CANCELED

January 22, 2013

February 26, 2013

March 26, 2013

April 23, 2013

May 28, 2013

June Meeting CANCELED

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UNIVERSITY OF MINNESOTA

Medical School

GRADUATE MEDICAL EDUCATION

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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.

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612-625-7634

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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://www2.aap.org/sections/ypn/r/resident/resident_teachers.html

American College of Emergency Physicians:

http://www.acep.org/practres.aspx?id=40272&ekmense=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 Oklahoma Health Sciences Center, Residents as Teachers:

<http://www.ouhsc.edu/egr/ResAsTeach.asp>

University of California, Irvine Residents as Teachers:

<http://www.residentteachers.com/Content/Curriculum.asp>

University of Southern California, Residents as Teachers:

<http://residentteachers.usc.edu/>

Chief Resident Retreat

Friday, April 20, 2012

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.

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](mailto:king0367@umn.edu) 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
<i>Team Leadership</i>	This module describes tips to help residents effectively supervise a team of learners. Topics addressed include: setting expectations; time management; and providing feedback.
<i>Giving Effective Feedback</i>	This module offers tips on understanding the level learners are at and giving effective feedback to learners.
<i>How to Give a Ten-Minute Talk</i>	This module provides tips and techniques so students and interns can understand how to give a concise, focused talk.
<i>Microskills Module</i>	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.
<i>Teaching at the Bedside</i>	This module provides tips and points for teaching focused skills (such as physical exam) at the bedside while effectively involving the patient.
<i>Teaching Evidence-Based Medicine (EBM)</i>	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.
<i>Professionalism</i>	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.
<i>Patient Safety and Medical Errors</i>	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.

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

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?

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.

ACADEMIC CONCERNS

Considerations

Keep in mind that there are many causes of academic/performance difficulties including:

- Difficulty with managing learning and/or understanding performance expectations.
- Difficulty balancing resident/fellow roles.
- Diagnosed or undiagnosed disability issues (Attention Deficit Disorder, Learning Disability)
- Mental health concerns (depression, anxiety etc.)
- Cultural, family or personal concerns

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.

PERSONAL CONCERNS

Considerations

Be **CLEAR** about what you can and cannot do.

RESPECT the resident's/fellow's value system and culture.

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 B624 Mayo.
- **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/>.
- **International Student and Scholar Services** 190 HHH Center Phone: 612-626-7100 <http://www.iss.umn.edu/>
- **Disability Services – DS UReturn** Suite 170 McNamara Alumni Center Phone: 612-626-1333 <http://ds.umn.edu/>
- **Office of Equity and Diversity** Phone: 612-624-0594 <http://www.academic.umn.edu/equity/>

See also Resident Dispute Resolution Policy at:

<http://www.med.umn.edu/gme/residents/dispute/home.html>

Rev 4/2012

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:

John Andrews, MD

Phone: 612-626-4009

andrews@umn.edu

GMEC Resident Leadership Council:

Please visit: <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.

To access UReport: https://secure.ethicspoint.com/domain/en/report_custom.asp?clientid=9167

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

Contact: <u>Jan Morse</u> Student Conflict Resolution Center (SCRC) Phone: 612-626-0689 Email: morse005@umn.edu Web: http://www.sos.umn.edu	Contact: <u>Mary Tate</u> Minority Affairs and Diversity and Medical School EOAA Unit Liaison Phone: 612-625-1494 Email: tatex001@umn.edu Office: B608 Mayo	Contact: <u>Marilyn Becker</u> Learner Development Phone: 612-626-7196 Email: becke024@umn.edu Office: B624Mayo	Contact: <u>(RAP) Resident Assistance Program</u> Phone: 651-430-3383 (local); 1-888-243-5744 (toll-free) Web: www.sandcreekeap.com
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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 (7272), by email sos@umn.edu or in person (254 Appleby 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.
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- **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 1-888-243-5744 (toll free); or the web www.sandcreekeap.com.

For more information on campus resources, visit http://www.sos.umn.edu/staffaculty/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/instpolicyman/disciplresdisputeresolpol/home.html>

As always, if you believe there is imminent danger to a student or others, please call 911.