Faculty Matters

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NEWS

Office of Professionalism Responds to Results from 2016 Climate Survey

Faculty members recently had the opportunity to respond to a confidential survey and share with administration their experiences within the working climate of the School of Medicine. A little more than 40% of the 3,660 faculty who received the survey responded.

According to Barry Rumack, MD, Director of the Office of Professionalism, the survey was an opportunity for the administration to understand how faculty members perceive their work. “It’s a way of getting a signal,” he explains. “It’s about identifying trends and patterns, so the School of Medicine and its departments can identify problems and address them accordingly.”

Dr. Rumack also explains how his office went to great lengths to preserve anonymity. For example, demographic data were analyzed separately from the survey data. For any group with fewer than five people, the information wasn’t reported. In addition, the survey was administered and analyzed under contract by a company outside of Colorado. No one at the school has access to the survey’s raw data and the company provided the reports that have been distributed.

A summary of the survey results has been distributed across campus, and department and division leaders have already received detailed reports.

“I was impressed with how the chairs and the division chiefs responded to the areas the survey identified as needing improvement,” he said.

Addressing Environmental Areas of Concern

Dr. Rumack says there were three responses that were of primary concern to the School of Medicine.

1. 61% of respondents agreed or strongly agreed with the statement, “My work environment is stressful.” Being a physician can be inherently stressful, so Dr. Rumack wasn’t entirely surprised.
“Of concern to me was the fact that 21% of faculty members didn’t know where to go for help if they were feeling stressed, burned out or depressed,” he said. “The Office of Resilience was created to address these issues, and they will be working this year to ensure that our people understand that this is the best place to start when you’re experiencing these circumstances including depression, anxiety or other issues.”

2. **18% of faculty members reported observing student and staff mistreatment.** The Office of Professionalism offers many levels of response to a report of unprofessionalism including counseling, coaching, remediation, mediation, facilitation and consultation. “Since the Office of Professionalism was created in 2014, we’ve handled more than 300 cases of unprofessional behavior. We want people to understand that any report of unprofessionalism is handled in a private, confidential setting with the goal of having the faculty member, resident, fellow or student resolve the issue and go on to have a successful career.”

3. **8% have observed discrimination due to race, ethnicity, gender or sexual orientation.** “This is a very complex area. The Office of Diversity and Inclusion, now led by Shanta Zimmer, MD, is actively involved in utilizing this information to address this issue,” he said.

“Doing a survey like this from time to time helps us determine if the programs being put into place are actually achieving their goals. We want to collect the right data to implement evidence-based interventions that get results.”

Dr. Rumack added that his office will be asking for wider input during the design phase of the next survey, expected to take place in the next 18 months.

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**Post-Election Message from Dean Reilly**  
*By John J. Reilly, Jr., MD*  
*Reprinted from the Nov. 14 weekly email*

I close this week’s message with some thoughts on the election and its implications for our school. Since Tuesday, I have spoken with a range of members of our school community about the results and their implications. Some are extremely depressed and concerned, others are elated and hopeful. These discussions also highlighted a clear area of agreement among all regardless of their political viewpoint: distress over the rancor and divisiveness of the campaign. The actions of our newly elected leaders will undoubtedly impact health care over the upcoming years and we will need to adapt our tactics for this changing environment. What we will not change, however, is our commitment to our missions of providing world-class health care to all in need, advancing the science needed to improve our understanding of biology and translating that understanding to improved prevention and therapy, and educating the next generation of researchers and health care providers. Also unchanged is our commitment to embracing diversity as a core component of our strategy. We will continue our efforts to
recruit and support a diverse student body, faculty and staff and to leverage their skills to meet the needs of the diverse population we serve. We will continue to support a diversity of ideas, respectful and civil dialogue among those with differing points of view, and a respectful and tolerant environment for all.

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Post-Election Reading List
By Suzanne Brandenburg, MD

The election was more than a month ago. Have you been wondering what people are reading? Numerous suggestions for political articles and books are circulating on the internet, but here is a list of what people are actually reading, based on Amazon’s “bestsellers” list.

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PROFILE

Patrick Kneeland, MD, Focuses on Patient and Provider Experience

It has been two years since Patrick P. Kneeland, MD, assumed the role of medical director for Patient and Provider Experience at University of Colorado Hospital. In an increasingly complex climate where burnout is common, he’s working to give faculty members access to tools that enhance their experience.

Dr. Kneeland has been focused on three primary areas:

1. Finding and implementing strategies that support improving the experience of patients and providers alike.

2. Using actionable and meaningful data to advance the conversation about measuring patient experience.

3. Developing and sharing a framework and mental model that defines patient experience.

“When we developed the position, it was important to me that patient and provider experience be considered at the same level,” he said. “We know from the literature that patients put a lot of weight on their direct interaction with their physicians. And we also know it’s hard to show up for patients in a meaningful way if, as a provider, you’re experiencing significant stress or burnout.”

That’s why a big part of his approach to improving patient experience is understanding the experiences of physicians and other health care professionals delivering care.
“So much comes down to relationship-centered communication—it’s so critical,” he said. “We’ve been focused on ways we can optimize interaction across our environments.”

Reconnecting to the human element of medicine enables clinicians to make the best diagnostic and treatment decisions. “It also helps us as clinicians reconnect to our own professional purpose.”

New Peer-to-Peer Curriculum Enhances Dialogue

Dr. Kneeland helped develop and implement an Excellence in Communication training curriculum, where faculty members learn “high yield” skills aimed at improving one-on-one interaction. The four hour, one-time course brings together 16 faculty member facilitators from across the clinical spectrum.

“It’s about sharing experiences of faculty members who are in this to do the best thing for patients,” he said.

The curriculum was launched in September. So far 120 faculty members at UCH have taken part in this training, and reviews have been positive. “It gives faculty learners access to a good cross section offering faculty members a chance to interact with people they might never encounter in their daily practice.”

Expanding the View of Patient Experience

Dr. Kneeland says that he occasionally hears the misconception that his role was created to “get physicians in line.” Yet the opposite is true.

“We want to be leaders in this space—in broadening how we think about patient experience beyond the typical survey. It’s using evidence-based practices to do even better by our patients, and by extension, our faculty,” he said.

He describes that patient experience data tells us, in general, that patients love our faculty and the care they receive. “But we also know there are opportunities to do better. Our goal is for every patient in every circumstance to receive optimal care, and to determine what our faculty can own in this space.”

“There are challenges in doing this well, but I’m optimistic about how receptive everyone has been, and how proactive they’ve been in incorporating these strategies into their own practices.”

Patrick P. Kneeland, MD is the Medical Director for Patient and Provider Experience at the University of Colorado Hospital and Director of Safety and Patient Experience for the University of Colorado Hospital Medicine Group. Dr. Kneeland is a graduate of the University of Colorado School of Medicine.
Teaching in the Operating Room
*A 30 Year Perspective*

*By MJ Taravella, MD*

It’s hard to believe at this stage of my career, but I began teaching residents in the operating room at the University of Colorado in 1987 (30 years ago!). Certainly much has changed in this time, not the least of which is our approach to surgery. In general, the old adage, “see one, do one, teach one,” and the apprenticeship model have evolved to a more evidenced based approach to teaching.¹ So what is my current approach?

1. **Learning procedures starts outside of the OR.**
   - There is a cognitive component to any procedure, and trainees must demonstrate knowledge of the indications, methods and potential complications of procedures.
   - Fortunately, there are many good resources at the present time at our fingertips. However, the amount of material available can be overwhelming. It is up to the supervising physician to recommend appropriate relevant articles and pare the information down to the essentials.
   - Videos illustrating the finer points of a given procedure are often helpful.²
   - Wet lab practice and simulation have proven to be effective in teaching many procedures.³
   - Observation of experienced surgeons in the operating room is a necessary step prior to allowing a novice surgeon to operate. However, this should be “active” observation. That is, the attending surgeon should engage and probe the learner to ensure that every step in the procedure is thoroughly understood by the novice. The number of cases to be observed as an assistant surgeon will vary with the complexity of the case and the ability of the learner to absorb the nuances of the different aspects of a given procedure.

2. **Safety first. In the operating room, this is paramount and supersedes the trainees’ need for experience and learning.**
   - A culture of safety starts from the top down. In the OR, it is the primary responsibility of the attending surgeon to instill in team members (including residents) the concept of “safety first,” and allow the resident or fellow to respectfully bring up concerns impacting safety in a non-punitive environment while always preserving patient confidentiality.
   - There is no room for attempts at intimidation of those we are trying to teach. Fear is seldom conducive to effective learning.
   - At the same time, it is appropriate to refuse permission for unprepared learners to perform a given procedure if in the judgment of the supervising surgeon it is unsafe to do so. This alone is usually enough to motivate most novice surgeons.
   - There is an art to supervising novice surgeons in terms of balancing safety and learning. It is often helpful to allow beginning surgeons to perform parts of cases, especially if less technically challenging, and then progress to more difficult aspects as abilities warrant.
Novice surgeons should be prepared to allow more experienced hands to guide them over the tough spots and the supervising surgeon must be able to recognize when a novice is struggling. The art of appropriate and timely intervention and complication prevention is one that comes through experience and observation.

3. Post procedure feedback is essential.
   - It is helpful to immediately provide feedback to the novice surgeon following the procedure (debrief)—not only pointing out deficits, but just as importantly, letting them know what they did right.
   - Video of the procedure is extremely helpful to identify areas needing improvement. It allows for review of the procedure in a relaxed and less stressful teaching environment.
   - Surgical proficiency is a core competency for all surgical subspecialties; however, documenting proficiency may vary widely from one program to another. Standardized forms completed by the supervising surgeon immediately following a procedure are useful tools to accomplish this.
   - Tracking outcomes including complications is important. It allows the supervising surgeon to assess progression and identify problems that need to be addressed. Results can be compared to departmental and national norms.

Teaching surgery to my younger colleagues has been very rewarding, and at the same time, challenging. Teaching a procedure forces one in to a deeper understanding of that procedure: it has always been my view that if you can’t articulate what you are doing then you don’t fully understand it. At the same time, there is no doubt that teaching requires learning on the part of the supervising surgeon if it is to be done well. I have no doubt that I am a better surgeon than I otherwise would be if I did not have the privilege and opportunity to teach.


FAQs

What are the policies and procedures for faculty salary increases and decreases?
The School of Medicine Base, Supplement and Incentive (BSI) Plan, which was initially approved by the Board of Regents in 1995, describes the salary components and salary adjustments for full-time faculty members (instructors and above who are at least 50% FTE) in the School of Medicine. Full-time faculty
members in all three series (regular faculty, research professor and clinical practice) participate in the BSI Salary Plan. Regent Policy 11C governs the policies and procedures pertaining to salary adjustments.

The university permits salary adjustments for full-time faculty members once a year. Consideration of salary increases occurs in the spring, for salary changes that will take effect on July 1st. In recent years, the regents have granted an additional opportunity to adjust salaries, which occurs in the fall (for salary adjustments that will take effect on January 1st). January 1st salary adjustments are permitted only for schools and colleges that have adopted a BSI compensation plan. Outside of these two opportunities, full-time faculty salaries are generally not adjusted at any other time during the year.

Salaries for all faculty members must be approved by the regents. All salary recommendations are submitted to the regents through a process managed by the individual schools and colleges. A “salary pool” is provided for use during the process, and all adjustments are required to fall within that pool. Typically, individual faculty salaries are based on merit and cost-of-living factors and cannot increase more than a pre-determined “threshold,” unless the department and the School of Medicine provide written justification. For example, a large salary increase may be denied unless it can be justified based on a substantial change in the faculty member’s responsibilities, market demands or equity considerations.

Decreases in a faculty member’s salary are occasionally recommended, and these adjustments follow the same processes and timelines. According to BSI guidelines, a faculty member’s salary cannot be lowered more than 15% in a given year without approval by the dean and chancellor. Faculty salaries cannot generally be decreased below the pre-determined School of Medicine base salary.

Stipends for specific administrative duties (e.g., program director, assistant dean, department vice-chair) are handled separately; they can be processed at any time during the year and require development of a new letter of offer outlining the additional administrative responsibilities.

EVENTS

Unless otherwise indicated, register at http://som.ucdenver.edu/FacultyDevelopment/

**Challenging Conversations and Contexts**
Feb. 2, 2017
9:00 a.m. to noon
Kirsten Broadfoot, PhD
Ed 1, Room 4103

**Developing Standardized Patient Cases for SOM CPE Faculty**
Feb. 13, 2017
1:00 p.m. to 3:00 p.m.
Eva Aagaard, MD
DECEMBER 2016

Antonio Francesco, MFA
Ed1, Room 4103

Challenging Conversations and Contexts
April 11, 2017
Noon to 3:00 p.m.
Kirsten Broadfoot, PhD
Ed 1, Room 4103

Challenging Conversations and Contexts
June 22, 2017
Noon to 3:00 p.m.
Kirsten Broadfoot, PhD
Ed 1, Room 4103

LINKS TO ARTICLES ABOUT ACADEMIC MEDICINE

http://www.ucdenver.edu/academics/colleges/medicalschool/education/academy/Newsletter/academicmedicine/Pages/dec-16.aspx

- Assessment of Technical and Nontechnical Skills in Surgical Residents
- Conducting Research in Health Professions Education: From Idea to Publication
- Foreword: Characteristics of RIME Papers That Make the Cut
- High-Functioning Primary Care Residency Clinics: Building Blocks for Providing Excellent Care and Training
- How Prevalent are Potentially Illegal Questions During Residency Interviews?
- How to Lead the Way Through Complexity, Constraint, and Uncertainty in Academic Health Science Centers
- Seven Dirty Words: Hot-Button Language That Undermines Interprofessional Education and Practice
- Situated Learning in Medical Education
- The Causes of Errors in Clinical Reasoning: Cognitive Biases, Knowledge Deficits, and Dual Process Thinking
• The Impact of Administrative Burden on Academic Physicians: Results of a Hospital-Wide Physician Survey

• The Importance of the Premedical Experience in Diversifying the Health Care Workforce

• The New CMS Hospital Quality Star Ratings: The Stars Are Not Aligned

• Three-Year MD Programs: Perspectives From the Consortium of Accelerated Medical Pathway Programs (CAMPP)

• What Attitudes and Values Are Incorporated Into Self as Part of Professional Identity Construction When Becoming a Surgeon?

• Why Does This Learner Perform Poorly on Tests? Using Self-Regulated Learning Theory to Diagnose the Problem and Implement Solutions