JUNE 2014

FACULTY MATTERS
The Academy of Medical Educators
The Office of Faculty Affairs

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NEWS

Graduation Level Competencies for the School of Medicine

Task Force to Continue Work in Implementing Competencies across the Curriculum

Medical education provides students, residents and fellows with the opportunity to learn and practice in a supervised work environment so that they can acquire the knowledge, skills, attitudes and behaviors necessary to treat patients independently within the scope of their medical discipline. In a competency-based system of training, outcomes are derived from the abilities and standards required of physicians for safe and effective practice. Educators, informed and guided by the needs of patients and learners, provide the framework, curriculum, instruction, and supervision for this training[1]. Educators are also responsible for assessing whether trainees are progressing appropriately toward independence, and ultimately determining whether they are prepared for unsupervised practice[2].

The Accreditation Council for Graduate Medical Education (ACGME) introduced the Outcomes Project in 1999, requiring resident training programs to assess trainee accomplishment of learning objectives across six general domains of competence[3]. The Next Accreditation System of the ACGME began this year, and includes competency-based reporting using milestones, a criterion-based developmental framework for reporting a resident's progress toward independent practice[4,5]. In 2013, the Association of American Medical Colleges (AAMC) further defined competencies for health professionals, adding two new competency domains[6]. These domains have subsequently been adopted by the Liaison Committee for Medical Education (LCME), the accreditation body of medical schools. Integration of these competencies into medical student education is a required element for LCME accreditation.

A task force of the Curriculum Steering Committee, consisting of 16 faculty with expertise in competency development and spanning the continuum of medical education has worked for the last year to develop graduation level competencies for the University of Colorado School of Medicine. These competencies describe the minimum expectations required of a student prior to graduation from this medical school.

To develop the competencies, they reviewed the extensive literature, including the milestones of all specialties currently available. They developed draft competencies for each competency domain. These were reviewed iteratively using a modified Delphi technique. The final competencies were approved by the Clerkship Block Directors and the Curriculum Steering Committee in May, and presented in total for assent by the Faculty Senate. (View the final version of the competencies.)

There is much work still to be done—this is only the first step. Over the next two years, the task force will be mapping the competencies to course and block level goals and objectives and assessments. In addition, "hard stops" at each phase of medical school will be identified with associated assessment tools. The work of the committee will be critical to the upcoming LCME self-study and accreditation process.

Medical Students Suggest "6 Best Practices" of Preceptorship at the Golden Stethoscope Banquet

Kristin Furfari, MD

Medical students from the Foundations of Doctoring curriculum recognized and thanked their program's volunteer and full-time clinical preceptors at the Golden Stethoscope banquet on May 5.

Students in all phases of the three-year Foundations of Doctoring curriculum were asked to write letters in support of their preceptors and nominate them for various awards. The following themes emerged as student's reported what they learned and valued as well as what makes for a successful clinical preceptorship experience.

1. Investment in relationships, both with patients and with students. *"My preceptor is aware of my particular interests, strengths and weaknesses."*

2. The value of listening. *"It is far more efficient and more effective at building trust between the patient and physician to remove the assumptions, to be quiet, and truly discover the patient, the person, and their understanding of their disease."*

3. Creating a safe teaching environment. *"My preceptor challenges me to move beyond my comfort level in order to improve my clinical and communication skills, while maintaining a safe and respectful environment for the patient. His feedback is always constructive and directed – even when I, for example, completely bomb the neuro exam I am attempting. Instead of simply dictating how to do something, he always explains why."*

4. The importance of goal development. *"We talk about my goals frequently. Every day he encourages and validates my selections. As a student, the list of things I'd like to be better at is endless, but equally valid are the skills that are less concrete."*

5. The value of the human touch. *"After a heartfelt talk about a patient's [challenging] situation and options, my preceptor's next move surprised me. 'Your heart must feel broken right now – do you mind if I listen to it?' With one hand on her stethoscope, the other rested reassuringly on the patient's shoulder, a seamless integration of compassion and doctoring."*

6. Demonstrating humanism. *"Every time we spoke and every shift I was with her, my preceptor asked about the most crucial parts of medical school – how I was coping, what I was eating, how much exercise I was getting, and what medicine still meant to me. It seemed completely natural because she did the exact same thing with her coworkers and her patients."*

Reminder: Faculty Should Review Payment Data Reported to the Centers for Medicare and Medicaid Services

Physicians on our faculty should take time to review information reported by pharmaceutical and medical-device manufacturers to the federal government about payments for research, consulting, gifts, travel or speaking honoraria, and entertainment. The Physician Payment Sunshine Act, which is part of the Affordable Care Act, requires the manufacturers to report such payments. As of June 1, physicians can register on the Centers for Medicare and Medicaid Services (CMS) website to review and dispute any of the data reported about them. CMS will make the data public on September 30, 2014. Dean Krugman urges you to review as, based on previous news reports, we expect intense interest in the information.

Faculty Affairs has prepared a useful summary of the issue.

Now Seeking Nominations for Faculty Professionalism Award

The Faculty Senate last week announced its call for nominations for the School of Medicine Faculty Professionalism Award. The award recognizes a full-time faculty member who has served as a role model for professionalism. It is presented in August at the School of Medicine matriculation ceremony. Award criteria and nomination packets are available online. Nominations are due by 5 p.m., Friday, July 11, to Director of Faculty Affairs, Cheryl Welch.

TEACHING TIPS

Tips on Evaluating Student Competencies

Joel Yager, M.D.

There are positive and negative aspects associated with the lists of general competencies and specialty-specific milestones set forth by the Accreditation Council for Graduate Medical Education (ACGME).

On the plus side, these well intended, high-minded and honorable lists of competencies ratify and draw attention to important areas of professional performance. As educators, we should be accountable to the public for assuring that trainees bearing our imprimaturs have achieved necessary levels of competence prior to independent practice.

On the minus side, a "competency-industrial complex" requiring formal assessment has emerged, generating large numbers of bureaucratic documentation requirements, chock-full of unintended consequences and unfunded mandates with regard to effort, time and staff resources.

The trick for educators and program staff is to (competently) conduct the necessary appraisals and fulfill documentation requirements without killing the spirit of educating trainees in the process. Competency assessment should not turn into mind-numbing, cynical exercises devoted to filling out valueless forms. Nor should formal evaluation stand in the way of (or stand in for) actually guiding progressive competence-building in trainees.

The following tips are provided with two goals in mind: 1) Helping trainees grow their competence AND 2) Satisfactorily documenting their progress.

5 Tips for Helping Trainees Increase Competence

1. **Appreciate that the majority of trainees accepted into our programs ultimately meet expected levels of competence.** When trainees know what's expected of them (i.e., are given the lists of expectations at the outset), most can acquire these abilities and, when necessary for Board certification, document that they've competently performed them. As educators we should approach trainees with the attitude and expectation that they will meet these competencies. Moreover, we should know what these expectations are in order to competently guide them toward achievement.

2. **Try not to generalize or set expectations about knowledge or skill-based competence from single observations, especially early in the trainee's experiences.** Appreciate that with repeated practice, demonstration, and feedback based on close faculty observation and encouragement, most trainees who seem initially to be inept ultimately turn out "ept."

3. **Use your specialty's competency milestone statements as the basis for offering trainees constructive comments for improvement as well as positive feedback.** Do so immediately after you observe a trainee's performance or as soon thereafter as feasible.

4. **Understand that a single observation of frank unprofessional behavior is worrisome.** Acts of frank unprofessionalism may reflect enduring personality issues, insecurity, or counterproductive responses to clinical pressures or workplaces stresses. Any act should be discussed with the trainee immediately and should serve as the basis for close scrutiny in the future.

5. **Understand that medical educators must act responsibility concerning the small number of trainees who are unable to master the requisite competencies and who act unprofessionally.** The ultimate public trust mandates that medical educators protect patients and their families from incompetent practitioners. There are resources available to support remediation of struggling learners through the Office of Lifelong Learning (contact Jeannette Guerrasio). The earlier you identify the issue, the better we are able to help improve the long-term outcome.

Tips for Formally Evaluating Competencies

1. **Unless these are "high stakes" ratings, don't waste much time developing your own competency or milestones assessment forms** (Unless you're planning to devote yourself to competence assessment as a major, time-consuming scholarly project!). Instead, use forms that have been developed and disseminated by professional educational associations or other educators in your specialty. Of note, if you have the opportunity to engage in cross-institution projects to develop and test competence assessment tools, by all means, participate if the project will not take up an inordinate amount of time and you are interested in the professional development and community-building aspects. You may benefit professionally as a result, while enjoying the company of educators from other institutions participating in the project.

2. **Remember that detailed narrative descriptions are generally more valuable than numerical rating systems.** However, many busy faculty fail to take sufficient time, or are insufficiently articulate, to offer nuanced accounts. Of note: faculty provided with detailed, descriptive "drop down" menus of complete sentences/paragraphs that capture important performance characteristics may help raters save time and ultimately provide program directors with higher quality information on which to act. Regardless, your comments and specific examples as a faculty member who has directly observed the behavior of the resident are INVALUABLE.

3. **Use the competency-based forms and milestone instruments as prompts for helping to organize your thinking about residents' performances.** In day to day activities, think about how each trainee's performance aligns with the various expected competencies and milestones.

4. **Understand that, except for specific procedural skills and at the extremes, most rating schemes of general domains (e.g., "medical knowledge", "systems-based care") on which faculty are asked to evaluate trainees have limited reliability and validity because they are broadly stated and poorly operationally-defined.** Realize that most assessments are inexact. Except in cases of frank incompetence or exceptionally brilliant performance, you're unlikely to encounter strong inter-rater reliability (not that such reliability is guaranteed even at the extremes). Whereas gross assessments of "safe", "unsafe," "smart" and "dumb" may be replicated, inter-faculty agreement on finer-grained distinctions within each area of competency may be much harder to achieve.

5. **Appreciate that competency-based evaluation forms offer trainees important opportunities for self-reflection and self-assessment.** Trainees should be asked to self-evaluate using these forms and to discuss their self-evaluations with faculty. Many trainees humbly undervalue themselves, often rating their competence as lower than perceived by faculty. On the other hand, finding trainees with an inflated sense of competence is potentially worrisome and may warrant closer future scrutiny.

Before Completing a Rating Form

1. **Know exactly who will see the form and how it will likely be used—now and in the future.** What are the intended consequences of their use, and what unintended consequences might you foresee – on the trainee's self-esteem, reputation, future recommendations and future prospects? How might any of your comments come back to you in the future? Before you err on the side of harsh evaluations, for example, do you feel sufficiently justified in the strength of the evidence on which you base your opinions (e.g., repeated observations or an egregious sentinel event) so as to rate someone in a strong, negative manner? Have you sufficiently documented the specifics involved so that the person receiving the evaluation can appropriately use the information to act on the information provided?

2. **Know your own rating biases.** Are you a generally hard rater or a generally soft rater? Are you taking these biases into account?

3. **Think about the rating biases of your peers and try not to succumb to "groupthink."** Don't allow yourself to be subconsciously biased or swayed because you've heard other faculty badmouthing or excessively praising a trainee. For your own assessments, do your best to discount others' comments and base your assessments entirely on your own observations and interactions. Be honest when you've had insufficient experience with a trainee to offer a useful appraisal.

We hope you find these tips useful as you work on the assessments required of you. Note that the Academy of Medical Educators is happy to come to your department, division, section or program meetings to provide faculty development training specific to your assessment framework. If you are interested, please contact Eva Aagaard.

FAQs

My career focuses on scientific research. How should I document my research accomplishments in my promotion or tenure dossier?

If your career focuses on research, you must submit a well-organized Investigator's Portfolio as part of your promotion or tenure dossier. This is the section of your dossier where you highlight and explain

your most noteworthy research discoveries, insights or advances. This is also the place where you can explain your unique contributions to multi-disciplinary ("team") research programs. Your curriculum vitae (CV), which lists your grants, publications and other scholarly activities, is not enough to judge research excellence.

According to the Promotion Rules of the School of Medicine (SOM), "basic, clinical, translational, educational and other forms of research are highly valued by the School of Medicine." The SOM also recognizes the importance of "inter-disciplinary science and the need for collaboration among investigators." (See additional information below regarding research "independence.")

As outlined in the SOM promotion matrix, "excellence" in research may be demonstrated through peer-reviewed scientific publications, competitive grant funding, a national or international reputation, and other evidence of originality, creativity and independence as an investigator. Naturally, when it comes to evaluating the quality of your scientific work, the information you provide in the Investigator's Portfolio will be supplemented by letters written by outside experts and peers in your field of study.

Note that this FAQ is for research-intensive faculty members: the FAQ in the next issue of Faculty Matters *will provide guidelines for documenting other types of scholarship (teaching, integration and application).*

Basic Elements of a Well-Organized Investigator's Portfolio

- **Narrative statement.** In the Investigator's Portfolio, you should include a narrative summary that explains the focus, importance and impact of your research and scholarly work to members of the SOM Faculty Promotions Committee. Examples are provided in the Investigator's Portfolio section of the *Guide to Building a Dossier for Promotion or Tenure* (Additional checklists, FAQs, and resources are available under the "Promotion and Tenure" section of the Faculty Affairs website.) You should also explain how your work has supported the research programs and missions and enhanced the reputation of your department, the SOM or the university. Your narrative statement should not exceed two pages.

- **Summary of funded research.** For your most important funded projects, list the grant and describe (briefly) the purpose of the project. Highlight your role, especially if you are not the Principal Investigator (PI). Provide a brief summary of the nature and importance of the problem (the "context") and the expected results or implications of the work. For multiple-PI grants and program project and center grants, be specific about how you contributed to the success of these grants. Limit this section to 250 words per project.

- **Annotated bibliography.** Help the promotions committee reviewers understand the significance of your publications. You should limit this section to a summary of no more than 10 of your "best" publications or scholarly works (i.e., those that have been the most significant or that have received the most attention). Greatest weight is given to recent publications (typically

those published after the date of your most recent promotion or tenure award). For each publication or scholarly work, provide a brief summary of the nature and importance of the problem (the "context") and the most important results. Provide electronic links, but not reprints, for the publications described in this section.

- **Impact factors.** As noted above, in your narrative statements and annotated bibliography, you will be highlighting the impact that your publications or scholarly work has had on your field. Metrics—such as the number of article citations, your h-index or others (e.g., those available at ImpactStory.org)—can be useful in making the case that the publication or scholarly work was significant. However, the Faculty Promotions Committee discourages the use of journal-based metrics (i.e., journal impact factors), since it is the quality and importance of the research contribution itself that is the key. Research importance can also be measured by its impact on policy, practice or the scientific discipline. Other outputs from scientific research, such as intellectual property, databases, software or others, may also be highlighted.

- **National recognition.** Provide additional details about the degree to which your publications and discoveries have been recognized by leaders in your field. For example, highlight: invited lectures, visiting professorships and plenary research presentations; work cited in editorials, scientific blogs or the lay press; service on NIH study sections or scientific advisory boards; editorship of scientific journals (or membership on editorial boards); and accomplishments recognized by national prizes or scientific awards.

- **Evidence of originality, creativity and independence.** This section of the Investigator's Portfolio is particularly important for faculty candidates whose research is multi-disciplinary and whose publications and other accomplishments reflect the work of multi-disciplinary teams. Note that in 2012, the SOM promotion rules were amended, and the following definitions of "independence" were added: The School of Medicine recognizes the importance of inter-disciplinary science and the need for collaboration among investigators. Therefore, as recommended by the National Academy of Science, the School of Medicine defines an "independent investigator" as one who demonstrates "independence of thought"— that is, one who has defined a problem of interest, who has chosen or developed the best strategies and approaches to address that problem and who has contributed distinct intellectual expertise.

  Therefore, use this section of your Investigator's Portfolio to clarify the contributions that you have made to multi-author publications and co-PI and co-investigator grants. Be specific about your intellectual contributions and the manner in which you defined the research objectives, led the research efforts, interpreted the results or shaped the overall research program. Additional evidence should also be provided, such as letters from the principal investigators or research group heads with whom you have collaborated, outlining in detail your specific contributions and the unique skills that you brought to the team. For multi-authored papers, letters from the first- or senior-authors may also provide evidence of your specific contributions. The overall

objective is to convey clearly and concisely to the Faculty Promotions Committee the importance, significance and broad impact of your cumulative research contributions.

- **Institutional service.** You should include descriptions of committee work and institutional service, if your efforts have been vital in supporting the general research missions of your department, the SOM or the university. Examples might include being a chair or member of an institutional review board or an institutional committee focusing on animal care, safety, conflicts-of-interest or scientific misconduct.

For a more complete discussion of these topics, refer to the *Guide to Building a Dossier for Promotion or Tenure*, which includes examples of narrative statements, annotated bibliographies and summaries of research funding.

For a complete list of Frequently Asked Questions, visit the Faculty Affairs website.

FACULTY PROFILE

Office of Professionalism Aims to Elevate the Learning Environment

Barry Rumack, MD, is curious: If you saw a colleague walking through the hospital corridor smoking a cigarette, what would you do?

He's asked this question of many people. Most answer decidedly: They'd ask the smoker to stop—immediately.

Next, he wants to know what you'd do if you saw a colleague berating a student in that same corridor.

Most people he talks to insist that the answer to this question is always more complicated. Yet Dr. Rumack insists that it shouldn't be. It's unprofessional conduct, and no one at the school should tolerate it.

"As faculty, we're all responsible for creating and maintaining a professional learning environment," Rumack explains. "And in the next five years, I'd like to see learner mistreatment become a thing of the past." Equally important, we are well aware that unprofessional behaviors also undermine trust and teamwork in clinical settings and threaten quality of care and patient safety.

It's a big goal, but in his new role in the Office of Professionalism, Dr. Rumack is well-positioned to help the School of Medicine shift its culture to one in which unprofessional acts are not tolerated at any level.

Helping Faculty Succeed When Faced with Conflict

Dr. Rumack's primary role is helping faculty members succeed by properly managing conflict throughout the school. He's also responsible for helping identify and rectify situations involving unprofessional behavior. Much of his work surrounds medical student mistreatment.

“We’ve known for some time that ‘fear’ is not a teaching technique,” says Dr. Rumack. “I’m here to help learners and faculty handle conflict appropriately.”

Since beginning this post in March, Dr. Rumack has seen a number of interpersonal conflicts arise and has helped the parties involved properly manage the issues. Dr. Rumack says so far, the strategies used in the Office of Professionalism have been helpful.

“A few people who I’ve worked with have stopped by to tell me ‘I learned a lot’ and ‘I think I’ll be better about it’ and ‘I’m sad about the situation but happy it’s been remediated,’” says Dr. Rumack.

Above all, Dr. Rumack wants faculty to understand that the program isn’t meant to be punitive.

“We’re going to do the best we can to help people succeed,” said Dr. Rumack. “It’s about helping people in stressful situations to not be ‘reactive.’ Remember, as faculty, one of our goals is to graduate medical students that are competent doctors. Unprofessional conduct gets in the way of that goal.”

On behalf of the Office of Professionalism, Dr. Rumack receives reports of misconduct and investigates matters as they arise. For lower level first time offenses, it’s often a matter of sitting down and having a cup of coffee.

“It’s usually nothing official if it’s a one-time occurrence. Stress happens in our settings and it’s not unexpected that people will be unhappy and express themselves negatively,” says Dr. Rumack. “We know through published data that in 80 percent of circumstances, the offender is mortified and apologetic for the incident. And most of the time, the behavior doesn’t recur.”

“It’s all about reminding the person that no matter what your stresses are, being unprofessional at the School of Medicine is not acceptable,” said Dr. Rumack.

In cases of mistreatment that recur, mechanisms are in place to help the faculty member succeed. Sometimes recurrence warrants further evaluation or work with the remediation resources provided at the Center for Professional Excellence. In higher level cases, remediation programs may become mandatory as a condition of employment and may eventually warrant removal from patient care or teaching responsibilities or dismissal if the appropriate steps are no taken.

For Dr. Rumack, developing a culture of professionalism is important for learners at all levels.

“I’ve been a part of the school since 1968, and I’m still learning every day. I know many faculty feel the same way,” said Dr. Rumack. “We all made a promise to act professionally. We all need to remember in all circumstances to be respectful and collegial, because that’s what makes a good learning, research and patient care environment.”

About the Office of Professionalism

The Office of Professionalism helps faculty, residents, fellows, and students of the School of Medicine effectively deal with and resolve conflict. This ranges from interpersonal disputes to personnel conflicts to acts of student mistreatment of any kind. The Office provides a resource for fair and equitable treatment in all such matters. Discussions remain confidential and private (with some exceptions). Services provided include consultations, short-term coaching, counseling, referrals, alternative dispute resolution and facilitation. The services of the Office of Professionalism are provided free of charge.

LINKS TO ARTICLES ABOUT ACADEMIC MEDICINE

http://www.ucdenver.edu/academics/colleges/medicalschool/education/academy/Newsletter/academicmedicine/Pages/June-14.aspx

- A holistic review of the medical school admission process: examining correlates of academic underperformance
- Assessment of cognitive biases and biostatistics knowledge of medical residents: a multicenter, cross-sectional questionnaire study
- Career Development for the Clinician–Educator: Optimizing Impact and Maximizing Success
- Developing medical educators - a mixed method evaluation of a teaching education program
- Development and evaluation of the evidence-based medicine program in surgery: a spiral approach
- Feedback Matters: The Impact of an Intervention by the Dean on Unprofessional Faculty at One Medical School
- Teaching patient-centered communication skills: a telephone follow-up curriculum for medical students
- Using tablets to support self-regulated learning in a longitudinal integrated clerkship

EVENTS

Unless otherwise indicated, register at **http://somapps.ucdenver.edu/facultyaffairs/faculty/**

Procedural Skills
June 24, 2014
2:00 pm to 5:00 pm
Matthew Rustici, MD
TBD

Introduction to Simulation Debriefing
June 27, 2014
9:00 a.m. to Noon
Margaret Sande, MD
WELLS Center

Conflict Management for Supervisors
Sept. 9, 2014
7:00 am to 10:00 am
Lisa Neale
TBD

Improving Diabetes Management through Patient-Centered Care & Better Communication
Sept. 18, 2014
Noon to 5:00 p.m.
Multiple Presenters
Library Reading Room 3rd Floor

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1 Frank, J. R., et al. (2010). "Competency-based medical education: theory to practice." Med Teach 32(8): 638-645.

2 Holmboe, E. S., et al. (2010). "The role of assessment in competency-based medical education." Med Teach 32(8): 676-682.

3 Swing, S. R. (2007). "The ACGME outcome project: retrospective and prospective." Med Teach 29(7): 648-654.

4 Nasca, T. J., et al. (2012). "The next GME accreditation system--rationale and benefits." N Engl J Med 366(11): 1051-1056.

5 Caverzagie, K. J., et al. (2013). "The internal medicine reporting milestones and the next accreditation system." Ann Intern Med 158(7): 557-559.

[6] Englander, R., et al. (2013). "Toward a common taxonomy of competency domains for the health professions and competencies for physicians." Acad Med 88(8): 1088-1094.