



# Points to ponder in framing a positive medical learning environment

By Dr. Loretta Jackson-Williams

In the first chapter of a book I have been reading, "Remediation in Medical Education," editors Adina Kalet and Calvin Chou include a paragraph that provides thoughts to consider regarding transitions within medical education, particularly for students transitioning to graduate medical education (GME).



Jackson-Williams

"Medical Education is a high-stakes endeavor," they write. "All our graduates are expected to use powerful cognitive, procedural, technological and pharmacologic tools under complex and uncertain circumstances, with life and limb in the balance.

"Furthermore they are expected to do so nearly perfectly for a lifetime. Mistakes can be very consequential. This is not for the faint of heart. We are training physicians."

For faculty in the School of Medicine, these are truly thought-provoking words which lend perspective to the significance of the work that we have chosen to do at the Medical Center. Being part of an educational program – UGME and/or GME – requires us to be active participants to ensure our students/interns/residents are appropriately equipped for this lifetime of important work.

Next month, a new group of students will transition to intern/resident and residents will transition to fellow/faculty. (Welcome to the other perspective!). This will be a great time for faculty to reflect on some questions as we help frame the learning environment for this new group.

What is the most helpful advice that you received and that proved to be valuable with your transition? Who were the individuals who helped with your transition?

How did you balance the demands of your new responsibilities and life?

When did you feel that you truly belonged in your position?

Our ultimate goal is to prepare this new group for the independent practice of medicine as competent, complete and capable physicians. These new physicians-in-training are entering medicine with different requirements for the training environment and different pressures within the health-care system. However, some things are important, regardless of the differences: promoting personal wellness and preventing burnout.

There are many components to personal wellness and burnout, so addressing in meaningful ways the issues related to managing the clinical demands of the environment, maintaining personal connections and activities, establishing balance between work and life, and mitigating the sense of isolation within the workplace are critical.

The clinical demands of this health-care environment are tremendous and extend beyond the direct care of patients. While these new physicians will have access to advanced procedural, technological and pharmacologic tools, we are expected to guide them in the efficacious, safe and cost-efficient use of each.

They will be called upon to be active in promoting a culture of safety and expected to actively engage in quality improvement endeavors. During the next few months, faculty will need to consider how we can help new physicians navigate these areas while ensuring

that the system that we put in place allows each of us to do the same.

In the midst of exploring their new roles and responsibilities as physicians, our new physicians will need to be reminded not to neglect their personal connections (family, friends, community, etc.) and activities to ensure that the complete person is not lost in this rigorous educational process. A part of this involves establishing reasonable and healthy work-life balance.

Finally, we all must work towards building an inclusive health-care community that does not promote a sense of isolation by our new and seasoned physicians in this high-stakes environment. This requires honest care and concern for our trainees and colleagues.

Even though the statements from the thought-provoking paragraph are true, I believe that it is also true that training physicians can only be done with "heart."

## Faculty spotlight: Dr. Norman C. Nelson

By Dr. Rob Rockhold

Recently, we celebrated the life of an individual whose historic tenure defined this Medical Center and exerted enormous influence over the health of citizens of this state, and whose vision continues to direct how we, as an institution, address training for new members of the health-care discovery and delivery team.



Nelson during his UMMC tenure

From the Norman C. Nelson Student Union building to the Nelson Order of Teaching Excellence, the Nelson Honor wall and the landmark Regions Bank TEACH Prize, Dr. Norman Crooks Nelson's spirit permeates the fabric of UMMC.

I consider myself fortunate to have had meaningful interactions with Dr. Nelson during formative periods of my career (some of which were extremely formative, and due to his acute perspicacity, not summative!). I learned, for example, that accepting open-ended, poorly defined tasks from a superior is really a fundamental opportunity for both personal and professional growth. As such, when offered, these opportunities should always be seized and pursued with extreme gusto.

The way in which that opportunity was delivered to me, casually during a quick interlude in an eleva-

tor ride, is only one of many anecdotes that illustrate the command of psychology that exemplified Dr. Nelson's leadership style.

Some of us will still remember the dark wood-paneled, traditionalistic academic dean's office and "inner sanctum" where Dr. Nelson would entertain visitors and faculty in more formal situations. That somewhat anachronistic image belies the breadth of imagination

for growth that Dr. Nelson nurtured for our campus.

I see that influence still, in direct line of descent through subsequent UMMC vice chancellors and deans of the School of Medicine, from Dr. Wally Conerly to Dr. Dan Jones, Dr. Jimmy Keeton and now Dr. LouAnn Woodward. In many significant ways, but particularly in the field of health education, Dr. Nelson shaped how we address recruitment, selection, training and dissemination of health-care and biomedical researchers across this state.

I am proud to have had some small part in continuing the legacy of this educational giant and look forward to watching that influence develop and grow in new directions as time and circumstances provide additional opportunities.

# Curriculum Corner

By Dr. Marc Majure



Majure

In 2001, the Institute of Medicine released its report, "Crossing the Quality Chasm: A New Health System for the 21st Century," which noted that the U.S. health-care delivery system does not provide consistent, high-quality medical care to all people.

The report listed unprecedented advances in medical science and technology as factors creating this chasm, which limits our ability to translate knowledge into practice and to apply new technology safely and effectively.

According to the IOM, part of the solution will be to affect changes in professional education. The report calls for a "new breed of citizenship" for health-care professionals. However, customary professional training may not nurture the skills, knowledge and attitudes to make this possible.

To support this new professional citizenship, academic medical centers can no longer exist in traditional silos of care, research and education. To keep pace with health care in the 21st Century, we must adopt a single mission of improving health care by advancing, applying and disseminating knowledge.

In keeping with this new mission, there must be a restructuring of clinical education throughout the continuum of undergraduate, graduate and continuing education for all professional training programs.

What does this mean for medical education? In addition to the traditional foundational and clinical sciences, we must now teach new sciences of systems and improvement methodology and systems skills. In addition, as educators we are challenged to engage our learners in authentic roles appropriate to their developmental stage. In doing so, we make our learners part of the "solution."

The Accreditation Council for Graduate Medical Education has outlined six competencies that all graduate medical trainees must meet. These include the competencies of practice-based learning and improvement and systems-based practice. These competencies embody the new foundational and clinical sciences of the 21st Century.

In alignment with the ACGME's CLER Pathways to Excellence, all GME programs at UMMC include formal educational activities to create competency in patient safety and quality-related goals, tools and techniques. Along with the didactics of systems and improvement science, our trainees prepare to enter the health-care system of the 21st Century by actively participating in the quality and safety endeavors of our institution.

As such, they are not only our learners, but they have become part of our solution.

# Innovation

By Dr. Rishi Roy



Roy

Resident engagement and ownership of practice patterns is an important part of education. No longer is it sufficient to learn the treatment algorithms for diseases, but "quality care" is the new standard.

This is not to say that the previous care was without "quality," however, outcomes are now measured and standardized. With this information, changes to practice patterns go from "This is how we have always done it" to a treatment-based focus on evidence.

Keeping this in mind, having residents and medical students ask the question, "Is there a better way?" has great potential for meaningful change.

Residents and medical students have started to conduct multiple Quality Improvement (QI) projects dealing with issues ranging from DVTs to educational videos on procedures to be posted on YouTube. To help with guidance and resources, a Resident Quality Council (RQC) has been established.

This RQC is resident-run and has representation from most of the larger residency programs at UMMC. It is certainly not restricted to just the larger programs, and those who have a particular interest in quality issues are always needed.

The RQC's primary role is to catalogue resident-driven QI projects in a hospital-wide database. This will provide a repository of completed and ongoing projects. The database will be searchable to provide points of contact, goals and findings.

For those interested in starting a new project, the database will be a valuable tool to see what has already been completed or is currently in production. The Graduate Medical Education (GME) office provides the support for this database.

The RQC co-chairs are also members of the Hospital Quality Board, helping link the educational programs at UMMC with hospital administration. Hospital administrators have been very helpful and understanding of residents' roles in providing quality care for patients.

Since the RQC's inception, residents have had an increased role in decision-making at a hospital level. This has been fruitful in providing more efficient changes to hospital systems that will amount to meaningful change.

More importantly, it has been a great learning process for residents to see how health systems work and to understand the rigors of the ever-changing environment in which they must provide quality care at lower costs. No longer can physicians just treat patients and leave the business aspect of medicine to the administration.

Additionally, RQC members are looking to add an educational component to the council's charge. This would provide classroom or online instruction on how to implement and complete productive QI projects. The eventual goal would be to have an earned certificate of completion at the end of the course.

For the institution, this has been a great success and will continue to be so as the RQC strives towards its goals of identifying, educating and supporting residents who are interested in helping push quality initiatives, not only at a departmental level, but a systems level.

## Education tip: feedback vs. coaching

By Leah Stayer

Last month, Shelia Chavez from LSU spoke to UMMC faculty about the effective delivery of feedback.

We learned that feedback helps learners maximize their potential, raise their awareness of strengths and areas for improvement, and identify actions to be taken to improve performance. Feedback is focused on past behavior and often used as an evaluative measure.

Most of the time, feedback is "telling"- or "advice"-oriented and is often delivered as an expert's opinion of another's work. There are times when feedback is most appropriate, but there are also times we should consider coaching.

Coaching and feedback are often used synonymously, but there are distinct differences. While feedback includes commenting on what just happened, coaching focuses on future behavior.

Coaching is typically developmental in nature. Most of the time it involves a lot of "asking" and "listening." Good coaching is inquiry-based and reflective.

If you want to try coaching, simply start by asking the learner three questions:

1. **How do you feel that went?**
2. **Why do you think it went that way?**
3. **What could you do differently to improve future outcomes?**

Regular coaching will build independence and support creativity, innovation and problem-solving. A coaching mindset requires the student to participate in self-reflection that promotes professional growth. Being mindful of the differences between feedback and coaching will allow educators to provide the most appropriate "just-in-time" support students need.

## CALL TO ACTION

The Call to Action informs faculty and students about specific opportunities for engagement. We hope to generate faculty participation in specific facets of the educational programs. Please let us know if you are looking for partnerships for a project on which you are working.

To submit opportunities for inclusion in the Call to Action, email Tanya Reed at [tmreed@umc.edu](mailto:tmreed@umc.edu).