Medicine, pharmacy, social work, and nursing combined to form an interprofessional student team that was integrated into a patient-centered medical home model with a focus on high-risk, uncontrolled people with diabetes. The internal medicine residency training site that provided the care was organized by Louisiana State University School of Medicine.

Registered high-risk patients with diabetes were invited to visit members of the care management team and received follow-ups by telephone. Medical students provided oral, foot, and eye exams and developed action plans related to patient goals. A social work intern screened patients for depression, nursing students assessed patients’ access to after-hour care, and discussed interest in home or group visits.

Pharmacy students reviewed medications for accuracy and appropriateness as well as adherence, making recommendations for better regimens. The residents managed medical care and referred patients for diabetes education, nutrition, and specialist input. At the end of a half day of planned visits, the team gathered to discuss patients and shared treatment plans. Two weeks later, one or more members of the team telephoned the patient as needed.

Each week the team met to make brief presentations on topics related to patients care. Among the topics included were criteria related to medication, linking patients to appropriate community resources, management of diabetes, and patient empowerment. All patients seen in the clinic were provided a coordinated written care plan. Just as important, the learners were part of a program leading to interprofessional knowledge improvement, improvement of attitudes towards members of the team, and the improvement of team work skills of the learners.

Exposure to Theater Arts Expands Discovery of Nuances of Successful Communication

Researchers at the Overlook Medical Center—part of the Atlantic Health System in Summit, New Jersey—hypothesized that physicians in training could learn empathetic communication through theater arts, so they developed a program to train and evaluate interpersonal communication skills using theater arts principles. Facilitated simulation education and evaluation (FSEE) focuses on the enablement of both medical students and residents to cultivate skills by acting and thinking like physicians.

Actors playing patients trained in the distinctions of medical communication interaction allow medical students to encounter people with lives beyond their chief complaint and to reach a better understanding of the nuances of communication. By participating in improvisation and simulation over time, students may be more likely to incorporate these skills comfortably and naturally in daily patient interactions.

FSEE actors are unlike standardized patients who relay the same information in an identical manner to each learner. The FSEE actor trains and tests the non-standardized, non-uniform patient-centered nuances of the interpersonal communication skills needed to accurately diagnose and manage emotionally challenging interactions.

Since the FSEE actor is not standardized, interactions with students are not predictable and more genuine. The successful FSEE actor candidate exhibits the ability to portray not only a patient with specific complaints, but one who also is able articulate at an intellectual and emotional level and evaluate the student or resident, and report on interpersonal strengths and weaknesses.

To reduce subjectivity, faculty evaluators are trained in observed simulation communication education and evaluation. This includes the domains of beginning effectively, listening actively, planning collaboratively, and achieving closure. Comments from faculty members said some educators mistakenly equate medical knowledge with interpersonal skills.

New Model Offers Objective Methods to Evaluate Medical School Performance

More rigorous and equitable approaches are needed to analyze and understand medical school performance, including replacing the subjective criteria used by the U.S. News & World Report ranking system. While the U.S. News & World Report provides a comparative analysis, it is based heavily on subjective and premedical student performance such as numerical ranking by medical school deans, MCAT scores, undergraduate grade point average, and school acceptance rates.

Even though the U.S. News & World Report evaluation methodology has had a number of changes, it remains subjective and limited to evaluating the quality of matriculating students rather than the value added by undergraduate medical education.

A new and proposed model is based on relevant and accessible objective criteria that replaces subjective qualitative criteria and outcomes reflecting the general mission, vision, and values of the nation’s medical schools. The model evaluates the medical school’s production of academic physicians who advance medicine through basic, clinical, translational, and implementation science research—based on data collected from Doximity, Inc. That information provides a comprehensive physician database wherein every physician is identified by a National Provider Identifier (NPI) number, with information from other databases such as the U.S. Department of Health and Human Services’ NPI Registry, state medical boards, and specialty boards.

A scoring system was devised that provides points for each published journal article ranging from one to three points with highly cited journal articles—resulting in more points than those cited less frequently. Physicians who received National Institutes of Health grants also received points as did those who were the principal investigator in clinical trials (based on the number of grants received rather than dollar amounts of the grants). Points were also assigned to physicians who received awards and honors based on the prestige of the programs.

New Model Offers Objective Methods to Evaluate Medical School Performance
**Hippocrates or Hypocrisy: Expel Sugary Beverages at Resident Luncheons**

Doctors ask patients to avoid drinking sugar-sweetened beverages, so should we not also extend that request to residents and eliminate sugary beverages from noon-time conferences? Many public school lunches have excluded sugar-sweetened beverages over the past decade.

The obesity epidemic plagues physicians as well as patients—with a 44 percent obesity and overweight rate in the United States among physicians in 2004. Are not physicians who advise patients to avoid sugary beverages hypocrites if they themselves drink such beverages?

The author recommends physicians serve as role models, since overweight physicians were less likely to provide counseling on weight loss, including the avoidance of sugar-sweetened beverages. A powerful message would be sent to residents if sugar-sweetened beverages were eliminated from their training programs and replaced with water or another non-sweetened beverage. While there has been a wide range of interventions in hospital cafeterias, public institutions, and other facilities targeting patients, the practice has eluded resident conference rooms.

(From Nagata JM. More Hippocrates, less hypocrisy; eliminate sugar-sweetened beverages from residency lunches. Academic Medicine. 90(127); 2015.)

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**Fourth-Year Medical Students Working in Pairs Prevent Diagnostic Errors**

Researchers from several medical schools in Germany investigated whether the effect of working in pairs led to fewer diagnostic medical errors than working alone. Volunteers for the research included 88 fourth-year students from a medical school in Berlin. The students responded to a video consisting of six diagnostic performance cases that allowed students to select from 30 diagnostic tests related to respiratory distress.

The students comprised two groups, 60 worked in pairs while the other 28 worked individually. The pairs were more accurate than the individuals and selected more relevant tests on average. Overall, the pairs were more confident in a diagnosis. It was concluded that working collaboratively reduced diagnostic errors among medical students.

(From Hautz WE, Kammer JE, Shauber SK, Spies CD, and Gaissmaier W. Diagnostic performance by medical students working individually or in teams. Journal of the American Medical Association. 313(3); January 2015.)

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**Study Examines Whether Long Resident Hours Compromise Patient Safety**

A study conducted by Christoper Parshuram, M.D., Ph.D., a critical care physician at the Hospital for Sick Children in Toronto, Ontario, Canada, showed continuity of care benefits may outweigh the risk of adverse events due to longer work schedules by residents. A previous study said there was an association with medical error and long resident hours, but that was observational.

According to the new study, residents in internal medicine, anesthesia, surgery, and emergency medicine—whether working 12-, 16-, or 24-hour shifts—did not exhibit any more adverse events per 1000 patient days. Patients admitted to the intensive care unit were eligible to be part of the study. The medical records of all the residents in the study were reviewed by physicians who did not know which shifts the residents were assigned.

James Wilson, M.D., Ph.D., professor of pathology and laboratory medicine at Penn Medicine in Philadelphia—a former resident at Massachusetts General Hospital—said, "In acute care medicine, you can be in the hospital 36 hours following the progression of a disease. If that had been interrupted, you wouldn't have the direct experience of following how a myocardial infarction, or stroke, or seizure disorder evolves. From an educational standpoint, it’s much more rewarding and well worth the downside of being awake a long time."

(From Lewis R. No evidence longer resident hours compromise patient safety. Medscape; February 10, 2015.)

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**Association of American Medical Colleges Report Focuses on Residents’ Choices**

Over the course of medical school, only a quarter of medical students indicated they preferred the same specialty they chose when completing the Association of American Medical Colleges Matriculating Student Questionnaire in their first year of medical school.

When looking at the largest specialties, women make up a greater percent of residents in family medicine, obstetrics/gynecology, pediatrics, and psychiatry. Men make up a larger percent of residents in anesthesiology, emergency medicine, internal medicine, radiology, and surgery.

From 2003-2012, 21.7 percent of those who completed residency were practicing in underserved areas. In addition, from 2004-2014, 52.9 percent of those who completed residency training were practicing in the state of their residency training. Between 2004-2013, 15.9 percent of individuals who completed residency training held a full-time faculty appointment at an M.D.-granting medical school in the United States.

(From Report on Residents Executive Summary. Association of American Medical Colleges; January 2015.)
The U.S. Navy has no trauma training facilities in the United States, resulting in an inability for military teams to treat military personnel with penetrating wounds. As a result, physicians, nurses, and U.S. Navy medics are sent to Stroger Hospital, a Chicago-based facility that emulates a war zone.

Lieutenant Commander Jared Bernard, a U.S. Navy trauma surgeon, said a patient shot with a single bullet on the streets of Chicago suffered a wound that caused the same massive infection as a wound inflicted by a roadside bomb in Afghanistan. The wounded man was being cared for in a U.S. hospital, but the process of saving his life was no different than it would be for someone wounded by a bomb exploding under a Humvee.

U.S. Navy physicians, nurses, and corpsmen rotate through Stroger, whose trauma unit serves troubled Chicago West Side and South Side neighborhoods plagued by violence. Reciprocally, the Stroger hospital staff is afforded the opportunity to observe military medics who are required to perform decisively when there is no physician available. The medics represent the difference between life and death.

The reputation of Stroger for treating gunshot wounds has police officers who have been shot insisting on being treated there. The head of Stroger’s trauma department, Faran Bokhari, M.D., said improvised explosive devices and land mines can cause similar injuries as those resulting from high-speed car crashes. Dr. Bokhari helped establish the partnership with the U.S. Navy and Stroger. He explained that what is done at Stroger is translatable to what is done on the front lines.