

Medical Education Digest



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Team Building Makes Successful Rounding Groups



For 21st century medicine, the benefits of teamwork are undisputable. It is time for physicians, nurses, and other caregivers to recognize the power of the interprofessional team in order to transform the delivery of health care. However, team building is a skill that must be taught. Certain exercises are encouraged to ensure that nurses, case managers, and physicians learn to work together. Rotations with residents and attendings need to be lengthened so there is sufficient time for trust and an understanding of the strengths and weaknesses of all members of the team to develop.

The medical team's patients should be housed on a single floor. Nurses also should care for the same patient so they are part of the same interprofessional team, allowing them to recruit patients and their families to be a part of the team as well. Resident teams should be designated as part of a block as teammates for a three- to six-month period, rotating to different wards as a team.

The rounding environment should be quiet and without distractions to ensure a meaningful discussion, designating a

two-hour quiet time on the ward. Effective team leaders ask guiding questions, encouraging all on the team to participate. The team should be in a full circle, including the bedside nurse, to encourage horizontal communication. SBAR (situation, background, assessment, recommendations) is a highly effective communication tool that allows nurses and physicians to describe unexpected clinical events. The presentation of the SOAP note (subjective, objective, assessment, and plan) is also recommended to efficiently relay daily progress.

Decision-making teams should ideally consist of six to seven members including physicians, nurses, a pharmacist, and a case manager. Larger teams are not as productive. Teamwork in health care can save lives, improve the quality of patient care, reduce errors, enhance patient flow, improve communication, and increase job satisfaction.

(Bharwani AM, Harris C, Soutwick FS. Business school view of medical interprofessional rounds: transforming rounding groups into rounding teams. Academic Medicine. 87:1768-1771; 2012.)



Shorter Curriculum Diminishes Debt, Not Quality of Training



About 16 students at New York University (NYU) Medical School, or about 10 percent, will be able to complete the curriculum in three years. Steven Abramson, M.D., vice dean for education, faculty, and academic affairs, is confident these students will be getting the same depth and core of knowledge without changing the training into

a trade school. The new doctors will be able to enter practice earlier, save a quarter of their \$46,500 annual tuition and fees, and even more when accounting for room and board and other expenses.

Similar programs are being introduced at several other medical schools such as Texas Tech Health Sciences Center, Mercer University School of Medicine, and Louisiana State University. Fifteen other schools have expressed an interest in doing the same. Dr. Abramson predicts that three-year medical school programs will begin to become more prominent, which could help respond to the growing shortage of physicians and curtail student debt.

A recent editorial in *JAMA*, the *Journal of the American Medical Association* (March 2012) stated that years of medical school training have been added without demonstrating evidence of enhanced clinical skills or quality of care. The NYU proposal has been approved by the Liaison Committee on Medical Education (LCME) since the program exceeds the LCME requirements of 130 weeks by five weeks.

A 1978 study by the Association of American Medical Colleges indicated that students in the three-year programs of the late 1960s and early 1970s performed as well or better on tests than four-year students. Two Canadian medical schools at McMaster University in Hamilton and the University of Calgary in Alberta, also accredited by the LCME, have had three-year programs for more than 40 years. NYU indicated that its adjustment to the three-year program will be relatively easy since it already changed the curriculum to begin clinical studies in the first two years rather than the traditional third and fourth years.

(Hartocollis A. NYU and other medical schools offer shorter course in training, for less tuition. New York Times; December 24, 2012.)

Michigan Wins Federal Grant for Primary Care Residencies

A \$21 million grant to the Detroit Wayne County Health Authority and Michigan State University (MSU) College of Osteopathic Medicine will support the training of 85 physicians at five health centers, clinics, and hospitals. William Strampel, D.O., dean of MSU's College of Osteopathic Medicine, stated that three residency positions in family medicine, psychiatry, and internal medicine have been approved for July 2013. In January or February, they hope to have approval for pediatrics, geriatrics, and obstetrics; if not, these will begin in July 2014.

The CEO of the Health Authority, Chris Allen, anticipates that many of these physicians will practice in Detroit assisting community medicine. The grants were provided by the Health Resources and Services Administration and the Patient Protection and Affordable Care Act.

(Crain J. Mich. Program to train doctors for places that need more. Modern Healthcare; December 3, 2012.)

Internal Medicine Residents Often Choose a Subspecialty



Despite a growing and severe shortage of generalist physicians, only about one out of five graduating internal medicine residents is selecting a career as a generalist. This is especially true for men, categorical residents, and international medical graduates. A study done at the Mayo Clinic Department of Medicine in Rochester, Minnesota, indicated that only about 20 to 25 percent

of graduates of internal medicine residencies entered a career in general medicine compared to more than half in the 1970s.

The survey included more than 400 internal medicine programs consisting of 67,207 residents and was completed by 51,239. However, even if half of all internal medicine residents chose primary care, there would only be an increase in generalist physicians from 20 to 27 percent, which is much less than the 40 percent rate recommended by the Council on Graduate Medical Education.

(West CP and Dupras DM. Most internal medicine residents plan subspecialty careers. JAMA online; December 4, 2012.)

Multiple Mini-Interview Assesses Competencies



Information based on the results of the multiple mini-interview (MMI) and other application data shows that students accepted by the medical school of McMaster University in Canada scored higher on the Canadian licensing examination than students not accepted by McMaster who attended

other medical schools. The MMI is a relatively new tool referred to as a holistic review. It is highly flexible, individualized, and balances consideration of the many ways an applicant thinks. It assesses the applicant's academic readiness, gauges interpersonal and intrapersonal competencies (e.g.,

integrity, compassion), and promotes a diverse student body.

The use of MMI attempts to enable the identification of students who have the potential to be the physicians of the future. Current academic measures may be eliminating some applicants who could become excellent physicians. While the traditional admissions process emphasizes grades and MCAT scores to select which applicants to interview, the MCAT is not reliable in predicting academic success in the third and fourth year of medical school, nor does it predict outcomes in practice. The MCAT is adding a new section on behavioral and social content in 2015 and also is revising its verbal section by testing applicants' reasoning by using excerpts from texts and other media in several disciplines.

(Kirch DG. Transforming admissions: the gateway to medicine. JAMA. 308(21):2250-2251; 2012.)

Amount of Debt Not Always Linked to Career Paths

The median debt among 86 percent of medical school graduates in 2011 was \$161,290, but 23 percent of those graduating from private medical schools had loans of \$250,000 or more. This is 3.5 times greater than in 1978, when correcting for inflation.

According to investigators at Boston University School of Medicine, there is no definitive proof that educational debt influences career choices of most medical students or residents. The investigators admit that debt may have some influence, but even stronger are factors such as demographics, interest in specialty content or level of patient care, role models, and a comfortable lifestyle. They concluded that household income and expenses across a range of borrowing levels in areas with both high and moderate costs of living should allow physicians even in primary care fields to

repay their loans at the current median level of education debt.

Options exist to mitigate the economic impact of education debt such as an extended repayment term or federal forgiveness/repayment program. However, medical students and

new physicians should understand the long-term financial implications of their career choices.

(Youngclaus JA, Koehler PA, Kotlikoff LJ, Wiecha JM. Can medical students afford to choose primary care? An economic analysis of physician education debt repayment. Academic Medicine.88 (1-10); 2013.)



Central Institutional Review Boards Recommended for Multi-Study Centers

Clinical studies were small, few, and usually performed in a single institution in 1966. Today, they have grown much larger. Additionally, sample sizes have increased and may now require as many as 100 sites. The Office of Human Research Protection (OHRP) has proposed that the "Common Rule" be changed, mandating multi-study centers to use a single Institutional Review Board (IRB) record for U.S. sites.

The OHRP points to evidence that multiple IRB reviews do not provide better protection to human subjects, are often duplicative, and may even weaken protections. A working group from the National Heart, Lung, and Blood Institute on Optimizing the IRB Process made a number of recommendations:

■ Define IRB best practices

This would include how to train board members. It would improve the IRB process as well as allow IRBs to see steps other IRBs have taken in their reviews so trust is developed.

■ Develop metrics to assess the quality and substance of IRB reviews and decisions

This would include the documenting of reasons for decisions as well as their validity.

■ Make specific IRB review requirements part of funding opportunity announcements (FOAs)

An example could be an FOA for a multicenter clinical trial requiring 90

percent of sites to process an IRB review within 90 days.

■ Require funders to use the most efficient IRB models

Methods would include comparison of both efficiency and appropriateness of alternative IRB decision-making models.

■ Develop systems, such as IRBShare, to permit multicenter study sites to share an individual IRB's process for decision making

This system could enhance the substance and efficiency of subsequent reviews, further enhancing best practices.

(Mascette AM, et al. Are central institutional review boards the solution? The National, Heart, Lung, and Blood Institute Working Group report on optimizing the IRB process. Academic Medicine. 87(1710-1714); 2012.)



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