



Professionalism Further Defined

Peter Coggan, MD, MS Ed

"Eighty percent of success is showing up." Woody Allen

Woody Allen, in this often quoted truism, observes that simply turning up and being present is enough to ensure success most of the time. At our 3rd Annual "Excellence in Clinical Teaching" faculty recognition dinner, our guest speaker, Dr. Joe Gilhooly, struck the same tone when he talked about the importance of "showing up", qualifying that "being professional is coming to work the best prepared you can be every day".

The professions, including medicine, have been granted certain privileges by society. These include the ability to set our own standards of medical knowledge, skills and behaviors, and the ability to censure members of the profession who do not comply. It is our professional behavior that demonstrates that we are worthy of the trust that has been bestowed on us by our patients and it is our professional behavior that is the cornerstone of the sacred contract between physicians and society.

The professional code of conduct outlined by Dr. Gilhooly included these elements of professionalism: honesty and integrity; reliability and responsibility; respect of others; compassion and empathy; self-improvement; self-awareness and knowledge limitations; communication and collaboration; and altruism and advocacy.

"Coming to work the best prepared you can be every day", Dr Gilhooly would argue, is much more than showing up and being present. It involves displaying all of these professional characteristics in our interactions with patients and others with whom we work on a daily basis. It also means coming from a place of work-life balance and well being in our personal lives that support these characteristics.

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MSU/CHM Update

Peg Thompson, MD

The Grand Rapids College of Human Medicine Block III (third and fourth year) office has successfully taken up residence at 234 Division, North, and our programs are running successfully with an increased number of students. For the 2009-2010 academic year, we have 46 third year students and 35 fourth year students. That means that each of our third year clerkships is running for ten months out of the year. To help manage the increased workload, we have hired several new staff members. Our current staff includes Campus Director of Clinical Education Christina Stavros, Curriculum Assistants Camille Bodziak (student records, fourth year electives), Susan Schmidt (Junior and Senior Surgery Clerkships), Mindy Nienhouse (Medicine and Advanced Medicine Clerkships, ERAS coordinator), Aubrie Vawter (Pediatrics and Core Competency), Deb Cleland (Family Medicine and Faculty Appointments), and Corey Madura (OB/GYN clerkship and assistant for the Department of Obstetrics, Gynecology, and Reproductive Medicine).

We are looking forward to moving into the Secchia Center in early June of 2010. While the Block III program staff and students move in June, we also eagerly anticipate the arrival of the initial class of 100 Block I (first year) medical students in August, along with 50 Block II (second year) students. As the number of students grows, so does the number of programs and services for our students. This year, we have a total of 17 second and third year students involved in the Engaged Partners Program with Ferris State pharmacy students and Grand Rapids Community College nursing students. These interdisciplinary teams meet with refugee families in Grand Rapids to educate them on a variety of topics, including dental hygiene and use of over-the-counter medications.

Going forward, we hope to pursue other avenues for interdisciplinary service and education as our student numbers increase. Dan Gerbens, PhD, Director of Student Services, and John O'Donnell, MD, Director of Preclinical Programs have developed a service elective for our students, which will match interested pre-clinical students with opportunities through Gilda's House and the American Cancer Society.

[Click here](#) for a message from Dean Marsha Rappley, MD, Michigan State University College of Human Medicine.

Upcoming Events

**Inter-professional
Education Conference**
January 15, 2010

Match Day, GRMERC
March 18, 2010

GRMERC Research Day
DeVos Place
April 21, 2010
[Submit an abstract](#)

**Secchia Center Grand
Opening**
September 14, 2010
www.secchia-center.com

**4th Annual Excellence in
Clinical Teaching Events**
September 22-23, 2010

Professionalism (*continued*)

While there are some who feel that these behaviors of professionalism are inherent and cannot be taught, the prevailing view is that they can and should be taught and modeled, preferably using a team approach. And, they can and should be evaluated, with appropriate remediation when deficiencies are identified.

How are we to keep professionalism front and center in our practice of medicine and our teaching of learners? Dr. Gilhooly encouraged us all to contemplate the point at which we are no longer able to sustain the degree of professionalism expected of us. This means attentive monitoring of ourselves and others for fatigue, depression and burnout – all significant threats to professionalism. Knowing when to step back from patient care because of personal concerns about our own “fitness for duty” is a difficult, but critical, judgment to make. Intervening with a colleague who is not able to make this judgment can be a challenge. Both, however, are examples of professionalism. In addition to monitoring, we need to be proactive about promoting professional wellness in ourselves and others.

In these challenging times of economic and social import, may we all remember that cultivating well-being, prioritizing work-life balance and avoiding burnout can preserve and promote our professional standards.

Overcoming Barriers to Clinical Research Part 4: The Research Question Jeff Jones, MD

“In creating the only hard thing’s to begin.”
J. R. Lowell, *A Fable for Critics*, 1948

In developing a clinical research project the first issue is the research question. This is sometimes the most difficult step for the inexperienced researcher. In fact, the best source of research material is often the most proximal – your own medical practice (Table 1 on page 3). Unexpected clinical observations should be viewed not only as good teaching cases, but also as a potential research issue. Good research questions often arise from critical thinking about clinical practices and problems, from applying new concepts or methods to old issues, and from alert observations during patient care and teaching.

Another general source of potential research is peer discussion. This may occur in a local, regional, or national professional meeting, or in a residency’s Morbidity and Mortality Conference, or Journal Club. Consider case presentations and lectures from the standpoint of, “What could be done differently? Is the pathophysiology of this problem similar to that of others that we treat differently?” Are there patterns here that have not been fully recognized? Reading the literature already published or listening to colleagues present their research can bring to light further issues and ideas that may be developed into projects. Many inspirations are solo affairs that strike while preparing a lecture, showering, or just sitting and thinking. The trick is to put an unresolved problem clearly in view and turn on the mental switch that lets the mind run freely toward it.

As you look through various possible research projects, try to pick areas that are not only of interest to you, but also of interest to a large fraction of the scientific community. Studying a minor aspect of a rare phenomenon may be a reasonable project if the outcome can affect some broader aspect of science. If the most interesting result is of interest only to two other people in the field, however, the research is never likely to be viewed as truly important or seminal. A good research question should pass the “so what” test.

Whether the question is a good one can be summed up in the mnemonic “FINER” meaning feasible, interesting to the investigator, novel, ethical, and relevant. Whether the question is novel and relevant has to be assessed through a literature search and the question put in context. Does a study need repeating? Is there a new relevant slant? A discussion then with an expert in that particular field will help you judge if this is an area worthy of effort. Be wary of those that try to put you off or advise you to do other projects for wrong or poorly thought out reasons.

The first thoughts when developing a research question are often vague and rather grandiose, tending to overestimate the resources available and underestimate the time needed to complete the project. However, without optimism much research would never be started. Obtaining a concrete answer to a small and specific question is much better than attempting to obtain an answer to a “big question”. At first glance a very specific question can seem rather irrelevant, however the big questions are usually answered by breaking the problem down into a series of smaller, and hence more manageable, problems. So do not worry if you are not going to give the whole answer – moving knowledge forward by one small increment should be your ambition.

ACGME Core Competencies

PATIENT CARE

What we do

MEDICAL KNOWLEDGE

What we know

PRACTICE BASED LEARNING & IMPROVEMENT

How we get better

INTERPERSONAL & COMMUNICATION SKILLS

How we interact

PROFESSIONALISM

How we behave

SYSTEMS BASED PRACTICE

How we work in the healthcare system

3rd Annual “Excellence in Clinical Teaching”

Outstanding Educator Awards - 2009

Undergraduate Medical Education

Core Faculty

Michael J. DeJong, MD

Community Faculty

Rebecca Caldwell, MD

Physician Assistant Education

Jenny Bush, MD

Timothy Gawronski, PA-C

Physician Assistant Education

Team

Khan Nedd, MD

Marissa Baty, PA-C

Graduate Medical Education

Core Faculty

Michael C. Bishop, MD

James R. Barron, MD

John W. Winters, MD

Community Faculty

Michael R. F. Jabara, MD

William L. Bush, MD

Scott A. Poortenga, MD

Housestaff Council Award

Jeri Kessenich, MD

Lisa Lowery, MD

GRMERC Community Award

Lowell R. Bursch, MD



For more information about the educational presentations and photos from the Faculty Recognition Dinner [click here](#)

The Research Question (*continued*)

The research question drives the development of the study protocol. After the question has been developed and the potential scientific or clinical relevance identified, it must be shaped and narrowed into an answerable format. Keep it simple. Research questions should be expressed in straightforward language that an intelligent layperson can understand. The “well-built” clinical question must be focused and well articulated for all four parts of its anatomy:

- The problem or patient being considered
- The exposure or intervention being addressed
- The comparison intervention or exposure (when relevant)
- The clinical outcomes of interest

Pick up a recent issue of any popular medical journal. Look at the various research questions or objectives spelled out in the abstracts. How many of the questions are well-built? The following web links will provide you with some further guidance while developing a research question:

Survival Guide to Research

<http://www.childrensmrcy.org/stats/plan/ideas.asp>

http://whqlibdoc.who.int/emro/2004/9290213639_chap3.pdf

<http://www.hsl.unc.edu/services/tutorials/ebm/Question.htm>

TABLE 1. Sources of Potential Research Questions

- Unexpected clinical observations
- Inadequate available treatment
- An accepted but untested clinical practice
- Application of new technologies
- Concept or technique utilized by another specialty
- Research presentations by colleagues
- Questions asked by students
- Peer discussion during conferences

The Teaching Moment

“Good teaching is more a giving of right questions than a giving of right answers.”

Josef Albers

Etiquette-Based Medicine in Bedside Teaching *Part 2: Proper Patient Introductions*

John N. Sheagren, MD, MACP

There should be “no teaching without a patient for a text, and the best teaching is that taught by the patient himself.”

Sir William Osler (1849-1919)

In Part 1 of “The Importance of Etiquette-Based Medicine in Bedside Teaching”, I emphasized how critical it is to format a brief, well organized verbal case presentation (VCP) to use when presenting patients at the bedside. And the most important starting point is quite simply **a proper introduction of the patient**.

During the bedside case presentation (often with family members present), it is of utmost importance to introduce the patient as a person. The only descriptors necessary in the introductory statement are the patient’s name, age and gender. I also believe that it is important to use the term “man” or “woman” since it is humanizing as well as proper English usage. (The use of “male” or “female” requires a species designation - *Homo sapiens* – to be accurate.) Likewise, use “young man” or “young woman” for an adolescent or teen-ager, and “boy” or “girl” for a child.

In my years as a clinician-educator, I have heard many introductions that include racial/ethnic, life style, sexual orientation and medical status descriptors (e.g., “This X year old white/black/Hispanic/Burmese/Arabian/Ashkenazi Jewish man/woman”; “This X year old intravenous drug-using/alcoholic/unemployed/imprisoned man/woman”; “This X year old gay/homosexual/sexually promiscuous/transgendered man/woman”; “This X year old dialysis requiring/paraplegic/incontinent/schizophrenic man/woman”). These racial/ethnic, life style, sexual orientation and medical status descriptors, as well as others, are completely inappropriate, not only in the presence of the patient and family, but in all types of verbal and written patient histories. While the basis of such introductory terms may have been a well intentioned effort to provide a “background sketch” of the patient prior to stating the Chief Concern (CC), it is far better to introduce the patient simply as the person he or she is!

Once the CC has been stated, one can then begin to report the History of Present Illness (HPI). At that time, and with great sensitivity, one might include selected racial/ethnic, life-style, sexual orientation, and medical status bits of information as background data which are relevant to the HPI, **but only when truly relevant, i.e., substantiated by data**. In fact, before entering the patient’s room, many of the issues described above need to be identified beforehand and left out of the bedside VCP in order not to upset and/or embarrass the patient and/or family or to violate confidentiality.

As an important aside, racial introductions, especially the “Black/White” descriptors, are distasteful reminders of days when ward assignments were based on skin color. Indeed, a Kellogg Foundation study commissioned in 1998 documented that racial segregation occurred in Detroit Hospitals well into the Twentieth century¹. Further, the definition of race, even if of some use medically, is becoming less and less well defined. My old friend and University of Michigan colleague, Francis Collins, MD (the originator and then first Director of the Human Genome Project and newly appointed Director of the National Institutes of Health) has credited the Human Genome Project with having “helped to inform us about how remarkably similar all human beings are—99.99% at the DNA level. Those who wish to draw precise racial boundaries around certain groups will not be able to use science as a legitimate justification”².

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Scholarly Activity Redefined

Alan T. Davis, PhD

Here in the exciting and dangerous world of research facilitation, we are often asked if it is necessary to bubble toxic fluids in a fume hood or perform complex surgeries on large farm animals in order to demonstrate evidence of scholarly activity. While both of these activities do lead to impressive photo ops, you may be surprised and delighted to know that scholarly activity covers a much broader range of activities. Take research, for example. Outcomes research is all the rage right now, with lots of folks evaluating their own clinical data, or that of their hospital and region, to see how they stack up against national or clinical society standards of care. Educational research is of great value in checking the current status of resident training, as well as assessing that cool new training tool that you’ve developed.

But what about non-research activities, such as the Collaborative Institutional Training Initiative (CITI) program? CITI provides training in the protection of human subjects in research, and successful completion of the program is now required by the research departments of both Spectrum Health and Saint Mary’s Health Care before a researcher can start a project. Even if you have no interest in research, however, the material in the program is interesting and enlightening, and also serves as evidence of scholarly activity. The same is true for educational lectures that you present to residents, medical students, and other health care professionals, and participation in journal club. What about online modules (e.g., LIFE Curriculum, IHI Open School) or participation in hospital rounds? Ka-ching! Ring it up, these all count as scholarly activities! This is also the case for participation in educational organizations or national committees, or even active support of scholarly activities by residents/fellows.

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Bedside Teaching: Proper Introductions (*continued*)

Sometimes, a presenter will justify including a racial or ethnic descriptor in the patient's introduction because of a language barrier which has hindered the gathering of an adequate medical history. In such cases, both in patient write-ups and VCPs, language barriers fall under the heading of "**The Informant**" where problems with data gathering are documented up-front. Examples include:

- **Language Barriers:** "Informant: The patient speaks only Spanish; thus, most of the history was obtained through an interpreter."
- **Administrative Barriers:** "The old patient records could not be located; thus, the information was obtained from family member recollections. In addition, patient's primary care physician is on vacation, and the on-call partner had only seen the patient a couple of times."
- **Patient Cognitive Barriers:** "The patient was semi-conscious on arrival to the E.D., and even after being aroused could only recall fragments of his/her medical history."

To summarize, patient introductions - both in patient write-ups and verbal presentations - should consist only of name, age, and gender. racial/ethnic, life style, sexual orientation and medical status information relevant to better understanding the hypothesis generated by the CC, should be included *after* the introduction and statement of the CC, and be included directly in the HPI. At the bedside, any such information which might upset the patient and/or family should be identified beforehand and omitted from the verbal presentation.

Importantly, adhering to these recommendations promotes the accomplishment of at least two of the six ACGME competencies expected of all residents and teaching faculty³. Using proper patient introductions encompasses the ACGME competency of "Professionalism" that calls for "sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation". In addition, the ACGME competency of "Interpersonal Skills and Communication" requires an ability to "communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds". Remembering to practice these behaviors at the bedside and in all patient encounters is one of the hallmarks of a highly professional, interpersonally skilled physician.

1. <http://www.med.umich.edu/haahc/Newsletters/spring.htm>
2. Collins and Mansoura: <http://www.ncbi.nlm.nih.gov/pubmed/11148583>
3. <http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf>

Scholarly Activity (*continued*)

In other words, if you are actively involved in resident and/or student education, you are involved in scholarly activity. And if you are strangely drawn to the research side, and the medication hasn't helped, we invite you to make full use of the amazing GRMERC Research Department. We are your one stop shopping site for all kinds of assistance, everything from protocol development to statistical analysis to poster editing and refinement and everything in between. If you've got a research question, we can help you with every other step of your research project. And speaking of impending deadlines hauling in like an out of control freight train on greased rails, abstracts for GRMERC Research Day are due on Friday, January 22. Research Day itself will be on Wednesday, April 21, at DeVos Place on the beautiful Grand River. The weather forecast is for 72 degrees with sunny skies, so we'd love to see you there! For more information on Research Day, or really anything involving research, please contact us at research@grmerc.net.

Newsworthy Notes

Congratulations to the following GRMERC programs for their outstanding ACGME site reviews and renewed accreditation:

- Colon and Rectal Surgery - 4 years
- Internal Medicine - 6 years (granted 1 additional yr.)
- Internal Medicine/Pediatric - 6 years (granted 1 additional yr.)
- Pediatrics - 5 years
- Surgical Critical Care - 4 years
- Transitional Year - 5 years

The status of GRMERC overall program accreditation is 4.8 years.

ACGME Site Reviews for 2010 include GRMERC programs in Family Medicine, General Surgery, Pediatric Hematology-Oncology and Pediatric Nephrology.

Congratulations to John Hoyle, Jr., MD, Educational Assistant for Pediatric Emergency Medicine, for publishing "Identification of children at very low risk of clinically-important brain injuries after head trauma: a prospective cohort study" in the September 15, 2009 issue of *Lancet*.

The GRMERC/MSU Emergency Medicine Residency had eight research presentations at the American College of Emergency Physicians October meeting. Six of the projects were presented by Grand Rapids MSU/CHM students.

Congratulations to Marte Bergman and Alicia Crispin, Program Coordinators in Emergency Medicine and Family Medicine, respectively, for achieving national certification as Training Administrators of Graduate Medical Education (TAGME).

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Questions or comments? E-mail us at newsletter@grmerc.net or call 616.732.6294

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