Introduction to Accreditation Council for Graduate Medical Education (ACGME) Competencies Web Based Training

"The Competent Physician"

Course Script

OHSU-10420

REVISION HISTORY			
NO.	NAME	DESCRIPTION	DATE
1	Jerry McCorkle, Lynn Redlin video scripts	First draft	06/29/04
1a	Jerry McCorkle	Incorporate video scripts into body. Add Physician Performance Evaluation reference sheet at end.	7/15/04
2a	Jerry McCorkle	Incorporate revisions to course evaluation and self-assessment sections.	7/27/04
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3c	Jerry McCorkle	Dr. Girard's intro, new PPDI	9/01/04
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5	Jerry	Working draft with added production notes and audio edits from Richard Moore	9/24/04
6	Robin	Production	11/28/04
7	Jerry	Alpha	12/1/04
8	Jerry & Clea English	discoverability changes	1/23/06

CONTENTS

#	Audio	Visuals
0.1	Pager beeping	Course starts with graphic of an OHSU pager and it goes off. (animate to show pager on vibrate?) Click the pager to return the call. Click here if you cannot hear the pager. (This course uses audio throughout. Be sure the computer you are using is equipped with speakers, they are connected and turned up.) (Goes to 0.6)
0.2	Female voice on phone: Thank you for returning our call Doctor. The Accreditation Council for Graduate Medical Education called the Dean, and the Dean needs you to spend a couple of hours reviewing some material on what they are calling "competencies."	(Photos of female receptionist with phone.) It is your call. How do you respond? 1. I am not even a resident. This obviously has nothing to do with me. **Ignore the request and get back to the work at hand** 2. Are you kidding me? I have 80 hours to do 120 hours of work, and you want me to waste my time and energy on something so trivial they did not even mention it in medical school? **Ignore the request and get back to the work at hand** 3. If the Dean and the ACGME think this is important, maybe I should look into.
0.3	Game Show "wrong answer" buzzer.	(Graphics? Surprised nurse and faculty?) 1. If you work with residents as staff or faculty at OHSU this call has everything to do with you. Only with your help can OHSU meet the ACGME requirements that will allow OHSU to retain its accreditation status. Try again, and think big picture. (back)
0.4	Game Show "wrong answer" buzzer.	(Graphics? Complacent or annoyed resident with pager?) 2. While you may think that you are doing everything you can, and should do to become the best doctor possible, it won't matter if the GME program is not accredited. And if OHSU does not satisfy the requirements of the ACGME, that is exactly what could happen. Try again, and think outside the box.
0.5	Game Show "you are correct" bell.	(Graphics, reluctantly accepting resident with pager?) 3. Good call. This is a new way of looking at medical education. OHSU has made this primer as quick and painless as possible. You might even enjoy it. Click Here to continue.
0.6		If the computer you are using is not equipped with speakers you will want to use a different computer to take this course. If your computer does have speakers be sure the are connected and turned up.
1. Course Introduction		
1.1 Introductory comments by Dr. Don Girard		
1.1.1.	Welcome to The Competent Physician. OHSU's Division of GME is introducing this multimedia-training curriculum as a primer for all residents, faculty and other health care professionals in the institution to introduce the ACGME competencies, understand their components, and how they may be evaluated	Video of Dr. Girard presenting the introduction The Competent Physician Title/ Logo This course: • Introduces the ACGME Outcomes Project and the key concepts of the competencies (Link to **About the ACGME:** this is the main NEXT button from here.)

#	Audio	Visuals
	in a consistent manner--- in part a shared language. We believe that if we are serious as an institution about the importance of these themes, then we all need to understand them, how they are complied with and evaluated--- to that end, we put forth the most able physicians for the 21st century. This program starts by discussing the ACGME Outcomes Project and the six core competencies, and specifically the knowledge, skills and attitudes that make up the competencies. Second, the program introduces assessment tools. The Physician Performance Diagnostic Inventory, can be used to measure an individual's knowledge, skills, and attitudes and as a guide for creating an individualized learning plan. Third, a Journal is included in the program. It allows those taking the course to record their experiences and reflect on the lessons learned, develop plans for improvement, and share those lessons with mentors. The Journal is an important part of the curriculum since it introduces a methodology that should be used during the entire residency experience and likely throughout one's entire professional career as a tool to self assess and refine and direct your professional development.	○ Medical Knowledge ○ Practice-Based Learning And Improvement ○ Interpersonal And Communication Skills ○ Professionalism ○ Systems Based Practice ○ Patient Care • Introduces The OHSU Physician Performance Diagnostic Inventory, a valuable diagnostic/ formative evaluation tool • Provides examples of skills associated with the competencies and consequences of good and poor applications of those skills • Provides a framework for presenting additional source materials on specific competencies (indicate Link to Resources) • Provides a skill application journal to support self reflection, and application of competency objectives to practice experience (indicate link to Journal)

#	Audio	Visuals
	ACGME is the regulatory body, which accredits all of our training to ensure that you residents can become eligible to become certified in your specialty; In a thoughtful process, entitled the ACMGE Outcomes Project, which considered the myriad changes occurring in medicine today, the ACGME has changed its approach for accreditation from one of process to one of outcomes; What that means for all of us is that our accrediting organization is interested in not just what you know, but how you apply what you know: from knowledge acquisition to knowledge application; And that paradigm shift allows for the introduction of a much more holistic set of residents' curricula and requirements for their evaluation; Now it is important that residents are able to be demonstrate competence in a number of abilities, including their knowledge base, including professionalism, communications skills, patient care, practice-based learning and improvement, and systems-based care. These changes will only serve us, and the public better. Indeed, the same expectations that are being introduced for GME will be introduced in CME. So you may expect that you will be evaluated during your entire careers on these important themes.	**ACGME requirements** In accordance with the ACGME Outcomes Project, programs must: • Begin to use educational outcome measures • Identify learning objectives related to the ACGME's general competencies • Use increasingly more dependable (i.e., objective) methods of assessing residents' attainment of these competency-based objectives • Use outcome data to facilitate continuous improvement of both resident and residency program performance

#	Audio	Visuals
	Thank you for participating in this course. I hope you find it helpful. I know your time is valuable to you and your patients. That is one reason we are using the Web to deliver this information. You can use the course in ten-minute chunks, or all at once depending on your schedule. I welcome comments about this course. You can use the course evaluation, the feedback e-mail address in the Library, or you can contact my office directly. You can go directly to any part of the course by clicking a section on the Section menu Within each section you can click any topic. You can move through the course in any order, but for the most continuity you may want to proceed from left to right your first time through. Use the buttons and choices in the topics to explore the material. There are no wrong answers so feel free to explore all the choices. Within a topic you can use the Pause and Repeat functions if you get interrupted. When you complete topics and sections, the corresponding targets fills in. The course itself is on the "Main" tab. The other tabs contain definitions of terms, additional learning resources, information on how to use the course, and who to contact if you have questions or problems with the course. When you have completed the entire course the lab coat button allows you to print your completion certificate. Click Continue when you are ready.	~~You can start the course anywhere you like. GME students will complete the entire course. If you are involved in assessing residents, you will want to review the sections on defining the competencies, and assessments. The Competencies Illustrated examples are valuable for everyone in the Graduate Medical Education Programs of OHSU.~~ Course Components (indicate Section menu items). (Indicate Topic items.) (Show sample continue and back to course buttons.) Show a nib empty, half full, then full) (Indicate Pause and Repeat buttons) (Indicate Main tab) (Indicate Glossary) (indicate resource tab) (info tab) (contact tab) (Show lab coat button) (Show Continue button) Next button enabled after video. button labeled FOR PROGRAM DIRECTORS
1.1.4.		**And now a message to the program directors** (This should pop up from a button labeled FOR PROGRAM DIRECTORS) This training program begins to address the requirements of the ACGME Outcome Project (text hyperlinks to content in next row) to increase emphasis on educational outcomes in the accreditation of residency education programs. OHSU can only satisfy these requirements with your help. This course and the resident journals are valuable tools for helping you and your residents identify competency areas residents need to address for learning and improvement.

#	Audio	Visuals
	Competencies are the key to understanding what doctors must do (rather than what they must know) to be effective as doctors.	(This is a lot of text, but it is all in an "aside." It would be OK to allow this to scroll, or break it up into multiple screens.) The ACGME initiated the Outcome Project in keeping with its mission to ensure and improve the quality of graduate medical education. ACGME accreditation offers the assurance that a residency program and its sponsoring institutions meet an accepted set of educational standards. The ACGME is beginning to focus on the outcomes of care. There is a concurrent movement within education placing emphasis on educational outcomes. The ACGME's goal is to apply these advances and promote educational excellence in a changing health care environment through a focus on educational outcomes. It has initiated this process by identifying six general competencies that are important to the practice of medicine: patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. The goal of this effort, called the "ACGME Outcome Project" is to base a program's accreditation status on how well it educates physicians and prepares them for practicing medicine.
	OHSU's Program directors will be the key to the success of this program in meeting the ACGME requirements.	The effective integration of the formative evaluations of the resident journals and The OHSU Physician Performance Diagnostic Inventory into your teaching will help you apply the principles of Systems-Based Practice and Improvement and Practice-Based Learning and Improvement. Using them yourself may help you identify and reconnect with the core values that were important to you when you decided you wanted to go into medicine. By participating in an approved curriculum and evaluation, you are also ensuring that OHSU can fulfill the requirements of the ACGME Outcomes Project.
		Click here for resources to guide the feedback processes you will use with residents in connection with this program. (indicate Resources tab) (End of FOR PROGRAM DIRECTORS segment)
1.2 Course Objectives		

#	Audio	Visuals
1.2.1.	This course will: • Introduce the ACGME competencies and how they will influence the practice of medicine, the study of medicine and OHSU's Graduate Medical Education programs • Demonstrate the skills associated with the competencies in real world medical situations • Introduce the OHSU Physician Performance Diagnostic Inventory to assess development of the skills, knowledge and attitudes that make up the competencies • Let physicians reflect on their practice experiences and identify areas in which to apply the competency objectives • Provide a diagnostic assessment of physicians to evaluate their level of understanding about what the competencies are and how they are assessed at OHSU	**Course Goals** This course covers: • ACGME competencies • Competency skills portrayed in realistic situations • OHSU Physician Performance Diagnostic Inventory • Self-reflection journal for residents • Self-assessment of residents
1.2.2.	By completing this course you will be able to: • Define the competency skills • Observe the competencies in context • Reflect on how the skills apply in practice • Use the OHSU Physician Performance Diagnostic Inventory to assess your performance in relation to the competency skills and identify areas for possible improvement	**Course Objectives** The course objectives are to: • Define the competencies • Demonstrate specific examples of the skills, knowledge and attitudes that make up the competencies • Help residents reflect on the application of the competencies in their practice • Help residents use the OHSU Physician Performance Diagnostic Inventory
1.3	This course is about ninety minutes long. Use the Menu to get started. Click "Information" for explanations of the course features.	**Course Technical Overview** Length of course: It will take approximately 90 minutes to review the material in this course. If you are interrupted, you can stop anywhere in the course and pick up later right where you left off. (Those 90 minutes do not include time spent writing in the Journal.) Course Menu: (includes visual indictor if necessary) You can move freely about the course using the menu. You can also use the menu to see where you are in the course and where you have or have not been. The material is organized so that it is useful in short segments to accommodate your busy schedule. Information: For more about the Journal, Resources, Glossary and navigation, click on 'Information'.
1.4	**Information**	Information (this section is under the Info button)

#	Audio	Visuals
1.4.1.	Information is the button you just pressed. Point to any part of the screen to learn more about it. Click "Contact" to send an e-mail for specific assistance. Click "Return to Course" to return to the course.	**Text labels for all components:** Information Library Dictionary Journal White Coat (course complete, hidden until 95% of course is viewed.) Table of Contents Location Forward Back Pause/Play Replay (These need to be described in the Information screen. The labels should name all shell components, and "point to item for information" expands name to describe functionality. Dictionary has a-z tabs on right side of screen, library???) No exit button unless required.
1.4.2.		**Contact** (Link at top of information page to e-mail for help, and phone number with name and hours. Jamie, who can this be?)
1.4.3.		**PPDI** The PPDI button opens a new window for the OHSU Physician Performance Developmental Inventory. This is the tool residents use to assess their performance on the skills, knowledge and attitudes of the competencies. You can take the assessment at any time, and as many times as you like. Be sure to save a printout of your self-assessment for your records.
1.4.4.		**Resources** The Resources tab contains many references and resources with additional information.
1.4.5.		**Glossary** The Dictionary contains the definitions of key words used in the course.
1.4.6.		**Progress Bar** The Progress Bar fills in as you complete the course. When you have completed the course you will be given the opportunity to complete an assessment of the course and print a certificate of completion for your portfolio.
1.4.7.		~~**White Coat (Course Completion)**~~ ~~The white coat is the invisible button. When you have completed 95% of the course, the mortarboard button allows you to complete the course evaluation and print your certificate of completion. To complete the entire course you will have to take a few detours along the way.~~

#	Audio	Visuals
1.4.8.		**Menu** The menu shows your current location in the course with the "You Are Here" marker. You can see where you have been by???? Your rate of completion is shown on the???
1.4.9.	The Journal button gives you access to your journal. With your self-assessment, you can start to set goals for your learning. With your journal, you can plan and record your progress towards those goals. You may want to print out your journal entries so you can discuss them with your program director, or to include them in your portfolio.	**Journal** • The Journal allows physicians to record actions and thoughts about the material in the course. • The Journal is always available. Specific questions in the course are designed to stimulate and guide the journal process. • Journal entries can only be seen by the person who makes the entries. • There is no limit on how many journal entries you make or their length. • Use this journal as a way to identify learning opportunities, plans and experiences while respecting patient privacy. • While we treat the journal as confidential, it may not be protected from discovery in the event of litigation, so be discrete and don't use real names or personal identifiers.
2. About the Competencies		
2.1	**Introduction** Since the ACGME requires us to assess resident performance of the core competencies, we have to be able to answer three questions. Who is the ACGME? What are the core competencies? How do we measure competence?	(Graphics????) Who is the ACGME? What are the core competencies? How do we assess competence?
2.1.1.	The ACGME is of course the Accreditation Council for Graduate Medical Education. They are the private, professional organization responsible for the accreditation of some 7,800 residency education programs. The mission of the ACGME is to improve the quality of healthcare in the United States by ensuring and improving the graduate medical education experience for physicians in training. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses the educational programs under its auspices.	**ACGME** Accreditation Council for Graduate Medical Education Who is the ACGME? ACGME Mission • Better healthcare • With better doctors • From better programs

#	Audio	Visuals
2.1.2.	The ACGME started the Outcomes Project in 1999. It is a long-term plan for the ACGME to emphasize educational outcomes in the accreditation of residency education programs. Previously the ACGME measured a program's potential to educate. The accreditation process was guided by questions such as: 1. Does the *program* comply with the Requirements? 2. Does the *program* have established objectives and an organized curriculum? The old process model of accreditation looked at what *programs* did. The new outcomes model looks at what *physicians* do.	Structure & Process Vs. Outcome & Product The ACGME Outcomes Project The focus is on how physicians are prepared to practice medicine in the changing health care delivery system. Previously the ACGME examined the potential of GME programs to educate physicians by looking at structure and process components. (We need to convey the difference between process and outcome evaluations. One example would be evaluating a meal by inspecting the plumbing in the kitchen. We can show a person with a clipboard in the kitchen, and then eating a meal. A better visual may be to change the focus from a faculty member to a resident using for instance the photo of the two reviewing the resident journal.)
2.1.3.	What are the Outcomes? Programs must: 1. Identify learning objectives 2. Assess physicians against objectives 3. Demonstrate that physicians and programs are advancing The questions being asked of GME programs are: 1. Do physicians achieve the learning objectives set by the program? 2. Can the program prove that physicians are meeting objectives? 3. How does the program demonstrate continuous improvement in its educational processes? This is a systematic attempt to shift away from a systems focus. (Yes, you heard right… "A systematic shift from a systems focus.")	When looking at the educational outcomes of a program, the ACGME requires GME programs to: • Identify learning objectives related to the skills, knowledge, and attitudes that embody ACGME's general competencies. • Use increasingly more dependable methods of assessing physicians' attainment of these competency-based objectives. • Use outcome data to facilitate continuous improvement of both resident and residency program performance.
2.2	The main outcome of a GME program is to prepare competent physicians who can practice without direct supervision. Then what does it mean to be a competent doctor? Good question.	**Outcomes Project** Does the program develop COMPETENT PHYSICIANS? (Graphics: Show competent physicians?)

#	Audio	Visuals
2.2.1.	The ACGME took the first step toward answering the question of what it takes to be a qualified physician with a study of existing research on general competencies for physicians. It also gathered input on the proposed competencies from various constituencies and stakeholders of GME. According to these experts, the skills of a competent physician fall into six categories: • Patient Care • Medical Knowledge • Practice-Based Learning and Improvement • Interpersonal and Communication Skills • Systems-Based Practice • and Professionalism Obviously, these six items, while not exhaustive, do represent a much broader body of knowledge than doctors were taught back in the 20th Century.	The competencies: • Patient Care • Medical Knowledge • Practice-Based Learning and Improvement • Interpersonal and Communication Skills • Systems-Based Practice • Professionalism (Click http://www.acgme.org/outcome/comp/compFull.asp to see full text version)
2.2.2.	The first step for us is to figure out exactly what "Patient Care" and the rest mean. GME at OHSU has developed a list of skills that describe the areas of competence in detail. These are the learning objectives called for by the ACGME.	The skills could be expanding text from the competencies (Click a competency above to see the skills) or they could be new screens, depending on what works better visually. Take a moment to review this list. You will be seeing them again! The American Board of Medical Specialties has adopted these same competencies as part of their certification requirements. (Graphics: Photos of physicians doing these things? Many of the photos from the video sessions should show the competencies.)
2.2.3.	Here are the eight skills that describe Patient Care.	**Patient Care** • Demonstrates **compassionate** (caring, and respectful) behaviors • **Gathers** appropriate **information** • Makes **informed** decisions that include patient preferences • Develops patient management **plans** • **Counsels and educates** patients and their families • Uses **evidence-based** practices to support patient care decisions • **Promotes** health care services aimed at **preventing** health problems or maintaining health • **Works well with other**s in the health care profession.
2.2.4.	Here are the three skills that define medical knowledge. Obviously, Medical Knowledge is an important part of being a competent doctor, but it is just one part.	**Medical Knowledge (and skill)** • Demonstrates **knowledge application** of the basic and clinically supportive sciences which are appropriate to their discipline • Demonstrates critical, investigatory, and **analytic thinking** • Performs invasive procedures considered essential for his/her area of practice (e.g. **technical skill**)

#	Audio	Visuals
2.2.5.	This is what is meant by Practice-Based Learning	**Practice-Based Learning and Improvement** • Utilizes **personal reflection**. • **Analyzes** practice **experience** and **performs** practice based **improvement** activities • **Evaluates evidence** from scientific studies. • Applies **knowledge** of **study designs** and **statistical** methods to evaluate scientific information • **Utilizes** on-line medical information and other **technologies** to support education • **Facilitates** the **learning** of others. • Manages health care information about patients to improve **patient safety**
2.2.6.	Interpersonal and Communication Skills includes all of these objectives.	**Interpersonal and Communication Skills** • **Addresses tense or difficult issues** and discusses controversial topics • **Encourages collaborative decisions** with contributions from other health care professionals. • Creates and sustains **ethically sound relationships** • Uses effective **listening skills** • Communicates effectively with patients • **Reads nonverbal cues** in order to understand the experience of others • **Communicates** (verbally and in writing) effectively about patient conditions **with other health care professionals** • Reads nonverbal cues in order to understand the experience of others • Communicates (verbally and in writing) effectively about patient conditions with other health care professionals

#	Audio	Visuals
2.2.7.	Professionalism includes these skills	**Professionalism** • Provides **effective leadership** as a member of an interdisciplinary team • Models **appropriate followership** as a member of an interdisciplinary team • **Understands divergent** points of view • Demonstrates **integrity** (respect, honesty and trustworthiness) • Demonstrates **accountability** and **responsiveness** to the needs of patients and society **that supersedes self-interest** • Demonstrates a **commitment** to on-going **professional development** • Demonstrates a commitment to **ethical principles.** • **Manages** his/her **emotions and behaviors**, especially during time of stress. • Demonstrates **sensitivity** and responsiveness to **culture, race, gender, age, and/or disabilities** • Reports and takes **responsibility for** personal **errors** and misjudgments
2.2.8.	System-Based Practice includes these four skills.	**System-Based Practice** • **Understands** the impact of patient care decisions on the patient and the entire health care **system**. • Practices **cost-effective** health care and resource allocation that does not compromise quality of care • **Assists patients** in dealing with system complexities • **Partners with** health care managers and **system providers**
2.2.9.	After reviewing the lists of skills that define the competencies, you could have one of several reactions. If you think that these competencies are not important, you are a victim of antiquated 20th Century thinking. To function effectively in today's health care system you need a much broader skill set.	Photos of resident on computers with caption or headline I am a surgeon. What my patients need is my steady hand and trained eye. Focusing on this other stuff is just going to keep me from learning important things.
2.2.10	If you think that you already know these things, or if you think you will never know these things, you are at least partly correct! Welcome to the world of formative evaluations, developmental assessment scales, and competence!	Photos of two different residents on computers with captions or headlines I do those things. I don't need to worry about this stuff. Nobody could ever do all of those things at the same time. This is impossible.

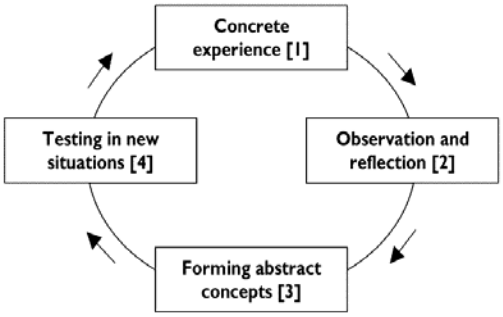
#	Audio	Visuals
3. About Assessments		
3.1	The ACGME calls the general competencies, "competencies" based on the research of the Dreyfus brothers. They demonstrated what has become a widely accepted model of how individuals progress through various levels in skill acquisition. They labeled individuals in these progressive stages as novice, advanced beginner, competent, proficient, and expert...according to their developmental level The ACGME expects graduating residents to therefore perform with the competence of an independent practitioner.	**Assessments** Start with picture of Hubert Dreyfus as professor at Berkley in 1968 (If we can find that picture) Or some other chart or photo? Dreyfus' stages of skill acquisition: • Novice • Advanced Beginner • Competent • Proficient • Expert
3.1.1.	Physicians develop their skills, knowledge, and attitudes gradually and in stages. They would typically be novices in medical school, early learners when they begin residency, and competent when they finish residency. With practice and a commitment to life-long learning, physicians will continue to develop through competence, proficiency, and expertise.	Photos? • Novice (flash the ones from before) • Advanced Beginner • Competent • Proficient • Expert
3.1.2.	As you progress from novice to expert, your comfort with the tasks at hand affects: • How you perceive the world • How you solve problems • How you frame situations • How you acquire new skill • What affects your performance	Graphics? Differences in your skill level create differences in: • Your view of the world • Your problem solving approach • Your mental models • Your learning processes • Your ability to handle new situations For more information on the application of the Dreyfus Model in Graduate Medical Education, click the link to review a paper by Dr. David Leach, Executive Director of ACGME. (Link to information on Dreyfus (DavidLeach.ppt))
3.1.3.	OHSU Graduate Medical Education has created The OHSU Physician Performance Diagnostic Inventory based loosely on the Dreyfus Model. It is modified to specifically apply to post graduate medical education. Physician performance is evaluated by physicians, and others, using this scale. The OHSU Physician Performance Diagnostic Inventory uses a rating scale that is "developmental" in that it compares the physician's expertise across the entire spectrum of expected practice. The following section introduces The OHSU Physician Performance Diagnostic Inventory, and provides examples of each of the skill acquisition stages.	**The OHSU Physician Performance Diagnostic Inventory Rating Scale** 

#	Audio	Visuals
3.1.4.	The developmental rating of the OHSU Physician Performance Diagnostic Inventory is a formative assessment. The question is not do you *know* this thing, or even do you *do* this thing. The question is *how* do you know it, and do it. As an example, consider the ability to ride a bicycle. Just saying that you know how to ride a bike is not accurate enough for our purposes. How do you ride the bike? Take a moment to examine how the developmental categories would apply to riding a bike.	**Developmental Assessment** Click on photos for descriptions Unsatisfactory (Photo from video of person crashing bike) Early Learner (Photo from video of person carefully riding bike, like the training wheels just came off) Competent (Photo from video of person riding bike, signaling turns, etc.) Proficient (Photo from bike messenger-like video) Expert (Photo from Lance Armstrong-like video)
3.1.5.	Working from left to right, the first category in The OHSU Physician Performance Diagnostic Inventory scale is "Unsatisfactory." Whereas Dreyfus started with a novice level, OHSU recognizes that it is a rare exception for a resident to be a novice. The years of training and experience residents bring to the program from medical school should prepare residents above the novice level. If someone is still performing key skills at a novice level, it is probably an indication that something is seriously wrong.	**UNSATISFACTORY** • Is unexpected to become competent within the assigned time frame. • Makes poor decisions or has an unsatisfactory approach to solving problems that results in poor care delivery or unacceptable behavior. • Repeatedly appears incapable of understanding concepts, performing tasks, exercising judgment or demonstrating behaviors that are important to show ability to learn the element being evaluated. SELECTING THIS RATING REQUIRES A DETAILED COMMENT Link to (video of person crashing bike)
3.1.6.	Sound effect, music or screaming?	**(video of person crashing bike)**
3.1.7.	Early learners know the steps, and the techniques, but their performance is controlled by following the rules. When the circumstances change, the early learner has trouble dealing with the unknown. A large part of being an early learner is that at this stage you do not yet know what it is you do not know. That is why additional supervision is required for challenging circumstances. In a nutshell, you can do the usual, but the unusual will either stop you in your tracks or you will keep going without stopping to get help when you should have gotten help.	**EARLY LEARNER** • Shows ability to learn. • Deals effectively with routine, repetitive, or non-stressful situations, but requires supervision in more difficult or challenging circumstances. • Incapable or inconsistent in using experience to address circumstances that are unexpected or non-typical. • The early learner is at a novice level and shows aptitude but has not yet had sufficient experience, training, or skill acquisition to achieve competence. • Unlike the unsatisfactory (who believes they already know it all), wants to engage in learning. Link to (video of person carefully riding bike, like the training wheels just came off)
3.1.8.	The Early Learner is given examples, and follows instructions in a detached, analytical frame of mind. The instructor's coaching and the use of maxims like, "follow all traffic rules" help the Early Learner develop context and make sense of the material.	**(video of person carefully riding bike, like the training wheels just came off)**

#	Audio	Visuals
3.1.9.	Ah, competence. Competence indicates that a learner has progressed beyond the rule-based mode of the early learner. Now the rules make sense, and if things don't vary too much things are fine. When circumstances change enough that the competent practitioner is uncertain about what to do he will seek the help he needs. In a nutshell, if you are "competent" you can do the usual, recognize the unusual, and get help when you need it.	**COMPETENT** • Routinely utilizes learned principles and applies them to guide actions in usual or predictable circumstances. • .Has developed adequate internal resources, knowledge, or skills to make good decisions or perform acceptably in routine cases. • IMPORTANTLY, the competent physician recognizes limitations and accesses support when needed, especially for more challenging situations. This is the level expected from those at the completion of training and indicates that they can effectively address the majority of routine situations and will access support when needed in other cases. Link to (Video of person riding bike, signaling turns, etc.)
3.1.10	The competent learner no longer focuses on the rules on pedaling and steering, but rides with a goal in mind. With experience, the competent learner develops a sense for what is important. A competent performer with a goal in mind sees a situation as a set of facts. The importance of the facts may depend on other facts. When a certain set of events happens, he responds in an appropriate way.	**(Video of person riding bike, signaling turns, etc.)**
3.1.11	Proficiency is marked by a learned intuition that guides an analytical thought process. Briefly, "proficient" practitioners can do the unusual as well as they do the routine.	**PROFICIENT** • Has a good grasp of information, excellent skills, and sound principles and applies them to guide actions in unusual or challenging circumstances. • Is consistently trusted to deal effectively with complex problems. • Has developed enough internal understanding, ability to flexibly apply knowledge and sufficient skills that they can reliably handle challenging situations without the need for external support. Link to (bike messenger-like video)
3.1.12	The Proficient learner intuitively understands the task and thinks analytically about what to do. The intuition of a Proficient learner comes from his deep involvement in the situation and recognizing similarities in experiences.	**(bike messenger-like video)**

#	Audio	Visuals
3.1.13	Everyone can picture an expert practitioner. Whether it is Mom's expertise with pies, the pitcher on your favorite baseball team, or a role model who taught you something important, you probably know expertise when you see it. The expert not only recognizes mistakes, he deals with them effectively. The expert has incorporated the skill in a way that lets him deal with new problems as they arise.	**EXPERT** • Can recognize errors or inadequacies in knowledge, judgment, skills, or behavior in complex situations and is capable of effective remediation. • Is a persuasive lifelong learner. • Understands the contextual "whole" and is fluid and flexible in performance. • Has a seeming 6th sense (or a well-developed "internal gyroscope") of how to respond to even the most unpredictable and challenging situations. • Is a resource mentor, teacher, and role model in this area. Link to (Lance Armstrong-like video)
3.1.14	An Expert knows what to do based on mature and practiced understanding. Because he is so involved in the task, performance becomes automatic. The early learner uses patterns. The competent person adds context. The Proficient person uses intuition. The expert can do it without having to stop and think about it. For instance, the Expert cyclist is totally engaged in the act of cycling and does not have to think about it explicitly.	**(Lance Armstrong-like video)**
3.1.15	Finally, there is an "Unable to Evaluate" category.	**Unable to Evaluate** (photo of rider-less bike)
3.2	How you deal with the unknown depends on your stage of skill development. As an Early Learner, actions are based on following a learned set of rules. Therefore, there is little sense of responsibility. An unfortunate outcome can be blamed on inadequately specified elements or rules. A competent learner is more involved in the act and feels personally responsible for adverse outcomes. This involvement in successes and failures is a mark of competence. A Proficient learner is even more intimately involved in the task at hand. He uses analytical thinking guided by intuition to deal with new situations. The Expert learner will critically reflect on his own intuition when new information requires him to do so. The Unsatisfactory learner is not progressing through these developmental stages. Unsatisfactory responses to the unknown include obfuscation, lying, and wrongly blaming others.	Show the still shots of bikes, and labels "early learner, etc. sequentially.

#	Audio	Visuals
3.3	VO: What do the developmental stages look like for a resident? In this case, a resident is asked to finish a procedure he has never done by himself, and the resident is not sure if he can do it. Choose Unsatisfactory, Early Learner and competent to see some possible reactions to this situation based on residents' different levels of skill development.	**Surgeon examples of developmental scale (VIDEO)** Photo of Surgeon asks the resident to finish the procedure. "Joe, I have to scrub in on another case. You go ahead and finish up." **"Development Scale Examples"** Busy surgeon asks the resident to finish a procedure, i.e., "You go ahead and finish up." Choose a developmental stage: • Unsatisfactory • Early Learner • Competent
3.3.1.		**Unsatisfactory** (Photos with captions fade in and out one at a time) "Don't worry about it, I am invincible." "Lemme at it! I know I can handle anything!" "If I hurry I can still make that dinner reservation." (back)
3.3.2.		**Early Learner** (Photos with captions) "I'll finish up, if you will stay and help." "Although I've never actually done this before, I can handle it with your assistance." "I do know the technique but am not too practiced in it. Will you be available incase something unexpected comes up? (back)
3.3.3.		**Competent** (Photos with captions) "While finishing the procedure, I ran into something I'd like to ask you about." "The procedure did go well. I am glad I got some more experience dealing with that kind of case." "I understand how to do the procedure. Can you point out some refinements to my skill in this procedure?" (back)

#	Audio	Visuals
4. Personal Journal		
4.1	**Using the Journal** The journal provides an opportunity to reflect on the material in this course, and on personal application of the material. Graduate Medical Education involves a lot of experiential learning, or learning by doing. The journal compliments and completes your hands-on experiences. As you know, simply doing something again and again is not going to make you better at it. Reflecting on your experiences is the first step toward learning from your experience.	(Show a sample journal, blank at first, and then containing a sample entry.) Click here for (more on reflective learning).
4.1.1.	(Imbed this and next screen in a linked path (more on reflective learning). This diagram shows how experience and reflection combine to strengthen the learning process. It starts with a personal experience. This could be something you did, or observed. When you reflect on an experience, you want to record the event, address your feelings about what happened and evaluate the event. The evaluation helps you form and identify the abstract concepts of the experience. This includes identifying problems encountered, the effectiveness of the approach used, and alternative approaches to try. When you try out an alternative approach (in the testing in new situations step) you gain another concrete experience. And the cycle continues indefinitely.	 Click here to see more information on learning styles and reflective learning. (Expands to show following) An event happens and we record it based on data coming into our senses. We record the event and begin to immediately make meaning of the event. (**Concrete Experience**) We make meaning through evaluative reflection, which means we fit the experience into our existing rules for understanding the event or our previously internalized schema/belief system. (**Reflective Observation**) In the next evaluative phase, we are more likely to move outside our proverbial boxes and try to see the event through new eyes. It means we have to choose to modify our existing schema and make room for something new or we will never develop new methods and approaches to solving problems. As Einstein said, "You can't solve a problem with the mind that created it." (**Abstract Conceptualization**) Finally, we test our new hypothesis or theory to see if it works. In other words, we create a plan based on our new conceptualization and then evaluate its efficacy (**Active Experimentation.**) We then begin again, through coming full circle, to where we started. (Concrete Experience)

#	Audio	Visuals
4.1.2.	Adult learners can be divided into four groups: Activists Reflectors Theorists Pragmatists Whatever your preferred or default learning style, a journal helps you learn to use all of these learning methods.	**Four Learning Styles** (Honey and Mumford, 1982) What kind of learner are you? Activists • 'hands-on' learners prefer to have a go, and learn through trial and error Reflectors • 'tell me' learners prefer to be thoroughly briefed before proceeding Theorists • 'convince me' learners want reassurance that a theory makes sense Pragmatists • 'Show me' learners want a demonstration from an acknowledged expert. (back to course)
4.1.3.	The journal is a running record of your responses, plans, and experiences. If you have used a journal before, the experience will be familiar. If you haven't, it will be less familiar, but good practice for being an all-round learner because it can help you articulate your learning and make it explicit.	**Benefits of a personal journal** • It helps you to think about your experiences and to express your learning more clearly • It encourages you to have experiences and take learning opportunities (in order to have something to write about!) • It enables you to review the plans you have made to ensure that you have put them into practice, not just left them as 'good intentions'.
4.1.4.	The journal is a great way to keep track of your Plan for Learning. In it you can record your: • objectives for improvement, • a plan with steps, • a schedule, • and assessment plan.	Plan For Learning • Description of Event or Evaluation • Self/ Other Reflection/ Appraisal • Plan (Steps for Learning) • Timeline • Evaluation

#	Audio	Visuals
4.1.5.	Your may chose to make the journal part of your GME portfolio. Your program director will review your journal as part of your normal review process. It is a good way for you to communicate your progress. Use your journal in the way that works best for you. You have to decide what the appropriate mix of action and reflection is for you. The practice of medicine takes practice. Practicing and reflecting, and practicing some more, is the mark of a life-long learner who is always striving for excellence. Change to read: You may choose to share your journal with your mentor or program director as part of your review process. It is a good way for you to communicate your progress. Use your journal in the way that works best for you. You have to decide what the appropriate mix of action and reflection is for you. The practice of medicine takes practice. Practicing and reflecting, and practicing some more, is the mark of a life-long learner who is always striving for excellence.	**Using the Journal** Photo of program director and resident in conference Click here for resources on: • Giving and receiving feedback • Portfolios
4.2 About the Journal		
4.2.1.	It is your journal. Feel free to use it to your best advantage.	Personal Journal: One writer (resident on computer) Two readers (resident and program director in conference) Think twice, write once For any questions about your journal, please contact your program director About your Journal • You are the only one who can write in your journal. • The journal may be used as a teaching and communication tool for residents, mentors and program directors. • Only you can read your journal. However, you may choose to share your journal with your mentor or program director. • While it is not intended that others will see your journal, there is no such thing as 100% security. Something you write in the journal could be seen by other than the intended audience. • Use this journal as a way to identify learning opportunities, plans and experiences while respecting patient privacy. • While we treat the journal as confidential, it may not be protected from discovery in the event of litigation, so be discrete and don't use real names or personal identifiers.

#	Audio	Visuals
4.2.2.	The journal questions (if done in sequence) start out fairly specific and defined, and later are more open-ended. You can answer the questions in any order. And you can answer as many times as you want. It is good to change your answers.	(This is not an answering machine. It is a questioning machine. My questions are two: Who are you, and what do you want? Ask yourself these questions and watch your answers change.) "Metaphysical Message Machine" New Yorker style cartoon with caption maybe? (We can do something else here too, if need be, but I would like to break it up a bit.)
4.2.3.		**Journal Sample** The journal automatically adds the date and time to your entries. When you answer specific questions from the course, you must write the question first, then the answer. (Paraphrasing the question in your own words counts double!) Sign your entries with your initials at the very end. It is a quick way to tell if the whole answer printed out. Journal: 6/10/4 My greatest weakness? Chocolate WW

#	Audio	Visuals
4.3	Time to try your hand at journaling. This is the first journaling exercise of 4 in this section.	**Journal 1** • Identify one of the skills from the previous lists that you have recently demonstrated. • Describe the situation and how you handled it. • Rate your performance on the developmental scale. • (Link to **List of Skills** document. The link text should be selectable so the learner can copy and paste into the journal.) • Link to **Developmental Scale** (early learner, competent, proficient, expert.) • Link to **Journal Example** below Journal: 6/10/4 Example of demonstration of 1 competency skill and self-rating Skill demonstrated: Utilize personal reflection, investigation, and evaluation to inform and improve patient care practice. Situation: Started using personal journal to record my teachable moments, and to plan and track my residency education. While it is too early to tell what affect this will have, I am going to try. If it can make me better at medicine, I have to. And who knows, maybe it will make it easier for me to communicate with my program director. We are both always so busy. My Rating: Early Learner. By the end of the year, I hope to be competent. RU
4.4	This is the second of 4 exercises in this section.	**Journal 2** 1. Identify one of the skills you observed demonstrated well (expert level) by any healthcare provider. 2. Describe the situation and how he/she handled it. 3. Rate his/her performance on the developmental scale
4.5	This is the third of 4 exercises in this section.	**Journal 3** 1. Identify one of the skills you observed someone perform poorly (Early Learner or Novice/Unsatisfactory). 2. Describe the situation and how he/she handled it. 3. What would have been more effective? 4. Rate his/her performance on the developmental scale

#	Audio	Visuals
4.6	This is the fourth of 4 exercises in this section. You may want to answer questions 1 through 3 first.	**Journal 4** 1. Identify one skill each under Professionalism, Practice Based Management, Systems Based Practice, and Communications to focus on for the next 6 months. 2. Why did you select these skills? 3. What is it about these skills that is difficult for you? 4. Why are they important to your practice of medicine? 5. What specific steps can you take to become more effective at each of these skills? (You will want to discuss this learning plan with your program director.)

#	Audio	Visuals
5.	**Competencies Illustrated** Select any photograph to begin.	The Competencies Illustrated (Presented as fine print) By example and non-example, this section illustrates the Knowledge, Skills, and Attitudes of competent physicians. Comment: (This section of the course consists of a collection of situations, decisions, consequences, instructional material, and reflection opportunities. Each of the situations stands alone. There is no particular order for the presentation of the situations. The learner can navigate directly to any situation from the menu, or from the internal splash page, that begins this section.) Montage of photos, each one representing a situation.
5.1	INTERIOR/NIGHT - Intensive Care Unit NURSE #1 is caring for a sleeping PATIENT #1 as a DOCTOR #1 rushes into the room. NURSE #1 looks up with a smiling greeting that quickly fades as DOCTOR #1 grabs the chart and brusquely reviews orders, barely glancing at nurse or patient. DOCTOR #1 (talks to self) "What?" No, no, no…" DOCTOR #1 shakes head, scrawls new orders on chart. DOCTOR #1 (finally acknowledges NURSE) "Hey, let's get him up to the ward." NURSE #1 (a bit surprised) "All right. What about the Lasix? During rounds the team thought…" DOCTOR #1 (interrupts) "I want the Lasix kept where it is for now." NURSE #1 "And the x-ray? They all wanted…" DOCTOR #1 (interrupts) "Don't bother with the x-ray." NURSE #1 "But the resident ordered…" DOCTOR #1 (impatient, mocking) "Look. This is *my* patient, *my* responsibility. I don't care *what* 'the resident ordered.' Just do what *I* say." DOCTOR #1 rushes out of the room. NURSE #1 watches him leave and sighs, refocusing on caring for the patient.	**New Med Order (Video)** Photo of Dr. reading chart at bedside. (Same as in navigation montage.) During rounds on her patient Dr. Robertson illustrates various levels of mastery of the following competency skills: • Manages his/her emotions and behaviors, especially during time of stress. • Works well with others in the health care profession • Gathers appropriate information • Uses evidence-based practices to support patient care decisions • Facilitates the learning of others. • Encourages collaborative decisions with contributions from other health care professionals. • Provides effective leadership as a member of an interdisciplinary team

#	Audio	Visuals
5.1.1.	VO: Sometimes you will discover a decision made by others with which you disagree. How you handle it depends on may factors. Chose a response to see what could happen next.	It is your call. What should Dr. Robertson do? a. Make and document the change and discuss it with the responsible party later. b. Use this as a teaching opportunity for the rest of the team.
5.1.2.	A. If it is a simple change, this is an appropriate response.	(If 'A' is chosen, show photo of dr. writing on prescription pad, documenting change in medication) OST feedback on "A": While this may be the most efficient way to make a change to a care plan decision made by others, it is not always the best way. Chose "B" to see when it makes sense to do more.
5.1.3.	INTERIOR/DAY - Intensive Care Unit NURSE #1 is caring for a sleeping PATIENT #1 as RESIDENT #1 and RESIDENT #2 reviews the chart. DOCTOR #1 enters the room. NURSE #1 looks up, smiles and joins the group. DOCTOR #1 (takes chart from resident and reviews, raising eyebrows in surprise) "Sorry I wasn't available for rounds this morning. Let's talk about some of these decisions you made. *I* think our patient is ready to be moved up to the ward, but you don't agree?" RESIDENT #2 "No, Doctor. We should up her Lasix for now." DOCTOR (to nurse) "What makes you think that?" NURSE #1 (rises to the challenge) "Well, her I and O was one liter positive overnight, and her respiration rate is up to 26 per minute." DOCTOR #1 "Hmm, that's good information. Could indicate a problem all right." RESIDENT #1 "Yes, we should probably get another x-ray?" DOCTOR #1 "I concur. We need to find out what's really going on here. Give me a call after you see the film and we'll figure out the best course of treatment. Nice work."	"New Med Order" - Team Consult INTERIOR/DAY - Intensive Care Unit (If "B" is chosen, show video of Dr. discussing case with interdisciplinary team. The start of the video is model for photo that would be used to launch this section.) B. Assuming of course that your decision is correct, you are obliged to share your knowledge with others. This is a clear illustration of effective leadership of interdisciplinary teams and facilitation of the learning of students and other health care professionals. While this approach could be appropriate, it could also be excessive if applied every time a minor change is required. Chose "A" to see another response that could be appropriate in this situation.

#	Audio	Visuals
5.2	Pharmacist pages resident. Dialog of pharmacist telling resident that the medication Dr. Kohler just ordered is contra-indicated for patient due to adverse reaction with another medication. Dr. Ryan: Hello? Dr. Gilhooly? This is Dr. Ryan in Pharmacy. I am calling about the sertraline ordered by Dr. Kohler. According to our records, that patient has a PRN order for intravenous promethazine for nausea. As you know this combination of medications has been shown to cause cardiac side effects in some patients. Since Dr. Kohler is not answering his pages, we need you to OK this script. Do you want to stick with this medication or do you want to use a different one that does not interact with the promethazine?"	Photo of pharmacist reviewing prescription Photos of pharmacist telling resident that the medication Dr. Kohler just ordered is contra-indicated for patient due to adverse reaction with another medication. Dr. Gilhooly has to make a difficult decision on his own. All six competencies can help ensure his patient's safety even when all of the facts are not readily available.
5.2.1.	VO: Perhaps Dr. Kohler failed to gather all the essential patient information in this case. Drug interactions are a common problem. Unfortunately, Dr. Kohler just left and you can't reach him to let him know about the pharmacy's concerns. How do you react to contradictory information from unknown sources? As Dr. Kohler's resident, what do you do?	It is your call: (chose one) A. Assume that Dr. Kohler knew what he was doing and OK the script. (If chosen, show photo of patient having adverse reaction– unstable EKG)) B. Ask the pharmacist for a recommendation and go with that instead. (If chosen show "next morning" video when Dr. Kohler is again rounding on patient, and dresses down the resident for countermanding the med change.) More information: Link to medication error course. (link for medication safety. http://www.ohsu.edu/medsafety/index_content.html
5.2.2.	A. (If chosen, show photos of patient having adverse reaction – EKG changes) Voice of Nurse: "Doctor, you better come take a look at this EKG. It does not look good."	A. It is difficult to point out a possible error made by someone in a position of authority over you. You are supposed to be learning from this person who has more experience than you do. In this case though, you have to weigh the pharmacist's experience with the medications against the doctor's knowledge of this particular patient. Judging from the interaction, maybe it would have been better to make a different call. See what else you could have done. (back, or try again button)

#	Audio	Visuals
5.2.3.	B. (If chosen show "next morning" photo with voice over. Dr. Kohler is rounding on patient, and dresses down the resident for countermanding the med change.) **Voice of Dr. Kohler (actor)** What do you mean my patient is not getting the **sertraline** I ordered? Why in the world would you have changed my orders, and why was I not immediately informed? It is imperative that we start the **sertraline** immediately. That so called interaction with promethazine **is** not enough reason to use a less-effective medication. He is under our care so we can monitor his EKG, and he hasn't even been given the promethazine **for** two days. If you thought there was a problem you should have changed the nausea med, not the SSRI.	B. The ability to deal with conflicting, incomplete, and contradictory information is one of the marks of a competent physician. In this case if Dr. Kohler had taken a little more time to explain that the potential for an adverse reaction was outweighed by the benefit of the medication, the resident would have been prepared to explain this to the pharmacist, and a collaborative patient-centered decision could have been reached. Dr. Kohler was very clear about WHAT to do, but skipped the WHY. Without this information, the resident was unable to respond appropriately. See what else he could have done. (back, or try again button)
5.2.4.	Have you ever been in a situation where you had to make a difficult decision and did not have all of the information available to you? Take this opportunity to write in your journal about a similar situation you have been in.	**Journal 5** **Journal your response** (Photos of a confused resident, or conflicted resident getting advice from 2 or more people?) Since neither of the choices provided demonstrates competence, how would you handle the attending's and pharmacist's conflicting advice? Which competency elements would you be using? Describe a situation where you did not have the information required, or you were getting conflicting information, and had to make a difficult decision. How did you handle it? How could you have handled it better? Could the problem have been avoided in the first place? How?
5.3	**Breast Cancer Consult**	Photo of female patient in gown sitting on exam table
5.3.1.	VO: This is your next patient. You have to meet with her to discuss surgical options for her breast cancer. Unfortunately, you are running 20 minutes behind schedule, so she has been waiting. So, do you…. Try to catch up or, Ignore the clock and do what needs to be done?	This is your first consultation with the patient. It is your call. The two things on your mind are taking adequate time with this patient, and being sensitive to the needs of the rest of the patients you need to see today. Do you: A. Try to catch up on your schedule? (selection launches video of rushed interaction, see below) B. To heck with the other patients! I'm taking my time. (selection launches video of slow interaction, see below)

#	Audio	Visuals
5.3.2.	a. (rushed interaction) DOCTOR #2 (taps on door) "We have to talk later." DOCTOR #2 enters the room with an automatic smile and little eye contact. PATIENT #2 appears frozen, "deer in the headlights" look. DOCTOR #2 "Ah, good morning, Mrs. Smith. Sorry you had to wait. Busy, busy, busy, you know." DOCTOR #2 sits down, referencing case files as he talks with PATIENT #2. DOCTOR #2 "Okay, we have a couple of surgical options here for your kind of cancer…" Closing her magazine, the PATIENT #2 gulps, and visibly withers as DOCTOR #2 jumps right in to sensitive topic. DAUGHTER grabs her hand.	**Video of Cancer Consult – Rushed** (Video of Surgeon who briefly apologizes for being late and starts the discussion of surgical options.) "Cancer Consult - Rushed Take 1" INTERIOR/DAY - Examining Room An apprehensive looking PATIENT #2 pages through an old magazine without really seeing anything on the pages. Her DAUGHTER watches her. DOCTOR #2 taps on the door and is invited in. DOCTOR #2 finishes a frazzled conversation with an unseen comrade in the hallway before walking in, paperwork in hand, and greeting the family.
	The rest of the patients on your schedule probably appreciate your attempts to see them sooner. Obviously, you are trying to practice cost-effective healthcare and resource allocation. As you can see from this interaction, it was probably not the best decision you could have made though. You sacrificed the communication with this patient and patient focused care. Chose another response to see how else this situation could play out.	A. Try to catch up on your schedule? B. To heck with the other patients! This woman needs my help. C. Happy Medium (new button launches take two video)

#	Audio	Visuals
5.3.3.	DOCTOR #2 (taps on door) "We have to talk later." DOCTOR #2 enters the room, smiling. PATIENT #2 appears frozen, "deer in the headlights" look. DOCTOR #2 "Ah, good morning, Mrs. Smith… and this must be the daughter I've heard so much about. Hello. Sorry to make you both wait. I only have a few minutes, so shall we get started?" DOCTOR #2 sits down, referencing case files and making eye contact as he talks. DOCTOR #2 "Okay, we have a couple of surgical options here for your kind of cancer…" Closing her magazine, the PATIENT #2 gulps. Daughter grabs her hand. DOCTOR #2 notices the reaction and responds with sensitivity. DOCTOR #2 "I understand this is a tough time, Mrs. Smith. Let me tell you a little about these procedures first and then I'll take you down the hall to meet with a colleague who can explain the details about these options and outcomes. Please know that you're not alone."	**Happy medium** INTERIOR/DAY - Examining Room An apprehensive looking PATIENT #2 pages through an old magazine without really seeing anything on the pages. Her DAUGHTER watches her. DOCTOR #2 taps on the door and is invited in. DOCTOR #2 finishes a frazzled conversation with an unseen comrade in the hallway before walking in, paperwork in hand, and warmly greeting the family.

#	Audio	Visuals
5.3.4.	DOCTOR #2 (taps on door) "We have to talk later." DOCTOR #2 enters the room, making eye contact and smiling. PATIENT #2 appears frozen, with a "deer in the headlights" look as she greets physician. DOCTOR #2 "Ah, good morning, Mrs. Smith; and is it Miss Smith? I'm Dr. Jones, the surgeon." DAUGHTER nods in greeting. PATIENT #2 nervously rolls up and twists her magazine. DOCTOR #2 (sits down) "I apologize for the wait. First of all, how are you? I know a diagnosis of breast cancer is scary." PATIENT #2 "I am scared all right." DAUGHTER grabs her mother's hand. Both women appear on the verge of tears. DOCTOR #2 "Well, there's been good success treating cancers like yours. Actually, my wife's a survivor -- 4 years now -- so I feel for your family. We'll work hard for a good outcome for you, too." PATIENT #2 and DAUGHTER visibly relax a bit, small thankful smiles. DOCTOR #2 So, how have you been feeling lately? PATIENT #2 "Pretty well, really. Just tired. Can't sleep." DAUGHTER (joking) "You were sure snoring in the car, Mom." DOCTOR #2 (smiles, to DAUGHTER) "It's hard work, fighting that cancer. (To PATIENT #2) You just nap whenever you feel like it. Doctor's orders! May I examine you now?" DOCTOR #2 respectfully approaches PATIENT #2, starting to carefully drape her form for the examination. DOCTOR #2 "Do you have any questions about your treatment so far?" PATIENT #2 "Oh, I have *lots* of questions, but I know you're busy…" DOCTOR #2 "Don't worry Mrs. Smith. Take all the time you need."	**Video of Cancer Consult – Considerate** INTERIOR/DAY - Examining Room An apprehensive looking PATIENT #2 pages through an old magazine without really seeing anything on the pages. Her DAUGHTER watches her. DOCTOR #2 taps on the door and both women look up, inviting entry. DOCTOR #2 finishes a frazzled conversation with an unseen comrade in the hallway before walking in, paperwork in hand, and greeting PATIENT #2 and DAUGHTER.

#	Audio	Visuals
	V.O. This interaction demonstrates competent patient care and good communication skills. There is good news and bad news…	• The surgeon shows compassionate, caring, and respectful behavior towards the patient, demonstrates the ability to gather essential information, and counsels and educates the patient. • The communication skills demonstrated include partnering with the patient, using effective listening, inquiry, and explanation skills. The surgeon also picked up on the patient's body language to improve communication. • Unfortunately your other patients are kept waiting. You might try spending less time with patients when you are getting behind. (Photo of mad patients in waiting room.) A. Try to catch up on your schedule? B. To heck with the other patients! This woman needs my help. C. Happy Medium (new button launches take two video) (After viewing all three choices, Continue button takes learner to the journal exercise)
		Journal 9 **Journal Exercise:** Identify an instance when two of the competency elements directly contradicted each other. Which elements were in conflict? How did you handle the situation?
5.4	**Jehovah's Witness surgery**	

#	Audio	Visuals
5.4.1.	V.O. One of the skills physicians are assessed on is their ability to make informed decisions about diagnostic and therapeutic interventions based on patient preferences, current scientific evidence, and their own clinical judgment. A proficient physician can balance these demands appropriately, even when they conflict. Observe our doctor friend counsel this patient. Notice his respect for his patient's cultural framework and how that affects the informed consent process. This in turn influences how he will demonstrate a commitment to ethical principles pertaining to the provision or withholding of care.	Competencies Illustrated: • Make informed decisions that include patient preferences • Evaluate evidence from scientific studies • Work well with others in the health care profession • Partner with health care managers and system providers • Assist patients in dealing with system complexities • Use effective listening skills • Communicate effectively with patients • Demonstrate sensitivity and responsiveness to culture, race, gender, age, and/or disabilities • Demonstrate accountability and responsiveness to the needs of patients and society that supersedes self-interest • Demonstrate a commitment to ethical principles • Communicate (verbally and in writing) effectively about patient conditions with other health care professionals **Video of patient consult** INTERIOR/DAY - Hospital Room With FAMILY and MINISTER crowded around the bed, PATIENT #3 listens as the DOCTOR #3 discusses treatment for her ailment.

#	Audio	Visuals
5.4.2.	INTERIOR/DAY - Hospital Room With FAMILY and MINISTER crowded around the bed, PATIENT #3 listens as the DOCTOR #3 discusses treatment for her ailment. DOCTOR #3 "We are ready to do the operation, Mrs. Johnson, but any surgery comes with a risk of bleeding. We may need to give you a transfusion to save your life." The group of visitors has negative reactions to this news, lots of head shaking and disapproval. MINISTER/FAMILY "No!" "No blood." PATIENT #3 (looks down, unsure of self) "Our religion doesn't allow transfusions." DOCTOR #3 "All right, if that is your wish. (To FAMILY) Now, if you'll excuse us, I'd like some privacy to finish the exam." With much kissing, arm patting, and comforting of the PATIENT, the FAMILY leaves the room. DOCTOR #3 (continues exam) "So you don't want a blood transfusion during surgery, even if you need it?" PATIENT #3 "I'm a Jehovah's Witness, and my church would never let me…" DOCTOR #3 "To save your life, we could give you blood during surgery so no one else would know." PATIENT #3 "But it will be written down on that chart for everybody to see!" DOCTOR #3 "We work to keep your medical care decisions private, Mrs. Johnson. Whatever you decide." PATIENT #3 "*God* will know, Doctor. No, no blood."	

#	Audio	Visuals
5.4.3.	In a situation like this a physician must decide:	OPTIONS: A. I can't do the procedure unless you sign this consent. We won't give you blood unless it is needed to save your life. B. If I can't give you a blood transfusion if you need it, I won't do the surgery. C. We will do the surgery without giving you any blood. D. I'll need to make sure my surgical team is willing to work under this condition.
5.4.4.		(Graphics?) A. Using simple rules like "patients must sign a consent" and "use a blood transfusion in case of blood loss" is the mark of a novice or early learner. Make another choice to see how a proficient surgeon would respond.
5.4.5.		(Graphics?) B. If the risk of blood loss is greater than the potential benefit of the procedure, it may be appropriate to refuse to perform the surgery. Assume for a moment that the danger of bleeding is less than the danger of not doing the surgery, and select the response that would be appropriate under those circumstances.
5.4.6.		C. If the risk of bleeding is not great it could be appropriate to do the surgery with the understanding that the patient will not receive a transfusion. You will need to ensure that the entire team is onboard first. Select 'Next to see how the team uses interpersonal and communication skills to collaboratively define the patient's care plan. (Next shows the team consult video that was under "D" before)

#	Audio	Visuals
5.4.7.	**"Jehovah's Witness Team Consult"** DOCTOR #3 "I thought Mrs. Johnson might let us give her blood during surgery *if* we could do it without her family's knowledge." DOCTOR #2 "But they deserve to know." NURSE #2 "It's her decision, not theirs." DOCTOR #3 "Well, she's decided no transfusions. Doesn't make me happy, but the patient is pretty healthy with normal vascular function so I think we're looking at a 95 percent chance of *not* needing blood during the procedure. I'm willing to accept that risk if you are." NURSE #2 "I don't like the idea of *any* patient dying in the O.R. from something as basic as bleeding." DOCTOR #1 "I agree. We're trained to save patients, *not* put their lives at risk. Can't we just *give* her the transfusion if necessary?" DOCTOR #3 "No, we can't. We must respect her wishes, but it is up to each of us to decide whether *we* are comfortable participating under that condition." DOCTOR #1 "Sorry, I can't do it, no matter how small the risk. I'll find someone else to take my place on the surgical team if that's all right." DOCTOR #3 "That would work. Just make sure your replacement is as good as you are! (To NURSE) How about you?" NURSE #2 "Count me in. But thanks for asking. I appreciate being included in the decision, Doctor."	INTERIOR/DAY - Conference Room/Lounge? Group of hospital professionals confers about Mrs. Johnson's case. Primary DOCTOR #3 explains the situation - religious beliefs and family pressure conflicting with medical necessity of blood transfusion before/during surgery. (After video display reminder in OST) Be sure to explore the other options to see if or when a simpler course of action would be appropriate.

#	Audio	Visuals
5.4.8.		Professionalism requires physicians to demonstrate sensitivity and responsiveness to culture, age, gender, and disabilities of their patients and colleagues. It is important that physicians develop the knowledge, skills, and attitudes needed to serve diverse populations. The previous scenes demonstrated a surgeon performing with sensitivity to patient and colleague preferences that were not necessarily consistent with his own. **Journal 6** **Journal Exercise:** Describe an experience with a patient and/or colleague that required you to demonstrate knowledge about and sensitivity to one or more of the following: culture, age, race, gender, and/or disability. What important information did you need to provide competent care and/or have an appropriate relationship with this person? How effective were you at understanding the other's perspectives and meeting the other's needs? How would you handle a similar situation now? What would you do the same, and what would you do differently?

#	Audio	Visuals
5.5	RESIDENT #3 "Mr. Young is a 60 year old male with emphysema requiring a subclavian line for vascular access. I placed the subclavian line with some minor difficulty and about two hours later he had a cardiopulmonary arrest after a tension pneumothorax. We successfully resuscitated him but he ended up staying in the ICU four more days." DOCTOR #1 "Well, did you see the chest x-ray after the procedure?" RESIDENT #3 "I was called to an emergency code at the time I finished the procedure…" DOCTOR #1 "But did you look at the chest x-ray?" RESIDENT #3 (nervously clears throat and takes a deep breath) "I had to go to the emergency room right away so I could not view the chest x-ray. And frankly, I've never had a problem placing a subclavian line before." DOCTOR #1 "Isn't it your *job* to look at the chest x-ray after putting in a subclavian line?" RESIDENT #3 (defenses up) "Do you want me to just let the other patient die? I *had* to go!" DOCTOR #1 "No, I want you to be more careful with *my* patients."	**Video of M&M conference** PREFACE - RESIDENT #3 performed a subclavian catheter placement procedure under the direction of Attending DOCTOR #1. After a bit of a struggle, the Resident was able to complete the procedure. While writing orders, RESIDENT #3 received a code page (cardiac arrest) and left to attend to the emergency. The original patient later went into cardiopulmonary arrest secondary to tension pneumothorax. (Present as a note, or a chart entry, or???) INTERIOR/DAY - HOSPITAL AUDITORIUM A patient's case is being presented at an M&M conference. An M&M conference can be a shining example of Practice-Based Learning and Improvement and System-Based Practice at their best, or worst.
5.5.1.	Between the attending's confrontational manner and the resident's failure to take responsibility for a mistake, this M&M conference deteriorated into a finger pointing exercise that benefits no one.	To replay this scene to see how it could be improved by the skillful application of: • Taking responsibility for errors • Partnering with team members • Collaborative decision-making • Practice-based learning and improvement Click here.

#	Audio	Visuals
5.5.2.	RESIDENT #3 "Mr. Young is a 60 year old male with emphysema requiring a subclavian line for vascular access. I placed the subclavian line with some minor difficulty and about two hours later he had a cardiopulmonary arrest after a tension pneumothorax. We successfully resuscitated him but he ended up staying in the ICU four more days." DOCTOR #1 "Well, did you see the chest x-ray after the procedure?" RESIDENT #3 (nervously clears throat and takes a deep breath) "I did not personally view the film at the time because I was called to a code immediately after the procedure. The chest film obtained after the procedure did show a subtle but definite pneumothorax. I know that ultimately I am responsible to check the images on procedures I perform; however, I mistakenly believed at the time that radiology would alert me to any problem. After Mr. Young's complication, I did some research. I discovered that pneumothorax is a common problem after subclavian line placement and it occurs in approximately four percent of cases at this institution, somewhat dependent on the level of experience of the person doing the procedure. I also discovered that there is no set policy on the immediate review of the images by radiology for these types of procedures. I discussed with other residents how they might have handled being torn between two responsibilities. They suggested using the resources around me, such as asking the nurse or radiology technologist to have radiology review the film immediately and text page me with a report. I invited some radiologists here today to discuss their findings on a chest film in cases of pneumothorax to help us understand and improve our system to better address the issues raised by this case." DOCTOR #2 (from back of room) "Before we get into that discussion, did an incident report get filled out? Was this error discussed with the patient?"	INTERIOR/DAY - HOSPITAL AUDITORIUM A patient's case is being presented at an M&M conference.

#	Audio	Visuals
5.5.3.	Several of the skills in the ACGME competencies were applied here. First, the resident took responsibility for the error. Then he gathered the available data, reviewed the available data with an eye toward improved patient safety, and Demonstrated investigatory, and analytic thinking. This lead to a practice improvement plan.	Photo of physician reviewing stacks of charts Competencies Illustrated: • Report and takes responsibility for personal errors and misjudgments • Gather appropriate information • Manages health care information about patients to improve patient safety • Analyzes practice experience and performs practice-based improvement activities
5.5.4.	Then by developing a new protocol collaboratively with contributions from the rest of the team he was able to ensure patient safety by analyzing how patient care decisions affect the patient and the entire health care system.	Competencies Illustrated: • Work with other health care professionals • Encourage collaborative decisions with contributions from other health care professionals • Manage health care information about patients to improve patient safety • Understand the impact of patient care decisions on the patient and the entire health care system. Manage health care information about patients to improve patient safety
5.5.5.	This story started with a simple oversight, and by applying aspects of all six of the competencies, the resident improved the chances for positive outcomes for many patients. This is exactly what the competencies are all about. It is not about preventing mistakes, it is about learning from mistakes. Take a moment now to reflect in your journal on a mistake you made, and how you applied, or could have applied the skills of the competencies to the situation.	**Journal 7** **Journal Exercise:** Describe a mistake you made in your practice. What did you do? What could you have done differently? Which of the competency skills apply to your situation? More information on medical errors: • Link to OHSU Incident report (http://ozone.ohsu.edu/HealthSystems/admin/1-07.htm) • Link to article on medical errors

#	Audio	Visuals
5.6	V.O. What kind of statement are you making if you are drinking on call? If you are on call and intoxicated? DOCTOR #1 (laughs) "Trust me, that is exactly how it happened!" As the group continues laughing, the doctor's pager audibly beeps. Excusing the interruption, DOCTOR #1 checks pager. The group quiets down, centering attention on the doctor's actions as he/she ignores the page. DOCTOR #1 "Excuse me. Hmm, maybe I should set this darn thing to vibrate." DOCTOR #1 tucks pager back into pocket and returns to conversation. DOCTOR #1 "So, anyway…" Again, the pager beeps. This time, DOCTOR #1 doesn't even bother looking at it, continuing to talk. DOCTOR #1 "As I was saying…" PARTYGOER "Gee, is that an emergency? Aren't you on call tonight?" DOCTOR #1 (nonchalant, dismissive) "No big deal. I'll be back there in an hour anyway. Someone else can get it for now."	**Video of doctor at cocktail party.** INTERIOR/NIGHT - Residence? Lounge/Bar? At a drug company reception, DOCTOR #1 is enjoying him/herself with a few drinks and conversation with new friends. With a glass of wine in hand, DOCTOR #1 is telling a story to an appreciative audience. .

#	Audio	Visuals
5.6.1.	Physician impairment is a serious issue. Whether a doctor is impaired by alcohol, drugs, or some other factor, we all understand the importance of putting our patient's safety and well-being first. Whether or not the physician in this case is sacrificing his patient's care with a cocktail, there is another issue in play here. He has contributed to a *perception* of either impairment, or a lack of regard for his patients. That negative perception can be as dangerous as the impairment itself.	About Impaired Physicians: (expands to show following paragraph.) Physician Impairment is a serious issue and physicians who are impaired must not assume patient responsibilities. If there is doubt, they must seek assistance in caring for their patients. All physicians are responsible for ensuring patient safety and must assist impaired physicians in seeking help. Physician impairment is not just about substance abuse. A physician may be considered impaired due to cognitive deficiencies, other mental health issues, lack of professionalism, and/or other issues. If you suspect that a physician is impaired, you have the responsibility to bring this concern forward to the appropriate medical leader, such as your faculty mentor, program director, departmental chair, or the Dean of Graduate Medical Education. You may also choose to approach him/her also with your concerns. Reporting concern is not a breach of confidence; it is insuring patient safety and physician wellness. **Journal 8** It is important to be aware of the messages you send to the public about yourself and the medical profession. • Describe a situation where you, or someone else, was under this kind of microscope and ended up sending an inadvertent message. • Who perceived it? • What happened, or could have happened? How could the negative perception have been avoided?
6. Self-Assessment		
6.1	This portion of the course is for residents' self-assessment. You will rate yourself on the skills, knowledge and attitudes that define the competencies. After you complete your self-assessment, your program director will review it, and compare it to other assessments of your performance. This will reveal any gaps between your assessment of your yourself and how others see you. Remember that this is a formative assessment, not a final exam. A low score on a particular item means that this is an area for future development. It is not a mark of past failure.	Self-Assessment OHSU Physician Performance Developmental Inventory Directions (goes to next screen as an aside)
6.1.1.	The Physician Performance Diagnostic Inventory (PPDI) is an assessment that measures learning and performance progress. The progressive stages are early learner, competent, proficient, expert, and unsatisfactory (when learning problems are not developmental). The PPDI is used to assess resident and faculty perceptions of performance, and create an individualized learning and evaluation plan for the learner (**formative**). It may also be used with support from other evaluations to guide **summative** or final evaluation.	**How to use the Physician Performance Diagnostic Inventory:** (use process map from last page of PPDI)

#	Audio	Visuals
6.1.2.	Step One: Resident, Program Director and Faculty members complete the PDDI	Show an assessment
6.1.3.	Step Two: After completing the PPDI, program directors discuss with residents the differences between formative, summative, single, and global evaluations.	o Single evaluations capture performance ratings on a single event and generally occur directly after the demonstration of a knowledge, skill, or attitudinal performance. o Global evaluations cover more than one performance event, and are often summative. o Formative evaluations provide feedback on performance and identify areas for learning and improvement. o Summative evaluations are summary, or final, evaluations of performance.
6.1.4.	Step Three: Program Directors and/or other faculty mentors meet one on one with each resident to review the resident's developmental ratings on the ACGME competency areas. In this review, the resident and program director will discuss the resident's self-assessment, the faculty's composite assessment, differences between these two assessments, and competency areas for future focus and development.	Photo of resident and program director
6.1.5.	Step Four: Based on information from the PPDI, the program director and resident create an individualized learning and evaluation plan to teach and assess the knowledge, skills, and attitudes necessary for achievement of competency (proficiency/expertise) in each of the previously identified ACGME competency areas.	Learning Plan
6.1.6.	Step Five: Resident performance assessments at six-month intervals allow each resident to provide evidence of improvement in each identified competency area based on evidence from earlier formative evaluations. The resident's individualized learning plan will be adjusted to reflect their present level of performance and to address areas for future learning focus.	All steps now "lit up".
6.1.7.	Take a moment to review the OHSU Developmental Assessment Scale to review the differences between the categories shown. (No other audio for this section.)	**UNSATISFACTORY** **Rarely demonstrates competence AND is unexpected to become competent within the assigned time frame**. Consistently makes poor decisions or has a consistently unsatisfactory approach to solving problems that results in poor care delivery or unacceptable behavior. Repeatedly appears incapable of understanding concepts, performing tasks, exercising judgment or demonstrating behaviors that are important to show ability to learn the element being evaluated. SELECTING THIS RATING REQUIRES A DETAILED COMMENT

#	Audio	Visuals
6.1.8.		**EARLY LEARNER** **Demonstrates competence occasionally; usually shows ability to learn in routine, repetitive or non-stressful situations. Requires supervision**. Incapable or inconsistent in using experience to address circumstances that are unexpected or non-typical. The early learner is at a novice level and shows aptitude but has not yet had sufficient experience, training or skill acquisition to achieve competence. Unlike the unsatisfactory (who believes they already know it all), wants to engage in learning. (photo of person carefully riding bike, like the training wheels just came off)
6.1.9.		**COMPETENT** **Demonstrates competence most of the time and under routine circumstances**. **Can perform without supervision in usual or predictable circumstances**. Has developed adequate internal resources, knowledge or skills to make good decisions or perform acceptably in routine cases. IMPORTANTLY, the competent physician recognizes limitations and accesses support when needed, especially for more challenging situations. This is the level expected from those at the completion of training and indicates that they can effectively address the majority of routine situations and will access support when needed in other cases. (photo of person riding bike, signaling turns, etc.)
6.1.10		**PROFICIENT** **Demonstrates competence most of the time and under most circumstances through applying intuition to guide an analytical thought process in complex and unpredictable situations**. Has a good grasp of information, excellent skills and sound principles and applies them to guide actions in unusual or challenging circumstances. Is consistently trusted to deal effectively with complex problems. Has developed enough internal understanding, ability to flexibly apply knowledge and sufficient skills that they can reliably handle challenging situations without the need for external support. (bike messenger-like photo)

#	Audio	Visuals
6.1.11		**EXPERT** **Demonstrates competence almost always through understanding the conceptual whole with appropriate intuitiveness and adaptability to the circumstance**. Can recognize errors or inadequacies in knowledge, judgment, skills or behavior in complex situations and is capable of effective remediation. Is a persuasive lifelong learner. Understands the contextual "whole" and is fluid and flexible in performance. Has a seeming 6th sense (or a well developed "internal gyroscope") of how to respond to even the most unpredictable and challenging situations. Is a resource mentor, teacher, and role model in this area. (Lance Armstrong-like photo)
6.1.12		**U Unable to Evaluate** You have not yet had the opportunity to demonstrate this skill. (Photo of bike leaning against the wall)
6.1.13	Please review the guidelines for completing the self-assessment. It will take about 20 minutes to complete the assessment. If you have done the self-assessment before, your previous responses will be over written. If you have not already done so, you can click the "Print Now" button to print your previous scores.	Guidelines: • Complete all items in the assessment at one time. There are 39 skills to evaluate. • When you finish your assessment, print it out so that you can put it in your portfolio. • The computer saves the scores you give yourself and the date of your assessment so your program director can review it. • You can do the self-assessment as often, or whenever you like. The computer saves only the last one you do. Be sure to print and save earlier scores in your portfolio before completing the assessment again. To start your assessment click the PPDI button now. (Indicate the button.) If you prefer to complete a paper-based assessment click here to "Print a blank self-assessment form"
6.1.14	Rate your current level of performance for each of the following skills.	This launches in a new window. Be sure to review the Self-Assessment portion of the course before completing the Physician Performance Developmental Inventory. Rate your current level of performance for each of the following skills: "Print my latest self-assessment" (Tech question: Can this only appear after the learner has actually completed a self-assessment?) (These present individually, and as soon as the learner selects a score, the next one presents until they get to the end. The level descriptions will expand when the icon is clicked as described above.)
		PATIENT CARE

#	Audio	Visuals
		Demonstrates **compassionate** (caring, and respectful) behaviors Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Gathers appropriate **information** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Makes **informed** decisions that includes patient preferences Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Develops patient management **plans** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Counsels and educates patients and their families Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Uses **evidence-based** practices to support patient care decisions Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Promotes health care services aimed at **preventing** health problems or maintaining health Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Works well with others in the health care profession. Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		MEDICAL KNOWLEDGE
		Demonstrates **knowledge application** of the basic and clinically supportive sciences which are appropriate to their discipline Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Demonstrates critical, investigatory, and **analytic thinking** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Performs invasive procedures considered essential for his/her area of practice (e.g. **technical skill**) Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		PRACTICE-BASED LEARNING AND IMPROVEMENT
		Utilizes **personal reflection** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Analyzes practice **experience** and **performs** practice-based **improvement** activities Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Evaluates evidence from scientific studies Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Applies **knowledge** of **study design** and **statistical** methods to evaluate scientific information Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Utilizes on-line medical information and other **technologies** to support education Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Facilitates the **learning** of others Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate

#	Audio	Visuals
		INTERPERSONAL AND COMMUNICATION SKILLS
		Addresses tense or difficult issues and discusses controversial topics Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Encourages collaborative decisions with contributions from other health care professionals Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Creates and sustains **ethically sound relationships**
		Uses effective **listening skills** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Communicates effectively with patients Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Reads nonverbal cues in order to understand the experience of others Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Communicates (verbally and in writing) effectively about patient conditions **with other health care professionals** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		PROFESSIONALISM
		Provides **effective leadership** as a member of an interdisciplinary team Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Models **appropriate followership** as a member of an interdisciplinary team Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Understands divergent points of view Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Demonstrates **integrity** (respect, honesty and trustworthiness) Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Demonstrates **accountability** and **responsiveness** to the needs of patients and society **that supersedes self-interest** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Demonstrates a **commitment** to on-going **professional development** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Demonstrates a commitment to **ethical principles** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Manages his/her **emotions and behaviors**, especially during time of stress Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Demonstrates **sensitivity** and responsiveness to **culture, race, gender, age, and/or disabilities** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate

#	Audio	Visuals
		Reports and takes **responsibility for** personal **errors** and misjudgments Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		SYSTEM-BASED PRACTICE
		Understands the impact of patient care decisions on the patient and the entire health care **system** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Practices **cost-effective** health care and resource allocation that does not compromise quality of care Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Assists patients in dealing with system complexities Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
		Partners with health care managers and **system providers** Un-satisfactory | Early Learner | Competent | Proficient | Expert | Unable to Evaluate
6.2	Your self-assessment is now complete. You can print it out now, or later. If you chose not to print it now, be sure to print it before redoing it or your responses will be overwritten.	Thank you for completing the self-assessment. Click "Print Now" to print out your assessment If you do not print the assessment your responses will be saved until the next time you answer the questions, but then they will be overwritten.
7. Course Evaluation and Completion		Course Evaluation and Completion (This section is tied to course completion of 95% of the screens. It does not appear in the menu. As soon as the learner completes 95% of the course, a message displays. Also available from home page after completion.)
7.1	Fan fare Congratulations! You have completed the Introduction to the ACGME Competencies Web-Based Training. Please take a moment to rate the course. After answering the following questions, print your Certificate of Completion.	"Start Course Evaluation"

	Course Evaluation (Onscreen only)
1. The course was useful in helping me understand the ACGME core competencies. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5	
2. The course concentrates on teaching concepts and solid skills Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5	
3. The course design and content format are user-friendly. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5	
4. The course is concise and avoids unnecessary jargon. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5	
5. The course content is technically accurate. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5	
6. The course uses appropriate tone and voice for audiences. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5	

#	Audio	Visuals
7. The course is easy to navigate. Features and controls are clearly labeled and explained. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
8. Course previews, introductions, reviews and summaries are helpful. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
9. The course's stated assumptions about learner knowledge are appropriate. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
10. Course makes appropriate use of journal for reflective and active learning. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
11. Length of course sections was appropriate to meet the stated objectives. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
12. Course structure was flexible enough to work with my schedule Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
13. Course visuals are clear, appealing and educationally useful. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
14. Examples provided are relevant and meaningful. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
15. Course headings, sub-headings and organization make sense. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
16. Course motivates learners by explaining benefits and relevance of content. Rarely-Seldom-Usually-Mostly-Always 1 – 2 – 3 – 4 – 5		
17. If you rated the course 1 or 2 on any of the above questions, please explain: _____		
18. Comments: What did you like, or dislike? What would you like to see changed? (free text) _____		

#	Audio	Visuals
7.2	Thank you for your feedback. You can click "Print Certificate" now to print your certificate of completion. You can continue to use the Library, Dictionary, and Journal to support your ongoing education.	"Print Certificate"

#	Audio	Visuals
7.2.1.	A special note of thanks to Jamie Dickey….(from the Thanks Jamie video)	(Note of thanks from Dr. Girard in video. Include screen capture of Jaime in her Academy Award winning portrayal of the Jehovah's Witness patient when Don says her name.) Following is OST, small print or self scrolling like movie credits. If it is movie credits, we can put titles or duties above their names: This program is a collaborative project between **Oregon Health and Science University** / **Planet Productions, Inc.** Dr. Don Girard / Dean McCrea Jamie Dickey, PhD / Jan Foster Dr. Ross Ungerleider / Aixé Djelal Dr. Jim Anderson / Jerry McCorkle Susanna Lai / Robin Coleman Susanne Briggs / Bryan Ledford Jon Brenard / Dean Williams Erhan Ergenekan Mike Hiveley Josh Bennett Lynn Redlin Richard Moore Kelley Baker and many others
	END	END

Resources

Title	Description	Target
Dreyfus's ladder of competence	Table describing and showing examples of the stages of mastery	Dreyfusexamples.pdf
Systems thinking overview	Article on Systems Thinking by Daniel Aronson	OverviewSystemsThinkingArticle.pdf
Professionalism in medicine	Article by Drs. Cruess and Cruess	Professionalism_defined.pdf
Medical Competence	Building and Assessing Competence by David C. Leach, M.D., Executive Director of ACGME	davidleach.ppt
Physician Credentialing	Credentialing Physician Specialists: A World Perspective	Credentialing%20Physician%20Specialists.pdf
ACGME General Competencies	Full version of ACGME competencies	ACGME_GENERAL_COMPETENCIES.pdf
Providing Feedback	How to provide feedback to students	http://www.ou.edu/idp/tips/ideas/quick11.html
Feedback Checklist	A checklist for giving feedback	http://www.uchsc.edu/CIS/FdbkChkList.html#anchor1716402
What Patients Really Want	Presentation on patient centered care Barbara Glidewell, RN, MBS, CEC Patient Advocate/Ombudsman, OHSU	WHAT PATIENTS REALLY WANT4.ppt
Professional Attitudes, Communication & Interpersonal Skills for Surgeons	Presentation by Jamie Dickey, PhD and Ross Ungerleider, MD	Surgeon attitudes.ppt
Physician Wellness	Presentation by Jamie Dickey, PhD and Ross Ungerleider, MD	Residentwellness.ppt
Professional Attitudes, Communication & Interpersonal Skills for Surgeons	Information on skills, knowledge, and attitudes important to all physicians	Professional Attitudes Communication _ Interpersonal Skills 2.ppt
Portfolio Assignment for Systems-Based Practice	Sample of questions to address when discussing or journaling on systems-based practice	Portfolio Guidelines to Facilitate a Discussion on Change.doc
TOOLBOX FOR ETHICAL DECISIONS	The Science of "doing" right by Barbara Glidewell, MBS, CEC	medical ethics slides.ppt
Communications and Malpractice	Good Communication Is a Key Factor in Avoiding Malpractice Suits	Good Communication Is a Key Factor in Avoiding Malpractice Suits.htm
Communicating Bad News	Breaking Bad News to Families Barbara Glidewell, MBS, CEC	Breakin1.ppt
Building Teams	Creating and Developing Effective Interdisciplinary Cardiac Teams, Jamie Dickey, PhD	Creating and Developing Effec 2.ppt
Physicians and Their Human Response	How doctors can improve communications and connections by developing a healthy self- and system-view	Human Response.ppt

The Paradigm Shift in Medical Education	Systems-based practice changes medical education	JDUParadigm.ppt
OHSU PPDI	Physician Performance Developmental Inventory	
PPDI Instructions	Instructions for using the PPDI	Ppdi_instructions.pdf
Disclosing Medical Errors	Discussion Leader's Guide: Disclosing Medical Errors	Discussion_Medical_Errors.pdf
Medical Error Procedures	Patient Safety / Quality Concern Reporting Procedures	Error_Cue_Card.pdf

Glossary

Professionalism:

Systems-based practice:

Communication:

Medical Knowledge:

Practice-based learning:

Easter egg:

Novice:

Advanced Beginner

Early Learner

Competent

Proficient

Expert

Activists

Reflectors

Theorists

Pragmatists

Accreditation:

Accreditation refers to the recognition of educational programs through review against particular standards. In the United States, accreditation is voluntarily sought by institutions and is conferred by non-governmental bodies. There are two types of educational accreditation: specialized and institutional. The ACGME is a specialized body, accrediting graduate medical education programs within an institution. Accreditation of graduate medical education training programs by the ACGME is accomplished through a peer review process and is based upon established standards and guidelines. The ACGME does not accredit institutions, but rather, recognizes them to sponsor GME programs.

ACGME Outcome Project:

The two major goals of the ACGME Outcome Project are to ensure: 1) that residency program educational content is aligned with the changing needs of the health care system; and, 2) that residency programs have outcome assessment systems that provide sound measures of the programs' educational effectiveness. To accomplish these goals, the ACGME has identified the six general competencies, grounded in a national consensus on what residents should know and be able to do. Language regarding the general competencies and increased emphasis on outcomes assessment has been added by the Residency Review Committees and the Institutional Review Committee to all core specialty program requirements and to the Institutional Requirements. Eventually, over the long term, changes to the accreditation process will reflect the shift to outcomes assessment.

Assessment:

In his book, Classroom Assessment, (Airasian PW. Classroom assessment (3rd ed.) New York: McGraw-Hill, 1997), Airasian defines assessment as the "process of collecting, synthesizing, and interpreting information to aid decision-making." (See further, "Considerations for Selecting and Implementing Assessment Approaches/Instruments.")

Certification:

The intent of the certification of physicians is to provide assurance to the public that a physician specialist certified by a Member Board of the American Board of Medical Specialties (ABMS) has successfully completed an approved educational program and an evaluation process which includes an examination designed to assess the knowledge, skills, and experience required to provide quality patient care in that specialty (taken from the ABMS Annual Report and Reference Handbook). Physicians who are successful in achieving certification are called diplomates of the respective specialty board.

Core Curriculum:

The term "core curriculum" is not an official term used in any of the ACGME's requirements. The term, however, has developed among practitioners when referring to those elements of a resident's curriculum common across all specialties. These common elements are now incorporated into the general competencies. The competencies themselves do not constitute a curriculum. Rather, they are the organizing principles upon which a core curriculum can be developed.

Curriculum:
A curriculum is a formal educational plan based on results of a needs assessment, and including goals and objectives developed to meet the needs identified, educational activities through which the plan is implemented, and evaluation of the plan with feedback to provide continued improvement in the educational process.

Dreyfus Model:
The research of Hubert and Stuart Dreyfus demonstrated what has become a widely accepted model of how individuals progress through various levels in their acquisition of skill. The Dreyfus brothers labeled individuals in these progressive stages as novice, advanced beginner, competent, proficient, and expert. These stages should be reflected in curriculum planning when considering at which appropriate levels residents should be introduced to particular skills.

Educational Taxonomy:
Taxonomies were developed in recognition that learning occurs in various domains, i.e., cognitive, affective, and psychomotor. Most often, taxonomies are used with regard to cognitive learning. While Benjamin Bloom and his colleagues developed the most recognized taxonomy, other individuals such as Marzano have proposed other taxonomies that organize cognitive knowledge in different ways. Taxonomies are useful in the development of educational objectives since they typically use particular verbs to specify desired learner behaviors that can be assessed at each level of knowledge acquisition.

Formative Evaluation:
In formative evaluation, findings are accumulated from a variety of relevant assessments designed for use either in program or resident evaluation. In resident evaluation, the formative evaluation is intended to provide constructive feedback to individual residents during their training. In program evaluation, formative evaluation is intended to improve program quality. In either situation, formative evaluation is not intended to make a go/no-go decision.

General Competencies:
The six general competencies endorsed by the ACGME at its September 1999 meeting are patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice. Language related to the general competencies has been added by the Residency Review Committees to each set of core Program Requirements and by the Institutional Review Committee to the Institutional Requirements. The competencies act as organizing principles for the curricula of all core specialty programs and reflect the expectation that graduating residents should exhibit behaviors reflective of these competencies at a level appropriate to an independent practitioner. The American Board of Medical Specialties (ABMs) has also endorsed the general competencies for use by certifying boards in the examination and recertification of physicians.

Generalizability:
Measurements (scores) derived from an assessment tool are considered generalizable if they can be shown to apply to more than the sample of cases or test questions used in a specific assessment.

Goal (educational):
An educational goal states the broad target of an educational effort. Goals are typically not measurable, but offer a general focus for an activity or set of experiences.

Graduate Medical Education Core Curriculum (AAMC):
This report from an AAMC working group presents five domains of learning that comprise the core curriculum: biomedical ethics, scholarly medical practice, communication in medicine, medical professionalism, and the healthcare system. For each domain, the report presents examples of measurable learning objectives. The terminology used to identify the domains differs from the general competencies. However, a table identifying parallel relationships between the competencies and the domains provides easy reference for how the objectives can be incorporated into GME competency-based curricula.

Objective Educational:
An educational objective is a measurable target to be achieved by an educational activity or intervention. The educational objective specifies the educational outcome to be assessed.

Outcomes Assessment (educational):
Outcomes are results providing evidence that goals and objectives have been accomplished. In the context of the ACGME Outcome Project, educational outcomes assessment refers to intermediate or end results of the educational process. General categories of outcomes relevant to determining educational program effectiveness include: student/resident outcomes (e.g., learning or development of knowledge, skills, and attitudes); graduate/alumni outcomes; faculty outcomes (e.g., improved teaching, increased knowledge, etc.); patients and society in general (e.g., better treatment, access to care, improved health); departmental outcomes (e.g., improved facilities, clinical benchmarks, etc.); and institutional outcomes (e.g., improved quality rating, staff satisfaction, etc.) Outcomes can occur (and be measured) at any time or point in a process, such as during a patient encounter, during a conference, throughout a rotation, throughout the educational program, etc. Outcomes can be immediate, short term, delayed, and long term.

Reliability/Reproducibility/Dependability:
A reliable test score means that when measurements (scores) are repeated, the new test results are consistent with the first scores for the

same assessment tool on the same or similar individuals. Reliability is measured as a correlation with 1.0 being perfect reliability and below 0.50 as unreliable. Evaluation measurement reliabilities above 0.65 and preferably near or above 0.85 are recommended. The terms reproducibility and dependability are often used interchangeably with reliability.

Summative Evaluation:

In summative evaluation, findings and recommendations are designed to accumulate all relevant assessments for a go/no-go decision. In resident evaluation, the summative evaluation is used to decide whether the resident qualifies to continue to the next training year, should be dropped from the program, or at the completion of the residency, should be recommended for board certification. In program evaluation, summative evaluation is used to judge whether the program meets the accepted standards for the purpose of continuing, restructuring, or discontinuing the program.

Validity:

Validating assessment measures is a process of accumulating evidence about how well the assessment measures represent or predict a resident's ability or performance. Validity refers to the specific measurements made with assessment tools in a specific situation with a specific group of individuals. It is the scores, not the type of assessment tool that are valid. For example, it is possible to determine if the written exam scores for a group of residents are valid in measuring the residents' knowledge, but it is incorrect to say that "all written exams" are valid to measure knowledge.

PC FISH screensaver, fish_principles_setup.exe