




***Honoring Our Covenant with  
Society:***  
**At the Crossroads of Quality and  
Medical Education**

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In honor of  
***Kathy Munning Simon, Ph.D.***  
who always reminds us that medical  
education is about the patient and  
nothing else



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Subject: Send me the handout

# Overview

1. There is a quality problem in medicine
2. We are, in part, responsible, which is a good thing!
3. Transformation of medical education, while difficult, will transform medical practice
4. We have the tool – CBE!

# Robert M. Pirsig on Quality

“You know what it is, yet you don't know what it is.”







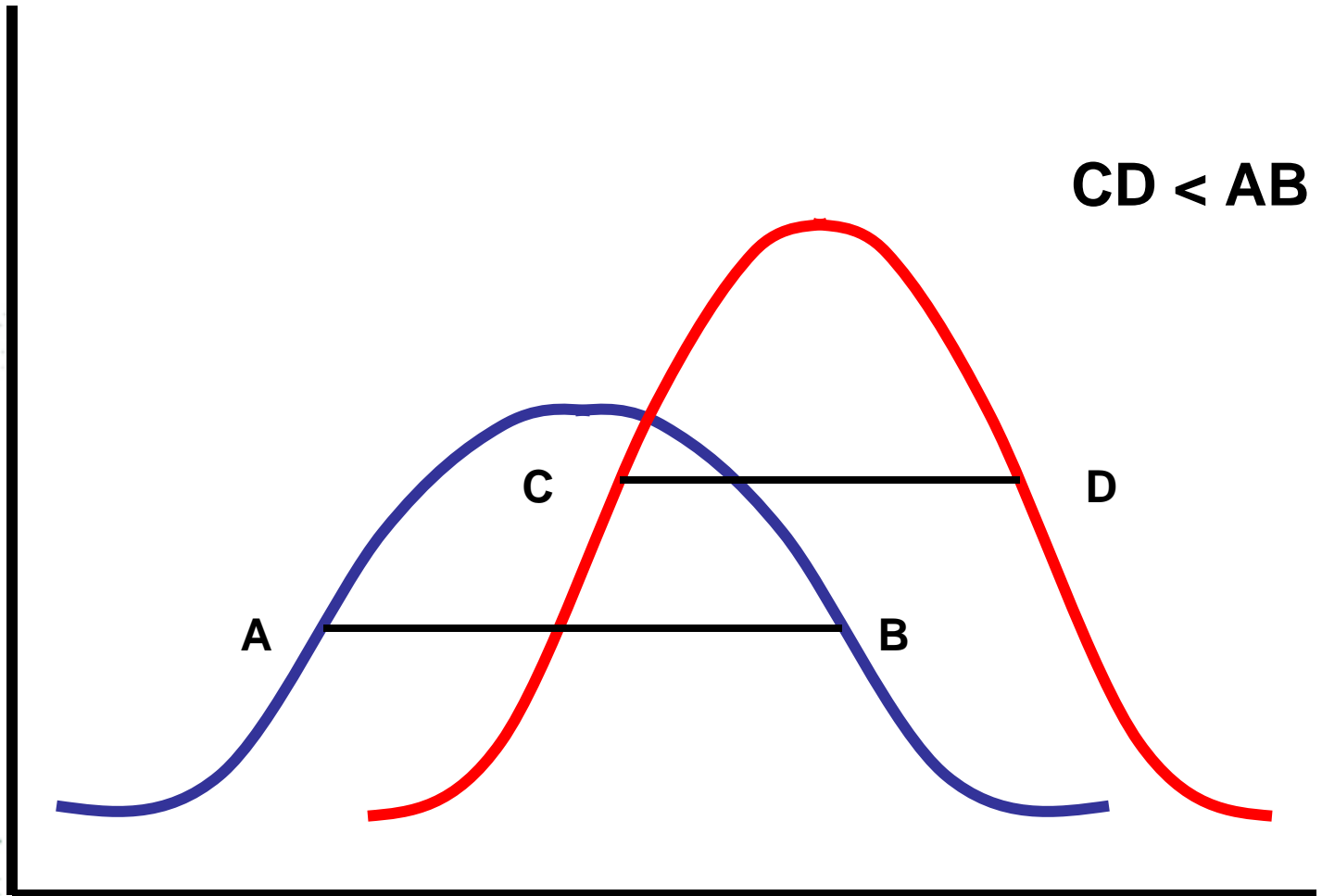






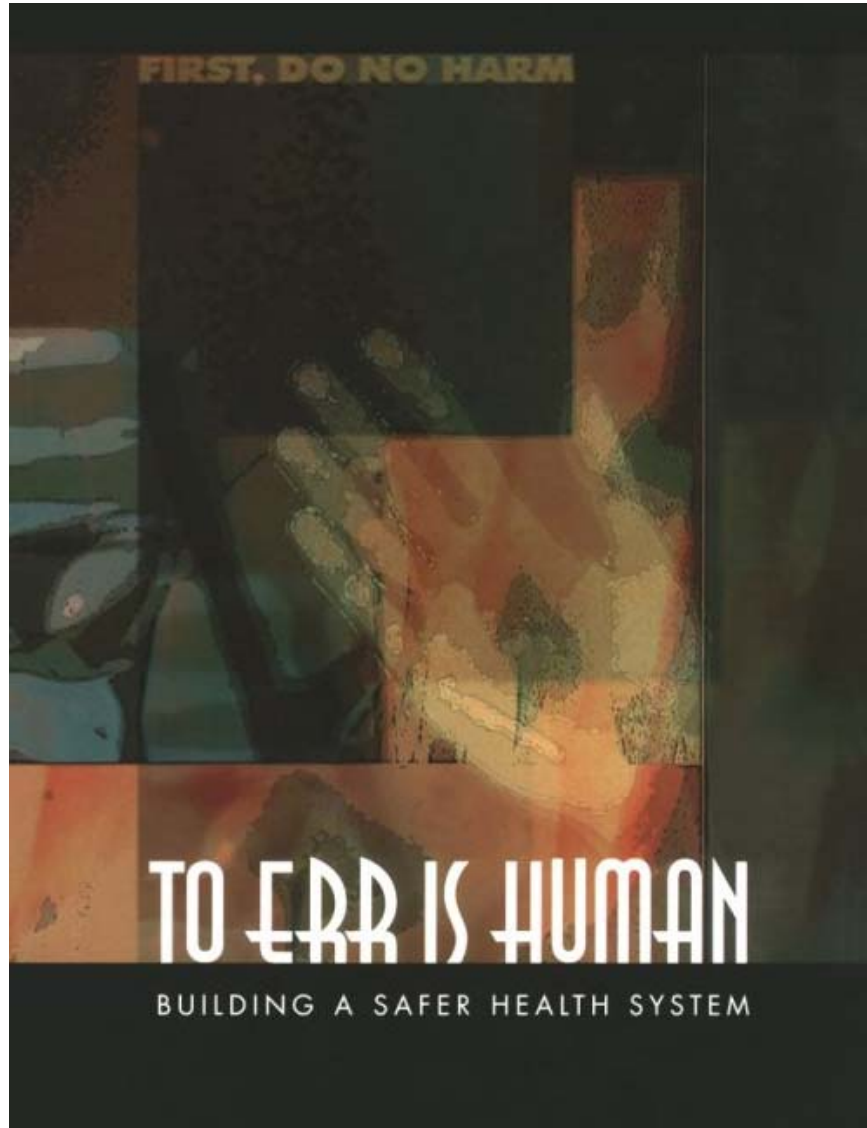
**Quality results from  
minimizing variation**


# Lessening Variation





# **1. There is a quality problem in medicine**



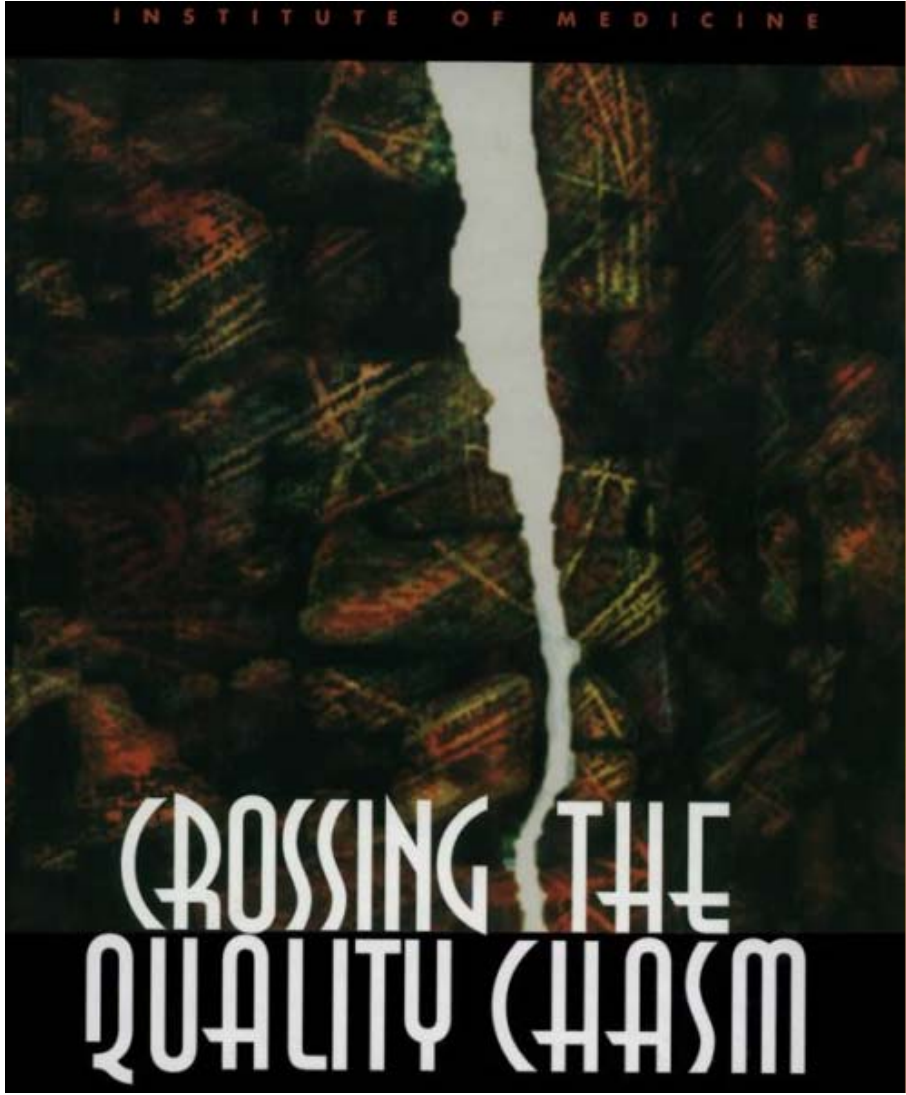


**Between 44,000 and  
98,000 persons die in  
American hospitals each  
year as a direct result of  
medical error.**

# To Err is Human

- Four-tiered approach to achieve a better safety record
  - Establish a **national focus** to create leadership, research, tools and protocols to enhance the knowledge base about safety
  - **Identify and learn from errors** via a nationwide public mandatory reporting system
  - **Raise performance standards** through the actions of oversight organizations, professional groups and group purchasers of health
  - Implementing **safety systems** in HCO's at every level







# Crossing the Quality Chasm

- Safety
- Effectiveness
- Efficiency
- Timeliness
- Patient-centeredness
- Equity (impartiality, justice)





**The Dartmouth Atlas  
of Health Care**

A decorative vertical strip on the left side of the slide, featuring a green chalkboard background. It includes two pieces of pink chalk, one standing upright and one lying horizontally. There are also some white chalk markings, including a curved line and a large, faint letter 'Y'.


**2. We are, in part,  
responsible, which is a  
good thing!**



[http://www.itellix.com/images/donut\\_of\\_quality.gif](http://www.itellix.com/images/donut_of_quality.gif)

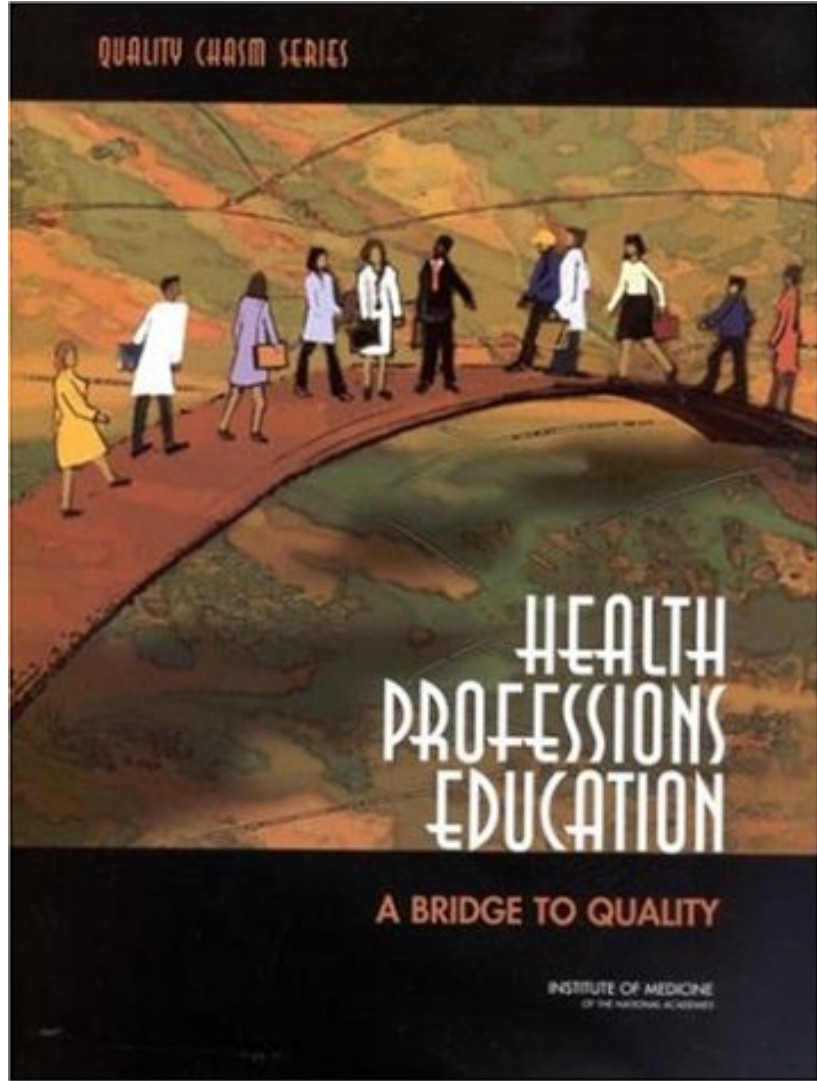
# Quality

- Continuous Integration
  - What varies within all that is medical education? Are we measuring it?
- Peer Reviews
  - Do we allow others to see what we do on behalf of identifying best practices in education and areas for lessened variation?
- Auto-Generated Documentation
  - Does our teaching generate a record to be examined?
- Issue Tracking
  - Once identified, do we monitor progress as a result of our improvements?
- Automated Testing
  - Do we have ways of spot checking our educational work?



Aron DC, Headrick LA. Educating physicians prepared to improve care and safety is no accident: it requires a systematic approach. Qual Saf Health Care 2002;11:168-173.

- **Few newly qualified physicians have the skills necessary to improve care and patient safety.** These include:
  - Ability to perceive and work effectively in interdependencies
  - Ability to understand work as a process
  - Skill in collecting, aggregating, analyzing, and displaying data on processes and outcomes of care
  - Skill in designing healthcare processes
  - Ability to work in teams and in collaboration with managers and patients
  - Willingness to examine honestly and learn from mistakes



# A Bridge to Quality 1


- The report says that doctors, nurses, pharmacists and other health professionals are **not being adequately prepared** to provide the highest quality and safest medical care possible, and there is insufficient assessment of their ongoing proficiency.



# A Bridge to Quality 2


- Educators and accreditation, licensing and certification organizations should ensure that students and working professionals **develop and maintain proficiency in five core areas:**
  - delivering patient-centered care,
  - working as part of interdisciplinary teams,
  - practicing evidence-based medicine,
  - focusing on quality improvement and
  - using information technology





Kao, A, Lim M, Spevick J, Barzansky B. Teaching and evaluating students professionalism in US Medical Schools, 2002-2003. JAMA (2003) 290(9):1151-2.

- Studies show that **medical students often receive conflicting messages** between what they learn in the classroom and what they observe in the clinical setting about important values to uphold and appropriate behaviors to demonstrate



Lester H, Tritter JQ. Medical error: a discussion of the medical construction of error and suggestions for reforms of medical education to decrease error. *Medical Education* 2001;35:855-61.

- A more theoretically informed approach may be to **address the genesis of medical thinking about error**, through reforms of aspects of medical education and professional socialization
- Mizrahi: three major mechanisms used by junior doctors
  - Denial
  - Discounting
  - Distancing
- Reform in medical education must include **reform in socialization**

# Socialization

- Cooperation among/within students; covering for one another
- Tribalism
- Feelings of elitism and collegiality
- Sense of exclusivity
- Personal idealism (helping others) deemphasized; professional idealism (desire for status and knowledge) emphasized
- MCQ's downplay the reality of ambiguity/uncertainty
- Completion of courses/grades suggests endpoints in learning
- Students do not witness faculty cooperation
- Core values of "doctoring" may not be the "core values of science"



# Reform in medical education must include reform in socialization

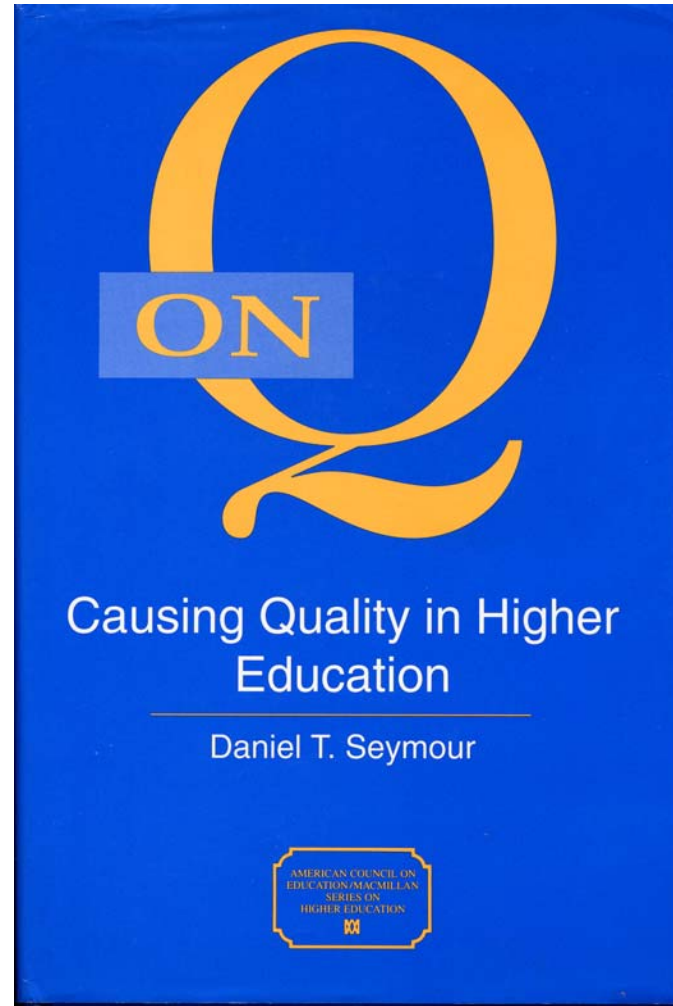
- Stress importance of lifelong professional education
- Strategic medical management for uncertainty
- EBM and PBL
- Emphasize positive value of cooperation in multidisciplinary teams
- Teaching on medical error – move away from name/blame/shame; near miss examination
- Improved communication; actively listening and empathy
- Compassion (instead of blaming patients for their misfortunes)





**3. Transformation of medical education, while difficult, will transform medical practice**

# On Q – American Council on Education/Macmillan Series on Higher Education




# Good Is The Enemy of Great

- There needs to be an **unwillingness to tolerate “good” performance** in order to engage in a quality effort
- Jim Collins: **“Good is the enemy of great.”**



# Causing Quality

- Involves the process of **creating and maintaining an “unshakably” prideful administration, faculty and staff**
  - This is a foundation that emanates from “Commitment Leadership”
    - There can be no culture of quality without **consistent and persistent leadership** throughout the organization
- Lessening Demotivation:
  - degradation, hassling and ignoring
- Motivation:
  - visible, challenging and unwavering expectations; pay attention; get people involved; incrementally solve problems; pride moves with progress; a little praise goes a long way\*




Having a customer orientation, working to understand and improve processes, developing measurement systems, and cultivating a service attitude in everyone, are necessary parts of a strategic quality management effort...but...they are not enough...**quality must be embedded in the institution's heroes**, it must be manifested in the way that the buildings are maintained, it must be evident in how people treat each other, and **it must be at the very essence of what the organization and its members hold most dear**



# System Defenses to Prevent Failure in Medical Education

- Entrance requirements
  - Argues for an assessment relative to outcome competencies as a condition for acceptance
- Curriculum
  - **High Reliability Organization (HRO)** recognize need for teamwork, flexibility, non-punitive
- Organizational Culture
  - (socialization issues, values mismatch between professors and learners – **are we committed to education?**)

Aron and Headrick: Educating physicians prepared to improve care and safety is no accident: it requires a systematic approach.




Steven DP. Finding safety in medical education. *Qual Saf Health Care* 2002;11:109-110

- High Reliability Organizations (HRO)
  - Adopt a culture that centers on mindfulness and **constant attention to failures**
  - **Adapt** organizational structure temporarily to meet unusual situations
  - Constantly **mindful of the unexpected** (Batalden: master)
  - Reliability is a dynamic “non-event”
  - Requires leaders who are **relentlessly committed to safety and reliability**



**Hoff TJ, Pohl H, Bartfield J. Creating a learning environment to produce competent residents: the role of culture and context. Acad Med:2004;532-540**

- Creation of a **supportive, learning-oriented culture is of utmost importance in creating competent physicians**
  - Sustained learning occurs only within contexts that provide supportive conditions (Senge)
  - Components include:
    - Self mastery – individual
    - Shared mental models – individual
    - Shared vision – group
    - Team learning – group
    - Systems thinking –group
- Many of the competencies (OP&OMM, PBL&I, SBP, I&CS) require the core elements of a learning organization




Leach DC. Changing education to improve patient care.  
Quality in Health Care (2001) 10(Supp II):ii54-ii58

- Two sources of change (Senge)
  - Authority
  - Learning
- Five reasons for resisting change
  - Failure to distinguish substance from form
  - Failure to distinguish mental models from reality
  - An educational model that is heavily utilitarian and only partially empowering of our human capacities
  - Lack of time and skill needed to manage and lead change efforts
  - Organizational models that do not facilitate efforts to change

# Resisting Change


- The substance of medicine is relationship (vulnerability, values, dignity, competence, compassion)
  - Current system sabotages relationships
- An educational model that does not **nourish** the teacher/learner relationship is not robust enough to support the contract of discern and obey the truth
- It should be **EASY to do the right thing** educationally and **HARD to do the wrong thing** educationally
- The quality of learning is directly impacted by the **quality of doing**





Whitcomb ME. AAMC Policy Guidance on Graduate Medical Education: Assuring Quality Patient Care and Quality Education. Academic Medicine (2003) 78:111-116.

- Academic community must **rededicate itself to the core educational mission** of GME and focus its attention on **enhancing the learning environments** where GME is conducted




Griner PF. The academic medical center working group of the Institute for Healthcare Improvement. The imperative for quality: a call for action to medical schools and teaching hospitals. *Academic Medicine* (2003) 78:1085-9.

- IHI Impact Network
  - Focused on safety, effectiveness, efficiency, timeliness, patient-centeredness and equity
- Emergence of
  - Interdisciplinary centers of excellence
  - Streamlined governance of faculty practice plans
  - Leadership recruitment and development
    - Less reliance on paper credentials and **more attention to qualities of leadership**
  - **Commitment to quality as an educational priority**


**4. We have the tool – CBE!**






Cohen JJ. Academic medicine's latest imperative: achieving better health care through global medical education standards. *Medical Education* 2003;37:950-951.

“...we can still argue that medicine's most fundamental tenets ... include the established scientific base underpinning our understanding of human biology and behavior; the universal set of genetic, developmental and environmental determinants of disease; the fundamentals of critical thinking, diagnosis and evidence-based therapy common to the core work of all doctors; and the universal array of ethical responsibilities vital to the healing relationship between doctor and patient in virtually every culture”



Epstein RM, Hundert EM. Defining and assessing professional competence. JAMA 2002;287(2):226-35.

The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served.



Shea CA, Plunkett PF. Forum for organizational change in health professions education: summary of the academic organizational approaches to transforming health science education conference. *Journal of Interprofessional Care* (2001) 15(3):297-299

- Integrated team work is essential
- Students and faculty must learn together, not in isolation
- Organizational change is the message; may be many approaches

# Shewart Cycle

- PDCA
  - Plan
  - Do
  - Check
  - Act

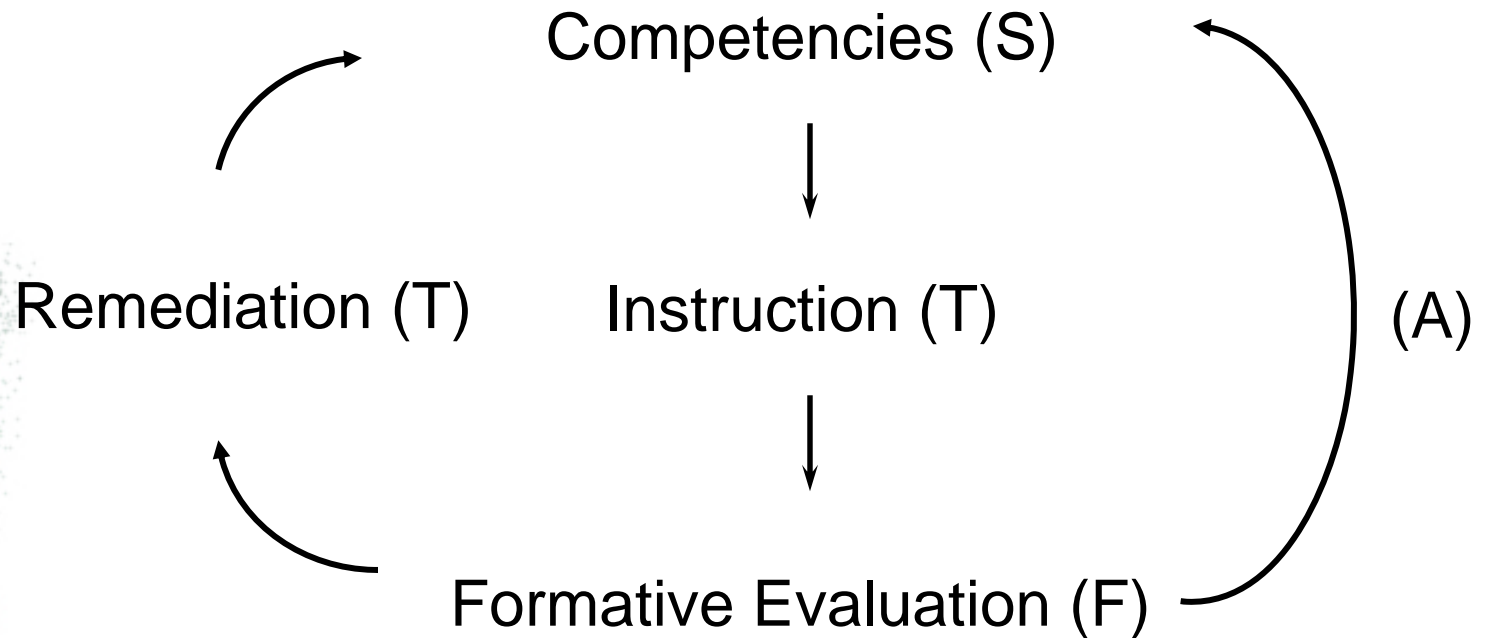


# CBE Cycle

- STFA
  - State
  - Teach
  - Formatively Evaluate
  - Adjust



# Competency Based Education



**“FED” Model**

**-Feedback**

**-Encouragement**

**-Direction**

# Crossing the Education Chasm

- **Safety** – CBE respects learners, teachers and the learning process itself
- **Effectiveness** – it is more likely that learners will attain competence when the outcomes of education are clear and they are given valid, reliable information
- **Efficiency** – clarity of educational purpose saves time and money (Nash's Immutable Rule)
- **Timeliness** – formative evaluation is real-time
- **Patient-centeredness** – the competencies focus on what the patient needs
- **Equity (impartiality, justice)** – because the patient is the focus, education is not “personalized”



# Final Thoughts



BANTAM BOOKS

**"ELECTRIFYING"**  
ONE OF THE MOST PROFOUNDLY IMPORTANT  
BESTSELLERS OF OUR TIME.  
THE FABULOUS JOURNEY OF A MAN  
IN SEARCH OF HIMSELF.



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**ZEN  
AND THE  
ART OF  
MOTORCYCLE  
MAINTENANCE**

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AN INQUIRY INTO VALUES

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**ROBERT M. PIRSIG**


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*NEW YORK TIMES* BESTSELLING AUTHOR OF *LILA*




"Quality is a direct experience  
independent of and prior to  
intellectual abstractions."





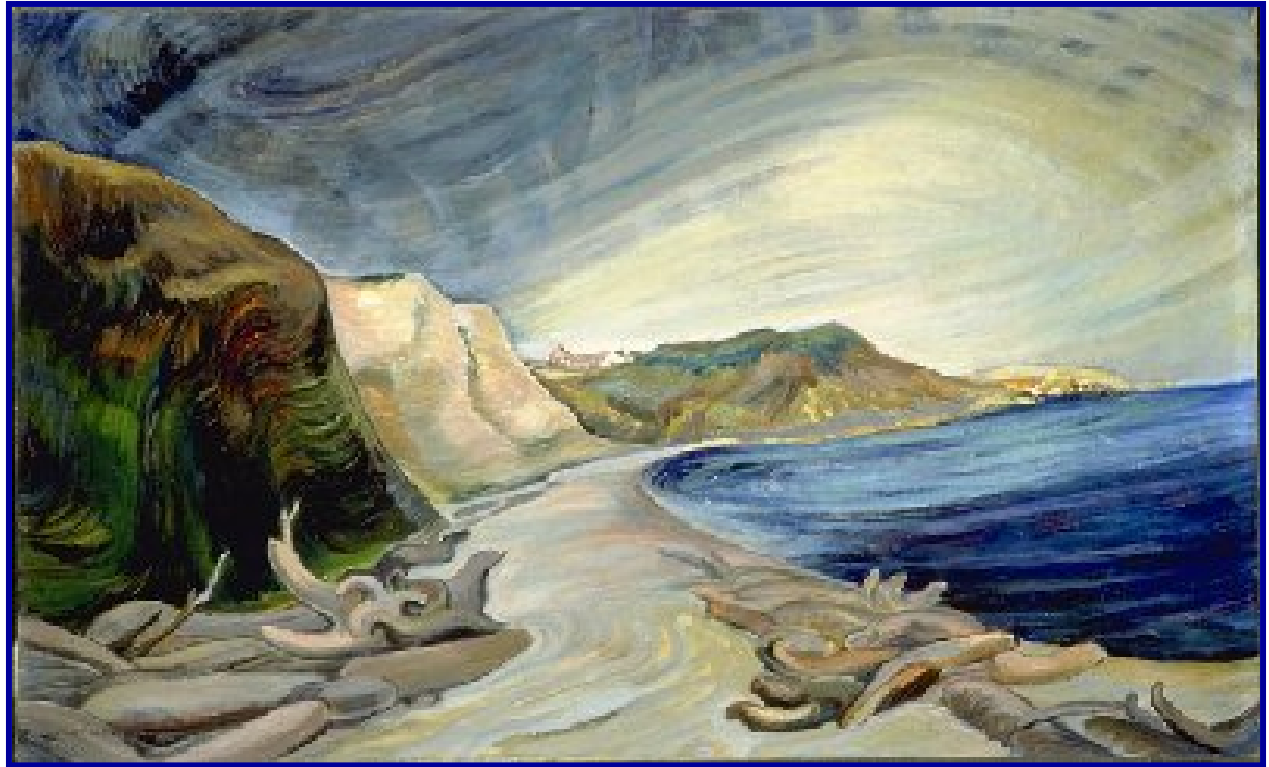
**Quality is experienced at the interface between the provider of quality (medical education) and the consumer of quality (students, residents, practitioners – *patients??*)**




If you want to achieve what you  
desire in life, it requires a  
persistent, relentless,  
determined and consistent  
effort to make it happen.

Matthew Adriance

# “Shoreline” by Emily Carr





Following from the Dreyfus Model of Skill Acquisition (novice, advanced beginner, competent, proficient, expert, master), once we **assure zero variation around minimal core competency** – *and we can set the bar high* - , we can then accommodate **significant variation around the expression of mastery** – each master as unique as a snowflake – in order that we all honor our covenant with society.

**Thank you for your generous  
time and attention.**

