An exciting initiative championed by Dr. Bagnell has been the development of a limited exchange relationship with Meharry Medical College in Nashville. Meharry is a historically black medical school fully accredited by the LCME. Meharry was cited in the June 15, 2010 issue of Annals of Internal Medicine article entitled “The Social Mission of Medical Education: Ranking the Schools” as the number two school in the country in fulfilling social mission – the same article which ranked QCOM as number 12 overall. Thus, we have some areas of overlapping interests. The goals of this exchange have been to increase our students’ exposure to racial diversity and to increase Meharry students’ exposure to diverse practice settings.

This program began in January 2010 and has been limited to pediatrics and surgery. The experience has involved Meharry students coming to QCOM and QCOM students going to Meharry for two week subsets of the surgery and pediatrics clerkships. (These rotations are so short in order to be in compliance with yet another LCME standard: ED-8. The curriculum of a medical education program must include comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.) Meharry students have been required to come to QCOM while QCOM students elect to go to Meharry. We have now had 27 Meharry students rotate through QCOM and a smaller number of our students rotate at Meharry. Students from both schools have found this to be an enriching experience and faculty working with the Meharry students observe them...
An exciting initiative championed by Dr. Bagnell has been the development of a limited exchange relationship with Meharry Medical College in Nashville.

Following are comments from some of the QCOM students who have rotated at Meharry:

While my entire experience at the Quillen COM has been extraordinary, the two weeks I was able to spend at Meharry was one of the most unique and remarkable of my medical education. I spent my two weeks doing the pediatric outpatient clinic and it was wonderful: the attendings were eager to teach and the students are able to take on additional responsibilities because there are no pediatric residents. While on a superficial level there appears to be significant differences between the patient populations of the two schools, after having seen both I can honestly say there is one important similarity: both are striving to bring healthcare to the underserved. Meharry also gives students the opportunity to serve patients who do not speak English. I was not aware before I went that at least 50% of their population base speaks Spanish as their primary language. If any student plans to do an international rotation in a Spanish-speaking country, this would be a wonderful way to practice using their Spanish in a medical setting. Matt Layman Class of 2011

The experience here has been invaluable. Students here have been receptive, and the attendings are knowledgeable and attentive. There are plenty of pediatric patients to see each day, and since there are no residents, students are the primary focus for teaching. There have been the occasional quirks in dealing with hospital staff, but that is expected in a public-hospital setting where funds and resources are limited. The quality of education in the outpatient setting is comparable to that of Quillen’s; the primary difference resides in the patient population, which is approximately one-third African-American and two-thirds Latin-American. It has been a great challenge communicating with Spanish-speaking patients, and I am glad to have been forced into situations where I must try and effectively communicate with patients who do not speak English as a first language.

Overall, I am grateful for my experience here at Meharry and for the opportunity to spend some time in Nashville. I certainly hope more Quillen students take advantage of the opportunity to experience inner-city medicine. It's been interesting to observe the similarities and differences between Quillen and Meharry in terms of the patient populations, the geographic locations, and the hospital settings. More importantly, I feel more confident in my ability to communicate with patients from diverse backgrounds. Kazeen Abdullah Class of 2011

The QCOM administration welcomes input from faculty regarding ideas for increasing the diversity of our student body.

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An Interview with Forrest Lang, M.D.
Penny L Smith, Ed.D.

The five year grant from the National Cancer Institute involves interviewing cancer patients to tell their stories. It’s a collaboration between the storytelling group and several oncology groups with Dr. Krishnan and the communications group. We’ve interviewed now a total of 65 cancer patients for an hour and a half each so we have over 100 hours of stories.

We listen to stories and do qualitative assessments of what they’ve told us. The educational research pieces that we use are stories from actual cancer patients to create modules for residents, fellows, students and others about what the cancer patients want to know when you’re with them, when you’re breaking bad news, when you’re talking about a disease not being curable, when you’re talking about end of life, when you’re talking death; what the patients want, what do they recommend you do, and how do they recommend you handle this.

I think that’s why the National Cancer Institute was intrigued by this collaboration. They thought the idea had merit. As we beefed up the educational research component with pretests and post-tests, they liked it a lot and gave it a very good score. We’re somewhat astounded but very pleased. We’re just beginning to do the educational research pretest, post-test modules, and interventions. We’re in the process now of publishing a couple of articles on qualitative findings of this sample.

We have some patients who are truly at the end of life. Often at the end of life they are feeling very sick and feeling vulnerable. They’re concerned about appearances: how they appear, if they’re looking ill, and their color’s not good. We are video recording all these interviews and we’re using the video but the face and the words are these patients to teach the next generation of physicians. It’s understandable that there’s a lot of reasons why people at the end of life do not want to be interviewed for this project. We just are beginning to increase our efforts in working with hospices in the area to recruit people who might be, for humanitarian reasons, wanting to help a project like this. And every year, the project addresses another module or two.

The start of this first year involves a module on breaking bad news. Dr. Bob Enck will be responsible for the next module on when you make a transition from curative care to palliative care. How do you communicate that? It’s often a secondary bad news situation that can be more devastating than the original news that they have cancer. It’s one thing to tell someone they have cancer; with all the great medications now, you kind of quickly get into the defense of I’m going to beat this thing. The more difficult and challenging of communications is really when the evidence is clear that cure is no longer possible. What we’re looking for is comfort/quality of life, prolongation of life maybe but the goal is no longer cure.

We are going to do self-learning modules that people will get either on CD or online where they can hear the patient’s own words and see the patients telling their stories; and also then giving recommendations in terms of how to handle different difficult moments. We will eventually have five modules from breaking bad news, transition from curative to palliative care, how can people live through the kinds of treatments, spirituality and religion and cancer, and one on how do you help and work with the families of cancer patients. The other use for these will be involving materials directly for patients. This is not part of what we were funded to do but we are committed to do it. Hearing patients tell about how they got through these things and what worked for them and what didn’t work for them, we think, will be very valuable for cancer patients. How do you communicate better your own needs to your health care providers? So there will be an instruction on communication for them as well as for the physicians, oncologists, nurses and others. Hopefully a lot of people will use this.

I’m very impressed with what storytelling has done with the play Dispatches from the Other Kingdom. They’ve taken some of these stories, some of the quotes in the stories, and put them into a script. These are basically ten of the most moving stories from these first 60 patients. I think they have six or seven different patients telling their stories. They each describe initially what it was like to break the bad news; then, in terms of treatment, difficult treatment issues. They will then come back, continue their story so these seven stories just kind of weave into each other then wind up with some very challenging conclusions at the end of this play.

Dr. Joseph Sobol has approached a number of storytellers who have cancer. He knew a dozen people who’ve lived with cancer; people who are willing to tell their stories as cancer patients and also as story tellers. That has been interesting. We’ve had some very powerful stories from people whose professional career is telling stories about events. Several of the storytellers who had had cancer and told their stories for the camera, their stories also got selected as part of this play. They basically played themselves. There are probably seven or eight different stories reenacted. A couple of the people playing these different parts were students in the Masters program for storytelling. Now there’s a script and somebody else could put it on as a play.
An Interview with Forrest Lang, M.D.

It was probably just 20 years ago where I said you know after doing this for 20 years this is what really fascinates me, this is what I’m really interested in. Maybe instead of doing a bunch of research projects in other areas I should focus my attention on communications. This is what I did. It was the right decision. I have been presenting on these topics at various meetings for the last 20 years. It is good. The area now is getting the recognition that it deserves.

I was recently named to be a member of the clinical skills exam for the NBME, the committee that writes the cases and oversees that process.

I’ve been at Quillen twenty-six years. When myself and my family decided to come here we were pretty well entrenched, at that time, in Philadelphia. There was this great opportunity down here. My wife and myself had worked as a doctor up in Haysi, Virginia, so we were familiar with this region. We were from Philly and knew that’s probably where we were going to be most of the rest of our lives. This school had just been opened a few years before. We came, visited, and liked it. We basically said this would be a great opportunity for us for two or three years being at a school where they really value primary care education. We basically told all our friends and family that we’d be back in two or three years. Of course, that was 26 years ago. We’re still here.

Educational research is probably what’s made my career before this NIH grant. I never had big funding so what I did is basically describe, analyze, report on educational innovations that I’d done over the years in various areas of rural medicine and communication and cancer communication and then published that. You don’t have to have a million dollar grant necessarily to be creative and to develop something that should be described in the literature carefully assessed, analyzed, and reported on.

It’s fascinating and literally I find this as challenging and interesting as I did 40 years ago. If you can have an interest in something that long and maintain the interest, you are fortunate. I feel I am fortunate.

National Board of Medical Examiners Visits Quillen College of Medicine

David Swanson, PhD (Vice President for Professional Services) and Aggie Butler, PhD (Vice President for Medical Education & Health Profession Services) were scheduled to fly from Philadelphia to Johnson City to talk about testing and changes that were happening at the national boards. Prior to leaving Aggie received word that a very close relative had become quite ill and she needed to remain there. Dr. Swanson followed through with the flight and very aptly presented both morning and afternoon sessions.

The scope of testing by the USMLE annually is overwhelming. Each year 70,000+ Basic Science Subject Examinations are administered (domestic and international combined). Surpassing this number, 115,000 Clinical Science Examinations are administered annually (domestic and international combined).

Transition of Paper Exams:

- All basic sciences examinations will be available in web format by July 1, 2010.
- Exams will be available in both paper and web format currently.
- All clinical sciences examinations will be available in web format by July 1, 2011.
- Paper examinations are likely to be phased out by 2015.

Dr Swanson spent most of the morning discussing construction of test questions for the Basic and Clinical Sciences. All attendees were given a book on this subject. If you were not able to attend but would like to receive a free copy of the book, contact me at smithpl@etsu.edu.
Educational conferences:


Lang F, Floyd MR. Teaching skills/ effective learner-centered teaching strategies for small group. Presented at the 43rd Annual Spring Conference, Society of Teachers in Family Medicine (STFM). April 25, 2010; Vancouver, British Columbia, Canada.


Faculty Education Publications and Presentations

If you have received educational awards or have presented or published educational research, please let us know for recognition in future issues of The Academic. Office of Academic Affairs, PO Box 70571, Phone: 439-8002, greenesl@etsu.edu
New Innovations Software  
Cindy Lybrand, MEd; Lisa Myers, BA; Cathy Peeples, MPH

Since 1995, the company New Innovations has provided residency programs with an online system to handle scheduling, evaluations, tracking of duty time, case logs, etc. In 2008, they began developing undergraduate medical education (UME) components of their software. At this same time, Quillen was looking at centralized software packages that would eliminate the need to maintain and cross populate multiple stand-alone systems, as well as replace existing paper-based systems. Primary goals were to provide students with online access to evaluations and to establish an online mechanism for identifying / monitoring / tracking the types of patient encounters and procedures required of our students.

Several companies, such as ONE45 and E*Value were considered, but we chose the New Innovations system in part because of additional incentives that included the opportunity to be involved with the UME product development. Also, many of our clinical faculty were already using the system and New Innovations offered a significant price reduction since we were a graduate medical education (GME) customer.

In May of 2009, Quillen began implementing Phase I of New Innovation’s UME software for the third year clerkships. Clinical departments worked to establish online faculty evaluation of students including a composite evaluation of students and the summary statement used in the Medical Student Performance Evaluation (MSPE). The MSPE is a required document for the students’ application to residency in the fourth year. Successful completion of Phase I will provide timely feedback to students, including mid-rotation feedback, through online access to their evaluations.

For 2010 – 2011, students’ required evaluation of the clerkship and faculty will be scheduled through this system as well. Of the many benefits of using New Innovations, one is that faculty and students will have a running list of and easy access to the evaluations for which they’re responsible.

There must be a system with central oversight to assure that the faculty define the types of patients and clinical conditions that students must encounter, the appropriate clinical setting for the educational experiences, and the expected level of student responsibility. The faculty must monitor student experience and modify it as necessary to ensure that the objectives of the clinical education program will be met.

Phase II’s focus is establishing an online, central collection of patient logs / diagnosis and procedures, specifically to meet LCME standard ED-2: