Didactic: Mastering Mentorship: Become a More Effective Fellowship Preceptor

PROGRAM CHAIRS
Danielle E. Luciano, MD & Magdy P. Milad, MD, MS
Joanna Cain, MD  Gary N. Frishman, MD
Target Audience
This educational activity is developed to meet the needs of residents, fellows and new minimally invasive specialists in the field of gynecology.

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PRCP-611
Didactic: Mastering Mentorship: Become a More Effective Fellowship Preceptor

Danielle E. Luciano, Magdy P. Milad, Chairs

Faculty: Joanna Cain, Gary N. Frishman

This course will provide a scaffold to operationalize an effective fellowship in minimally invasive gynecology. It is designed for surgeons interested in starting a fellowship or current preceptors interested in enriching their fellowship. Topics will include the following: developing a curriculum and recruiting faculty, participating in the application/match process, funding a fellowship, promoting research, and fostering a successful learning environment for your fellow. Tips on how to be an effective surgical mentor and how to provide feedback and debrief will be shared as well. These topics were chosen based on a survey of current fellows and preceptors, to determine which will be the most valuable to our audience. The didactic lectures and group discussions are both designed to be informative and interactive.

Learning Objectives: At the conclusion of this course, the clinician will be able to: 1) Design a curriculum for a Fellowship in Minimally Invasive Gynecology; 2) explain how to recruit and promote excellent faculty and fellows; and 3) discuss and review the characteristics of an effective mentor, including: providing feedback, fostering learning, and assisting with career development.

Course Outline

12:30 Welcome, Introductions and Course Overview
   D.E. Luciano, M.P. Milad
12:35 Development of Curriculum and Educational Objectives
   G.N. Frishman
1:00 Fellow Recruitment, Selection, NRMP (Match)
   M.P. Milad
1:25 Breakout
   M.P. Milad, D.E. Luciano
   Research Opportunities, Research Funding, Program Budgets, Fellowship Funding
2:15 Program Budget and Research Opportunities
   D.E. Luciano
2:25 Break
2:40 Mentorship Fellows, Teaching Techniques, Giving Feedback
   J. Cain
3:20 Fellow Evaluation, and Remediation for Fellows in Trouble
   G.N. Frishman
3:55 Recruiting Faculty and Motivating Them to Teach
   J. Cain
4:20 Questions & Answers
4:30 Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
Art Arellano, Professional Education Manager, AAGL*
Amber Bradshaw
Speakers Bureau: Myriad Genetics Lab
Other: Proctor: Intuitive Surgical
Erica Dun*
Frank D. Loffer, Medical Director, AAGL*
Linda Michels, Executive Director, AAGL*
Johnny Yi*

SCIENTIFIC PROGRAM COMMITTEE
Arnold P. Advincula
Consultant: Intuitive
Royalty: CooperSurgical
Sarah L. Cohen*
Jon I. Einarsson*
Stuart Hart
Consultant: Covidien
Speakers Bureau: Boston Scientific, Covidien
Kimberly A. Kho
Contracted/Research: Applied Medical
Other: Pivotal Protocol Advisor: Actamax
Matthew T. Siedhoff
Other: Payment for Training Sales Representatives: Teleflex
M. Jonathon Solnik
Consultant: Z Microsystems
Other: Faculty for PACE Surgical Courses: Covidien

FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Joanna Cain*
Gary N. Frishman*
Danielle E. Luciano*
Magdy P. Milad*

Asterisk (*) denotes no financial relationships to disclose.
Development of Curriculum and Educational Objectives (made easy)

Gary Frishman, MD
Professor of Obstetrics and Gynecology
Warren Alpert Medical School of Brown University
Women & Infants Hospital of Rhode Island

Disclosures
• I have no financial relationships or disclosures relevant to this presentation

Objectives (mine)
• At the end of this presentation the attendee should be able to
  – *Navigate the web and AAGL FMIGS website* to identify resources
  – *Identify support services* at their institution to aid in development of a curriculum
  – *Accept and Embrace* that (for curriculum development) plagiarism is good

Objectives (yours)
• Develop a curriculum that will
  – Train your fellows
  – Make your institution and you proud
  – Make applicants want to come to you!

Start with what you need

Resources: FMIGS
More information on FMIGS:
- 2005 fellowship deadline – Sunday, November 15, 2005 at 5:00pm
- Compensation among graduates of FMIGS fellows
- 2005 FMIGS agreement
- 2005 interview schedule
- Program requirements
  - Applicant in the program
  - Field for the future
  - Fund for the future recipients
  - FMIGS history
- Fellowship mission statement
- Educational objectives
- Fellowship board
- Fellowship opportunities
  - Current fellows
  - Former fellows
  - Alumni
  - Prospective
- Fellowship candidate
- Maryland case list
- Surgical competency list
- Fellowship committee
- Policies

Fellowship in Minimally Invasive Gynecologic Surgery
https://www.AAGL.org/service/fellowships/
Resources: FMIGS

Educational Objectives

These educational objectives are directed toward the standardization of training in minimally invasive gynecologic surgery. The fellow is expected to become attuned to the competencies set forth in the CReIVE educational objectives related to gynecologic cancer. [www.aagl.org]

I. Anatomy

The fellow should demonstrate an understanding of the descriptive and functional anatomy of:
1. the pelvis including the bony structures, muscles, blood vessels, lymphatics, and nerves
2. the abdominal wall and its relationship to the abdominal wall
3. the retroperitoneal spaces of the pelvis, including the prevesical, parametrical, vesicovaginal, paravesical, and pararectal spaces
4. variabilities of the major blood vessels in the lower abdomen and pelvis
5. the genitourinary tract including the course of the ureter
6. pelvic support as relates to uterine ureteral and urethra inherent incontinence
7. the embryological origin of the pelvic visceras as relates to congenital anomalies

II. Vaginal Surgery

The fellow should have an understanding of the principles, advantages, limitations, and complications of vaginal surgery.

III. Diagnostics Hysteroscopy

The fellow should have an understanding of the principles, advantages, limitations, and complications of diagnostic hysteroscopy and hysteroscopy in the hospital and ambulatory settings.

Educational Objectives

[www.aagl.org/service/fellowships/educational-objectives/]

More Information on FMIGS:

- 2013 Fellowship Competition - Sunday, November 15, 2013 at 5:00pm
- Consequences Among Fellows: FMIGS Fellow
- 2013 FMIGS Agreement
- 2013 Interview Schedule
- Program Requirements: Consequences of Failure
- Fellowship Mission Statement
- Educational Objectives
- Fellowship Board
- Fellow's Proctorship
- Current Fellows
- Fellow's Case Log
- Minimum Case Log
- Surgical Competency
- Fellowship Information

Resources: FMIGS

Fellowship in Minimally Invasive Gynecology Surgery

[www.aagl.org/service/fellowships/]

Resources: FMIGS

PROGRAM REQUIREMENTS FOR A POST-GRADUATE
FELLOWSHIP IN MINIMALLY INVASIVE GYNECOLOGIC SURGERY (FMIGS)

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Minimum Number of Fellows per Program
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Fellows
Fellows' Proctorship
Curriculum
Research Training
http://www.aagl.org/service/fellowships/apply-to-the-program/

Resources: FMIGS

2013 Core Reading in Minimally Invasive Gynecology Surgery

http://www.aagl.org/content/uploads/2013/03/AAGL_Core_Reading_List_2013-09-11.pdf
Resources: FMIGS

Curriculum
Didactic. Education of fellows must include structured teaching conferences, seminars, and didactic instruction in both basic science and clinical aspects of the specialty as outlined in the Educational Objectives. This can include online coursework. The fellow’s schedule and responsibilities must be structured to allow regular attendance at national conferences.

http://www.aagl.org/service/fellowships/apply-to-the-program/

Resources: FMIGS

- New Learning Objectives
  - Out soon!
- Revised and Updated Reading List
  - Out soon!

Resources: FMIGS

Fellowship Curriculum
Standardization Subcommittee
Sawsan As-Sanie, MD co-director
Gary N. Frishman, MD co-director
Kimberly A. Kho, MD
Stacey A. Scheib, MD
Sangeeta Senapati, MD
Bethany D. Skinner, MD
Amanda C. Yunker, DO
Rosanne M. Kho, MD

Abnormal Uterine Bleeding

Physiology/Pathophysiology:
Understand the normal menstrual cycle and what defines abnormal uterine bleeding (MK).

Evaluation:
History:
Elicit a comprehensive menstrual and medical history (PC). (See Menstrual Cycle Physiology topic.)

Physical exam:
Perform a focused physical exam looking for markers of reproductive hormone abnormality (PC).
Abnormal Uterine Bleeding

Diagnostic tests:
Order appropriate laboratory tests and imaging, such as cervical screening, ultrasound (MK, PC, PBLI, ICS, SBP). Perform endometrial evaluation as indicated, such as endometrial biopsy and/or hysteroscopy (MK, PC, PBLI, ICS, SBP).

Differential diagnosis:
Form a differential diagnosis based on history, exam, and diagnostic testing, using a classification system such as PALM-COEIN (MK).

Abnormal Uterine Bleeding

Management:
Discuss the risks, benefits, alternatives, and comparative effectiveness of the options below.

Non-surgical:
Discuss non-surgical treatments and counsel patients regarding the risks, benefits and alternatives of medical therapies (MK, PC, ICS).

Procedural:
Discuss interventional treatments, such as myomectomy, hysterectomy, endometrial ablation, and interventional radiology procedures (MK, PC, ICS, SBP).

Abnormal Uterine Bleeding

Other considerations:
Review fertility-sparing options, including risks, benefits, and alternatives. (MK, PC, ICS)
Identify comorbidities, such as morbid obesity, smoking, cardiac disease and chronic pelvic pain, that impact treatment options. (MK, PC, ICS)
In patients who have failed treatment, determine why a chosen treatment may not have been successful, identify potential misdiagnosis, and counsel patient about alternative options. (MK, PC, PBLI, ICS)
Perform all of the above in an ethical manner, accounting for all appropriate surgical and non-surgical options. (MK, PC, SBP, PBLI)

Abnormal Uterine Bleeding

Objectives (see what you have)

- See what you already have for curriculum
  - Your collaborating departments (e.g. Urology, Surgery, Ob/Gyn Fellowships)
- See what you have for infrastructure
  - Simulation center (check their curriculums!)
    - Check with the company reps as well
  - Robotics cmte; Surgical council; Medical staff office
    - Often have policies or standards
    - May have simulation for maintenance of privileges

Using standardized measurement tools

- GOALS
- OSATS
The Global Operative Assessment of Laparoscopic Skills (GOALS)

[1] depth perception
[2] bimanual dexterity
[3] efficiency,
[4] tissue handling
[5] autonomy


Objective Structured Assessment of Technical Skills (OSATS)

[1] respect for tissue
[2] time and motion
[3] instrument handling
[4] flow of operation and forward planning
[5] knowledge of specific procedure


Using simulation

• Utilizes metrics and benchmarks
• Can provide data
  — Ideal if computer based and data captured is not dependent on fellow manually recording it
• Can be faculty independent
• Debated
  — Validity
  — Relationship to skill acquisition, long term impact


Using simulation

• D-box, a webcam-based laparoscopic basic skills trainer box
  http://www.d-box.no/
Using simulation


Expand your horizons

- Have your fellow teach
  - Participate in residency/faculty simulation courses
  - Develop and teach curriculum for resident on service
- Self motivated learning may be best
- Dedicated teaching of residents may favorably influence their perception of fellow’s impact on resident education (i.e. not just “stealing” cases)
- Ability to independently teach may be selling point for your fellowship

Expand your horizons

- Have your fellow develop a curriculum for your fellowship
- Could be a research project
- Regardless, goes on their CV
- They can take it with them

Internal Simulation Curriculum

- [Image] - [Image] - [Image] - [Image]
Internal Simulation Curriculum

Module 1

Insert the needle through the skin and into the body. Use a sterile needle to make the incision. Use a sterile suture to close the wound. Use a sterile dressing to cover the wound. Use a sterile bandage to hold the dressing in place.

Resources: The Web

Online Faculty Development Resources

SCORE: General Surgery Resident Curriculum Portal
www.surgicalcore.org

APGO Faculty Development Resources
www.APGO.org/faculty/online-resources.html

ACOG Resources
www.ACOG.org

Acog Online Education Resources
www.ACOG.org/education-learning.html
(1) identify normal female pelvic anatomy;
(2) identify divergence from normal anatomy;
(3) identify and endoscopically trace major pelvic blood vessels, ureters, bowel, anatomic hallmarks, and abdominal wall ligaments, among other features;
(4) know major branches of anterior and posterior division of the internal iliac artery and the implication of injury to a particular branch;
(5) name the major nerve supplies to the pelvis (e.g., superior and inferior hypogastric plexuses, obturator nerve, and ilioinguinal and genitofemoral nerves);
(6) understand the physiology and principles of creating and maintaining pneumoperitoneum;
(7) understand the principles of electro surgery;
(8) know the difference between monopolar and bipolar electrosurgery;
(9) understand the principles of ultrasonic energy;
(10) understand the theory of the various laser energy sources used in endoscopic surgery; and
(11) be familiar with plasma-generating devices, argon beam, and ultrasonic surgical systems and their application to gynecologic laparoscopy.

Conclusions

• Developing a curriculum can be intimidating
• Work backwards from what you want and what you have
• MANY resources exist
  — Check out your institution
  — Check out the web
• Don’t forget about FMIGS website!

REFERENCES


http://www.aagl.org/service/fellowships/


www.APGD.org/faculty/online-resources.html

https://www.AAGL.org/service/fellowships/

http://www.aagl.org/service/fellowships/apply-to-the-program/

https://www.AAGL.org/service/fellowships/educational-objectives/
Recruiting and Matching

Magdy Milad, MD, MS
Northwestern Medicine, Chicago, IL

I have no financial relationships to disclose.

OBJECTIVES

- Develop insight into differentiating characteristics of successful candidates.
- Review factors that are commonly sought by PD’s
- Discuss the NRMP process and its importance

Fellowships: NRMP and Others

www.nrmp.org

Approved Fellowships

MIGS Match

www.aagl.org www.nrmp.org
Fellowships and the Applicant Pool

Fellowships in Ob/Gyn

- ABOG
  - REI and REI/Genetics
  - Gyn Onc
  - MFM and MFM/Genetics
  - Pediatric and Adolescent Gynecology (Focused practice)
  - Critical Care (added recognition)
- ACGME
  - FPMRS
- Specialty Societies
  - MIGS
  - Family planning
  - Breast diseases

Advantages of the NRMP

- Favors fellow applicants
- Allows for couples matching
- Gives both programs and candidates the opportunity to interview widely

Match Agreement - Highlights

- Matches are binding.
- Applicants and programs must accept/offer the matched position and enter training in good faith on the date specified in the contract.
- Matched applicants and programs cannot discuss, interview for, or accept/off er a position for a concurrent year position without prior waiver approval from the NRMP.
- Applicants and programs are responsible for providing complete, timely, and accurate information during the interview process.
- Programs cannot request applicants to reveal ranking preferences, nor can programs require applicants to reveal the names or identities of programs to which they have or may apply.

Communication between Applicants and Programs

- Section 6.0:
  - It is a breach of the Match Participation Agreement for:
    - (a) a program to request applicants to reveal ranking preferences; or
    - (b) an applicant or program to suggest or inform the other that placement on a rank order list is contingent upon submission of a verbal or written statement indicating ranking preferences; or
    - (c) a program to require applicants to reveal the names or identities of programs to which they have or may apply; or
    - (d) a program and an applicant in the Matching Program to make any verbal or written contract for appointment to a concurrent year residency or fellowship position prior to the release of the List of Unfilled Programs.
Prohibited Communication

- In the 2015 fellowship match, Dr. Holly Golightly interviewed with the MIGSS Central Hospital Center. She was encouraged at the end of her interview to send the program director a note indicating her level of interest in the program so that the director would know how or whether to rank her.

- In the 2015 fellowship match, Dr. Harry Potter interviewed at Hogwarts Medical Center. Dr. Potter was unsure how to respond when the program director asked where else he planned to interview and if he planned to rank the Hogwarts program as his first choice.

FAMOUS EASTERN MIGS HOSPITAL

Dear Applicant:

We have thoroughly enjoyed your visit with us and it is clear that you will excel wherever you choose to go. You represent the kind of candidate that has traditionally done well in our program and we hope to have the opportunity to work with you in the coming year.

Yours sincerely,
Program Director

Violation Investigations

- Report potential violation to Executive Director
- Information gathered by NRMP
- Preliminary Report reviewed by all parties
- Case reviewed by Violations Committee
- Review Panel Report to violator
- Violator can arbitrate
- Final Report distributed

Violation policy is at www.nrmp.org

Violation by an Applicant

- Final Report sent to:
  - Applicant’s medical school
  - Directors of residency programs
  - American Board of Medical Specialties
  - FSMB* (if applicant is to be permanently barred)
  - Interested parties
- Applicant may be identified as a match violator in R3 System or barred from future matches for one to three years, or permanently.
- Applicant may be barred from match-participating programs for one year.

Final Considerations

- Do not wait until the last minute to enter your rank order list. The servers may be overloaded and very slow.
- Do not make last minute changes to your rank order list. Most such changes are not well thought out and applicants frequently regret the changes.
- No changes can be made to ROLs after the deadline, and only certified lists will be used in the Match.
- The NRMP will NOT enter a list, add, delete or move programs or in any way modify a rank order list.

Points

- Prepare a rank order list worksheet with program codes in order of preference before entering them on the “My Rank Order List” screen.

  Be sure to certify your rank order list.

  Complete your list at least a week before the deadline.

  Relax!
DATES

**IMPORTANT DATES OF THE 2016-2018 FELLOWSHIP YEAR**

- **PROGRAM START DATE:** July 1, 2016
- **MATCH OPEN:** June 3, 2015
- **RANK ORDER LIST CERTIFICATION DEADLINE:** September 30, 2015
- **APPLICATION DEADLINE:** July 15, 2015
- **MATCH DAY:** October 14, 2015

Application

- Photo
- CV
- 2 letters of reference
- Application
- Surgical experience
- Personal statement

**METHODS**

- Questionnaire - fellowship directors – 2011
- Selection practices were evaluated
  - pre-match preparations
  - screening of applications
  - interview processes
  - recommendations given to applicants
- Fellowship directors were asked to grade selection factors

**RESULTS**

- Total of 187 fellowship directors (ABOG) were surveyed
- 124 completed the survey (66% response rate)
- Similar response rate between the 4 specialties
- Essential across all subspecialties:
  - High-quality residency (100%)
  - Clinical research experience (99%)
  - High-quality medical school (91%)

**Results**

- Characteristics most valued by program directors at the time of the interview:
  - Work ethic
  - Works well with staff
  - Ability to handle clinical workload
  - Significantly Less important/ not valued: significant other’s occupation, hobbies, marital status, race, sex
CONCLUSION

- Education pedigree
- Research experience

two of the most important factors considered by fellowship directors when selecting fellowship applicants.


Notable Characteristics

- Laboratory research - REI > non-REI director (rated least important by Urogyn)
- Personal experience w/ candidate - REI > non-REI program directors
- Oral presentations - more important to Urogyn directors
- Surgical experience - gyn onc > non-gyn onc fellowship directors
- Majority of fellowship directors
  - did not contact any candidates (47%)
  - fewer contacted their top choices (30%)
  - some contacted every candidate (12%)
  - very few contacted their #1 candidate (5%)


As a First-Year Resident

- Find a research mentor
  - Established
  - Track record
  - Used to working with residents
- Start a project
- CREOGs
  - Up to 50% of competitive programs ask for them
- Meet and obtain advice from as many as possible of your sub-specialty advisors
- Network at meetings
- Consider away rotation

www.nrmp.org
www.acog.com
www.abog.com
www.aagl.com

Program Budget and Research Opportunities

Danielle E. Luciano, MD
Assistant Professor OB/GYN
University of Connecticut

I have no financial relationships to disclose

Objectives

• Review the Requirements for fellowship programs in order to determine a budget
• Review the fellowship research requirements
• Address barriers to research performance

Budget Considerations

• Stipend
  — Equivalent to a PGY-5 or PGY-6 house staff officer in the geographic region of the program.
• The following benefits are required:
  — Health, disability and professional liability coverage
  — Research associated costs (IRB, equipment, publication) must be covered.
  — Course in Clinical Research
• Recommended benefits:
  — AAGL Essentials in Minimally Invasive Gynecology (EMIG) examination fee
  — Travel to the annual meeting of the AAGL and/or ASRM
  — Certification as console surgeon for robot-assisted laparoscopy

Funding

• Resident Coverage
• Moonlighting
• Clinic coverage
• University

Research Requirements

Research Training:

• Complete a minimum of one course in clinical research, research design, biostatistics or epidemiology.
• May be given the opportunity to work towards an advanced degree (e.g. MPH) or certificate in clinical research.
• A classroom setting or an online course.
Research Requirements

Research training should:
• Provide structured basic science, translational, clinical or surgical research as applied to MIGS
• Enhance the fellow’s understanding of the latest scientific surgical techniques
• Promote the fellow’s academic contributions to the specialty
• Further the ability of the fellow to be an independent investigator

Research Projects
• Complete by the end of their final academic year at least one IRB approved research project relevant to minimally invasive gynecologic surgery.
• Should be initiated in the first year of fellowship training.
• A research mentor must be appointed.
• Original data-driven project, meta-analysis or a systematic review that conforms to PRISMA guidelines.
• Writing a textbook chapter, clinical opinion review article, or production of an educational video does not meet criteria for an approved research project.

Barriers to Research
• Picking a research project
• Protocol/Methods
• Statistics
• IRB submission/Training
• Funding
• Administrative Support
• Research Mentor

Fellows Pelvic Research Network
• A joint venture with SGS (Society of Gynecologic Surgeons)
• Encourage multicenter prospective fellow driven research projects
• Fellows can send project ideas to the steering committee and get help setting up these projects

References
• Implementation of Medical Research in Clinical Practice Sept 2012

Breakout Groups
• Research Opportunities
• Research Funding
• Program Budgets
• Fellowship Funding
Summary

- Summarize the ideas generated in these small groups
- Answer any questions
Mentorship Fellows, Teaching Techniques, giving Feedback

Joanna M. Cain, M.D.
University of Massachusetts Medical School

Disclosure/Objectives

I have no financial relationships to disclose

Objectives
• Develop ideas of mentorship or teaching beyond “Yoda”
• Utilize a FUNCTIONAL mentor model for ourselves and fellows
• Structure a successful mentoring relationship

To set up effective mentoring, need to get beyond “Yoda”

In Greek mythology, Mentor was the Teacher and Guide of the son of Odysseus in Homer’s epic The Odyssey.

“Mentor” actually was Athena, the goddess of wisdom, in disguise.

The archetype of mentor is one of benevolent, guiding wisdom

Everyone: Faculty and fellows need MENTORS (broader than teachers)

Mentoring has three key areas *

Educational: mentee acquires and integrates new learning (coaching, tutoring)

Personal: mentee manages transitional states (counseling)

Professional: mentee maximizes potential to become a fulfilled and achieving practitioner (sponsorship, socialization)

Mentoring can occur in many different forms

There are multiple types of mentors; One does not necessarily fit all needs

Mentees may need a mosaic of mentors

**FIRST IDENTIFY the NEEDS**

The first step is to identify a project/skill/goal or issue that is important for progress in a career: **Structure matters!**

Ask yourself the following questions:

- What knowledge, skills, or expertise do I need to be able to do this project or tackle this issue?
- What strengths do I bring to this project?
- What are my areas of need?
- What specific help do I need to be able to complete this?
- What are the outcomes that I need to accomplish?
- What scholarly products do I hope to generate?

Functional Mentoring is the sharing of a mentor’s specific skills/expertise to impact the specific needs of the mentee focused on completion of a project/skill/goal by the mentee

**FIRST IDENTIFY the NEEDS**

Mentees with needs

? Mentors with expertise

Functional Mentoring

What are SPECIFIC needs you can think of that Fellows or Faculty need a mentor for?

A mentoring agreement is a useful tool to define goals and expectations

**Effective Mentees and Mentors:**
- Define the goals and objectives for the mentoring relationship
- Agree on the steps and timeline to reach the goal
- Discuss mutual expectations and boundaries, ethics and vision
- Negotiate a schedule for meeting

Skills for mentoring/teaching are similar

**Mentor/mentee? Teacher/Student?**

**Practice/observe/refine/retry**
- By defining the “function”, you define the teaching
- For skills: simulation; repetitive surgical experience; feedback; retry
- For Feedback: Expectation/Observation/plan for moving forward/circle back
- Surgery: What went well? What went not so well? Things to address/Change?

Key ingredients for successful Mentoring/Teaching Relationships: Keep it functional!

**Values**
- Trust and Honesty
- Mutual respect
- High standards
- Mutual commitment
- Clear goals; shared goals

**Process**
- Clear expectations
- Regular interaction
- Effective communication
- Feedback: giving/receiving
- “Chemistry”

Skill for Mentors or Teachers: setting expectations

- Scope of the relationship/commitment
- Scheduling and logistics
- Frequency and mode of communicating
- Responsibility for rescheduling any missed meetings between mentor/mentee
- Confidentiality and “Off-limits” conversations
- Giving and receiving feedback both ways

Be REALISTIC in your Expectations

No one is perfect
Everyone has different strengths
We need more than one mentor*
Sometimes things don’t go as planned...life happens
*eg. We CAN send someone to another faculty with a specific goal...

What should you expect of your mentee/learner?

**Professionalism:**
- respond to your messages
- keep to schedule or give notice in good time
- Be honest about needs

**Listen** to your advice (but not necessarily take it!)
Provide you with feedback about their needs
Don’t forget you can learn from your mentee...
Everyone needs mentors lifelong

- No Yodas
- Functional mentoring is efficient, effective and a way to think about “teaching” as well
- Requires CLEAR goals
- There is WORK to do as a mentor/mentee
- Finally: **SET SOME TIMELINES to reevaluate the mentoring relationship and Goals**
- And HAVE FUN!

Some references

Objectives

• At the end of this presentation the attendee should be able to
  – Develop a plan to identify trainees in need of remediation
  – Identify resources at their institution to aid in remediation of trainees
  – Establish a plan, including documentation, for remediation of trainees

Overview

• Prevention
  – Choosing candidates
  – Setting expectations
• Early identification
  – Evaluation system in place
• “Academic Warning” and Remediation
  – Meeting and developing a plan
  – Documentation

Overview

• Major areas requiring remediation
  – Professionalism
  – Clinical Knowledge
  – Technical abilities

First step is... picking your fellow

• Compared with a previous 10-point composite scoring system
  – Faculty evaluations of personal characteristics and letters of reference were likely to predict subsequent resident clinical performance.
  – USMLE scores and academic grade performance were predictive of subsequent formalized testing such as ABSITE, but were poorly predictive of resident clinical performance.

Brothers, TC. Importance of the faculty interview during the resident application process. J Surg Educ 2007, 64(4), 378-385
First step is... picking your fellow

- Disciplinary action by a medical board
- Strongly associated with prior unprofessional behavior in medical school
- Odds ratio, 3.0 (1.9 to 4.80)


First step is... picking your fellow

- Consider CALLING letters of reference
  - Letter writing is an art form - hides as much as it tells
- Obtain input of everyone from interview day
  - Fellows, support staff, etc.
    - Often will have insight

Paglia MJ Frishman GN. The trainee in difficulty a viewpoint from the USA. Obstetrician Gynecol 2011;13;247-251

Second step is... prevention

- MANAGE EXPECTATIONS
  - Set clear guidelines, expectations, etc.
  - If the fellow doesn’t know what you expect it will be difficult to meet your expectations
  - Should be ongoing process

Paglia MJ Frishman GN. The trainee in difficulty a viewpoint from the USA. Obstetrician Gynecol 2011;13;247-251

Second step is... prevention and identify early

- Surgical cases should provide real time feedback with documentation
  - Ideally include fellow’s perspective in documentation
- Rotations
  - Expectations laid out ahead of time
    - Can be written/emailed
  - Feedback given at mid point
    - Ideally in person with documentation of fellow’s comments
  - Feedback at end of rotation

Paglia MJ Frishman GN. The trainee in difficulty a viewpoint from the USA. Obstetrician Gynecol 2011;13;247-251

Second step is... prevention and identify early

- 360 degree evaluations
  - Include nursing, staff, patients, junior trainees
- Need to obtain evaluations!
  - Speak to Chair for buy in
    - Rewards for compliance
    - Negative incentives for non-compliance
    - Make it EASY and TRACK

Paglia MJ Frishman GN. The trainee in difficulty a viewpoint from the USA. Obstetrician Gynecol 2011;13;247-251
Have the tools in place!

“Having a clear remediation mechanism was highly associated with reporting remediation, which reflects the capability to detect struggling residents.
Surgical training leadership should invest more in standardizing the assessment of surgical skills.”

Assessing how we assess

- Subjective (non-standardized) assessment of technical skills (I know operative skills when I see them)
  - i.e. Direct observation of specific procedure
- POOR RELIABILITY
  - Poor interrater reliability
  - Poor test-retest reliability

Tools for identifying early

• Simulation: McGill Inanimate System for Training and Evaluation of Laparoscopic Skills (MISTELS)

<table>
<thead>
<tr>
<th>Junior (n=82)</th>
<th>Intermediate (n=66)</th>
<th>Senior (n=67)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peg</td>
<td>42 (36–48)</td>
<td>65 (60–71)</td>
<td>76 (72–80)</td>
</tr>
<tr>
<td>Cut</td>
<td>38 (34–43)</td>
<td>51 (47–56)</td>
<td>63 (58–68)</td>
</tr>
<tr>
<td>Loop</td>
<td>33 (28–39)</td>
<td>47 (39–54)</td>
<td>62 (55–69)</td>
</tr>
<tr>
<td>IC knot</td>
<td>26 (20–32)</td>
<td>54 (46–60)</td>
<td>69 (64–75)</td>
</tr>
<tr>
<td>EC knot</td>
<td>41 (35–48)</td>
<td>58 (51–66)</td>
<td>67 (60–74)</td>
</tr>
<tr>
<td>Total</td>
<td>36 (32–40)</td>
<td>55 (51–59)</td>
<td>68 (64–72)</td>
</tr>
</tbody>
</table>


**Tools for identifying early**

- Link surgeries to global assessment

<table>
<thead>
<tr>
<th>Assessed Area</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient information</td>
<td>Assess resident effort to meet and examine the patient proactively and</td>
</tr>
<tr>
<td>(including preoperative note)</td>
<td>obtain understanding of clinical findings</td>
</tr>
<tr>
<td>2. Prepared for case (diagnosis)</td>
<td>Assess resident knowledge of relevant pathophysiology being treated</td>
</tr>
<tr>
<td>3. Prepared for a case (technical)</td>
<td>Assess resident knowledge of technical aspects of procedure</td>
</tr>
</tbody>
</table>


**Early identification**

- Ensure mechanism for timely and appropriate documentation exists
  - Can be online or written
  - Try to avoid verbal only unless written follow up
  - Make sure faculty know WHAT and HOW to document

Dudek Acad Med 80 2005

**Early identification**

- Ensure all parties know resources and processes available and in place for helping trainee and remediation if indicated
  - If supervising faculty knows they will not be responsible for establishing remediation process or filing paperwork may be more willing to report
  - Similarly, if supervising faculty knows action will be taken may be more willing to report

Dudek Acad Med 80 2005

**So I have identified a trainee in difficulty- now what?**

**Setting up the meeting**

- Make your plan up front
  - Resources
  - Plan
  - Timeline
  - Consequences
- HAVE DOCUMENTATION READY
  - Know what you are going to share and not share

**Moving forward**

- Speak to
  - DIO and Graduate Medical Education Committee
  - Your Chair
  - Risk management/Institution's legal counsel/HR
  - CCC if applicable
- Earlier rather than later
  - Heads up
  - Make sure process if followed
  - RESOURCES!
Setting up the meeting

- Choose timing for fellow
  - NOT when tired, before big case or exam, etc.
  - Confidential
- Consider whether you want the resident to be evaluated medically, psychiatrically, etc.
  - Regardless, offer this
  - Using outside agency offers anonymity and expertise shifting role of “bad guy” for this aspect of fellow’s “fitness”
  - Check your institution’s policy on whether consent or prior notice is needed for drug testing
- Block out follow up meeting in 24-48 hours in case desired by fellow after they process info
  - They may not have realized there was a problem

Remediation plan

- Ask Fellow what their perception is of problem, solution, timeline etc.
- Are there other contributing issues
  - Depression, anxiety, or personal or family illness?
- Are there larger educational or system issues in the fellowship that may contributing to this problem?
  - Hazing, lack of oversight, excessive duty hours

Short of “pulling the trigger”

Date
Notes of meeting with Drs. Frishman, XXX and YYY (third party witness)
I understand that I have been given an Academic Warning for both Professionalism and Interpersonal and Communication Skills based both my history of behavior and the recent events surrounding my nursing and medical student evaluations.
I understand that an Academic Warning does not affect me after I graduate and “goes away” if my behavior improves but that the next step may be Probation which has much more significant and permanent negative consequences in that it would be noted on applications for licensure, hospital privileges etc.
I agree to resume accessing the resources of the Rhode Island Employee Assistance Services making and keeping appointments (and Dr. Frishman will help me with this regard as I request if necessary) until we mutually agree this is no longer beneficial.
We discussed other resources for support including the resident ombudsman if I feel that I am being mistreated.
I agree to meet again in 6 weeks to assess my progress. I will be responsible for obtaining at least six faculty evaluations focusing on Interpersonal and Communication Skills during this time in addition to any other evaluation process.
I have read and acknowledge the above. I have received a copy of this note.

XX, MD (Fellow)  
XXX, MD (Fellowship Director)

Short of “pulling the trigger”

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Notes of meeting with Drs. Frishman, XXX and YYY (third party witness)
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XX, MD (Fellow)  
XXX, MD (Fellowship Director)

Short of “pulling the trigger”

- Decide on mentor/champion
  - MANDATE meetings
    - Can have mentor report but ensure compliance
    - Dictate content
      - Discussion of progress and issues
      - Oral or written exams
Remediation plan (my emphasis in italics)

1. Identify the specific concerns/issues that need to be improved, **EARLY and in writing**. Once suspicious, conduct discrete interviews then formal meeting with fellow.

2. Define expectations to be achieved, along with clear goals and objectives. Maintain confidentiality when possible.

3. Detail how the goals/objectives will be evaluated, assessed, or measured; and who will be involved in reviewing the resident’s performance and progress. Decide how fellow will interface with junior trainees, level of independence, etc.

4. Establish clear and reasonable plan for completion of the remediation as well as the frequency (or specific dates) for any progress meetings with the program director.

5. Clearly detail consequences for unsuccessful remediation (including possible dismissal or nonrenewal of contract).

6. Assist trainee in identifying support (employee health programs, faculty mentor, resident ombudsperson, etc).

7. Put remediation plan in writing (signed by trainee and director) and document (in writing) initial and all subsequent progress meetings with the resident and maintain all documents and evaluations in the resident’s permanent file.

8. Discuss with the trainee any future consequences of verbal or written warnings, incident reports, documentation of poor performance, remediation, probation, or dismissal.

Remediation plan

- Open lines of EASY communication
- Ensure all parties know resources and processes available and in place for remediation
- Ensure all parties know goal is SUCCESSFUL remediation

Follow up

- With probation or termination
- Agree on wording for any documentation to be provided to future employers, agencies, etc. and have them sign this
- Hold a debrief with senior leadership
  – How to prevent this again
  – Decide what information can and can’t be shared
  – How to help morale with co-workers

We are not alone

Wide variation in how action is taken in Emergency Medicine Residencies

Domen, RE. Resident remediation, probation, and diminution: basic considerations for program directors. *Am J Clin Pathol* 2014;141:784-790

We are not alone

- 141 Ob/Gyn program directors completed survey
- 84% indicated problems with professionalism most commonly come to their attention through personal communication
- For remediation
  - 59% felt efforts were somewhat successful
  - 24% reported that their efforts were not

Adams, KE. How resident unprofessional behavior is identified and managed: a program director survey. Amer J Obstet Gynecol 2008;198:692.e1-692.e5

Conclusion

- Prevention
  - Choosing candidates
  - Setting expectations
- Early identification
  - Evaluation system in place
- “Academic Warning” and Remediation
  - Meeting and plan
  - Documentation

Domen, RE. Resident Remediation, Probation, and Dismissal Basic Considerations for Program Directors. Am J Dir Pathol 2014;141:784-790.


Dudek Acad Med 80 2005


Tools for identifying early

- Link surgeries to global assessment
  1. Appropriate tissue handling
  2. Secure knot tying
  3. Demonstrated dexterity with intact knot tying
  4. Demonstrates dexterity with instruments
  5. Efficient planning and movement
  6. Independently moves operation forward

Tools for identifying early

- Procedure-based assessment
- 10 checklist items used to evaluate
  - Technical skills
  - Decision-making skills
- Inter-rater variability was observed
  - However, average rater agreement was reliable

Table V. Inter-rater agreement in judging a single laparoscopic inguinal herniorrhaphy.

<table>
<thead>
<tr>
<th>Item</th>
<th>Judge’s rating*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevation of peritoneal flap</td>
<td>A</td>
</tr>
<tr>
<td>Reducing the sac</td>
<td>4</td>
</tr>
<tr>
<td>Mesh insertion</td>
<td>5</td>
</tr>
<tr>
<td>Knowledge of anatomy</td>
<td>5</td>
</tr>
<tr>
<td>Prevention of complications</td>
<td>5</td>
</tr>
<tr>
<td>Respect for tissue</td>
<td>4</td>
</tr>
<tr>
<td>Time and motion</td>
<td>4</td>
</tr>
<tr>
<td>Flow of operation</td>
<td>5</td>
</tr>
<tr>
<td>Overall performance</td>
<td>4</td>
</tr>
</tbody>
</table>

*5 = highest rating; 1 = lowest rating.


Table 3 Distribution of assessment tools used by specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>OSATS</th>
<th>Videotaped analysis</th>
<th>Residents surgical portfolios</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS</td>
<td>1</td>
<td>2 4 5</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>2 3 10</td>
<td></td>
</tr>
<tr>
<td>Otolaryngology (ORL)</td>
<td>1</td>
<td>0 1 3</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0 1 0 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMF</td>
<td>0</td>
<td>1 1 3</td>
<td></td>
</tr>
<tr>
<td>Plastic</td>
<td>0</td>
<td>1 0 4</td>
<td></td>
</tr>
<tr>
<td>OBGY</td>
<td>1</td>
<td>1 0 2</td>
<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td>3</td>
<td>0 1 5</td>
<td></td>
</tr>
</tbody>
</table>


Table 4 The association between remediation and both different assessment tools and the presence of a remediation mechanism

<table>
<thead>
<tr>
<th>Remediation</th>
<th>Odds ratio (95% CI)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSATS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.53 (0.314-7.457)</td>
<td>0.596</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Videotaped analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9.05 (1.080-80.675)</td>
<td>0.026</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Surgical residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>1.08 (0.406-2.065)</td>
<td>0.878</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Surgical portfolios</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>7.03 (1.997-24.759)</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>


Recruiting Faculty and Motivating Them to Teach

Joanna Cain, MD
University of Massachusetts Medical School

I have no financial relationships to disclose.

OBJECTIVES

Will be able to:
• Describe motivations for teaching
• Identify individuals to be recruited
• Develop a plan for recruitment of teachers
• Reward your teachers

Identify the faculty to be recruited first
• Where are the gaps in the program?
• What characteristics (patience, prior efforts with students/residents, ability to translate complex anatomy into understandable components???) about their teaching are important?
• What additional training/ development do they need?
• What motivators do you think are the most important to them?

The motivation to teach comes from a deep rooted desire for generativity
• That nearly all (but not all) professionals share
• It gives meaning that we get from no other relationship: a legacy
• We all have something of value to teach

Studies show that to recruit you need rewards both tangible and intangible
• Intangible are legacy, satisfaction of seeing development of a colleague, ongoing professional relationships with learners
• Tangible: practice/ role enhanced by being chosen as a faculty member; recognition (also think of competition)
• Tangible: monetary (many models)
The “approach” requires thinking about the rewards

- What does this potential teacher do that is of particular value for the learner?
- How can the teaching occur that advances their career goals or practice goals?
- What “competition” exists to encourage them to be better teachers/learn?

What are the barriers to recruitment and teaching?

- Money, time, location
- TIME: ever increasing press for RVUs
- TIME: time to consider best approach or learner’s needs/develop faculty
- TIME can = Money
- Money can be minimal to be effective: Awards, planning time, support for conference
- Location: inner and physical site

Describe some “teachers” you would like to recruit:
What tangible and intangible rewards matter to them? Write this down.

Discuss in groups of 3 or 4
What is the best approach for this individual?
Then we will share the approaches

Meaningful rewards for teaching help retain faculty

- Recognition: status in field, in institution, by learners, by program, by colleagues
- Ability to leverage learner’s presence: safety and quality, research, new procedures, personal growth—both gain
- Peers: a new circle of learning and friendship
- Knowing that your influence reaches generations into the future
- Find a way to give TIME

How do we retain effective faculty?

- Meaningful feedback (no fault and formative)
- Meaningful and public rewards
- Peer mentoring/development
- “public” reporting of status of mentoring/teaching (eg. Time given to teaching)/competition
- OTHER REWARDS YOU CAN USE?
REFERENCES


Thank you.
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law **AB 1195** (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California's physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

**California Business & Professions Code §2190.1(c)(3)** requires a review and explanation of the laws identified above so as to fulfill AAGL's obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at [http://www.imq.org](http://www.imq.org).

**Title VI of the Civil Rights Act of 1964** prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 [http://www.usdoj.gov/crt/cor/pubs.htm](http://www.usdoj.gov/crt/cor/pubs.htm).

**Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency,"** signed by the President on August 11, 2000 [http://www.usdoj.gov/crt/cor/13166.htm](http://www.usdoj.gov/crt/cor/13166.htm) was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

**Dymally-Alatorre Bilingual Services Act** (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

~