

Clinical Education Committee

January 9, 2015

Minutes

Attendance:

MEMBER	CLERKSHIP/ROLE	ATTENDANCE
James Nixon	INMD 6805-6806-6807 Essentials of Clinical Medicine 3A-B-C; Process of Care Clerkships	X
Keith D. Henry	EMMD 7500 Emergency Medicine	x
David Power	FMCH 7600 Family Medicine	X
Chris Fallert		X
Briar Duffy	MED 7500 Medicine I MED 7501 Medicine II	<i>X, Chris Miller</i>
Miguel Fiol	NEUR 7510 Neurology	<i>Julie Pierce</i>
Yasuko Yamamura	OBST 7500 Obstetrics & Gynecology	<i>Deb Egger-Smith</i>
Katherine Murray	PED 7501 Pediatrics	<i>Dani Hans</i>
Sheila Specker	ADPY 7500 Psychiatry	<i>X, Anne Edvenson</i>
Robert Acton	SURG 7500 Surgery, CEC Chair	<i>X, Mitch Gmyrek</i>
Cornelius Lam	NSU 7200 Neurosurgery	
Edward RG Santos	ORSU 7200 Orthopaedic Surgery	
Jennifer Hsia	OTOL 7200 Otolaryngology	
Paul Gleich	UROL 7200 Urology	<i>Liz Mayock</i>
James Pacala	FMCH 7700 Primary Care Selective – Fam Medicine	
Sally Berryman	MED 7700 Primary Care Selective – Medicine	<i>Chris Miller</i>
Cindy Howard	PED 7700 Primary Care Selective – Pediatrics MED 7701 Primary Care Selective – Med/Peds	<i>Dani Hans</i>
Kathy Brooks	INMD 7200 Rural Physician Associate Program (RPAP)	X
Jacob Prunuske	Duluth Faculty Representative	<i>Paula Guisfredi</i>
Stephen Richardson	MS4 Student Representative	X
Ryan Dean	MS4 Student Representative	X
Maros Cunderlik	MS3 Student Representative	X
Anna Gregoire	MS3 Student Representative	
Mark Rosenberg	Vice Dean for Education	
Kathy Watson	Senior Associate Dean for UME	X
Majka Woods	Assistant Dean for ACE	
Anne Pereira	Assistant Dean for Clinical Education	X
Suzanne van den Hoogenhof	Measurement Specialist, Assessment & Evaluation	X
Heather Peterson	Registrar	X
Brooke Nesbitt	Clinical Education Manager, CEC staff	X
Abbe Holmgren	Clinical Scheduler	X
Leslie Anderson	OME Chief of Staff	X
Adam Maier	LMS Manager	X
Scott Slattery	Director of Learner Development	X

Review of minutes - November 7, 2014 - approved as is

Announcement -

Dr Bob Englander (AAMC) conducted a workshop during his December visit including a Qsort exercise addressing CEPAER's. This is a way to sort the 13 CEPAERs by relative importance and by size of the gap

between existing student performance and desired performance. Dr Woods will conduct this exercise with CEC at the February meeting. Attendance is strongly encouraged.

Student Issues - continued discussion of EMR access and training for medical students.

Updates - Scheduling Lottery 2015 (Class of 2017)

Scheduling Lottery is process for MS2 students to schedule clerkships and electives for MS3 and MS4.

Phase A - Requireds only

Changes:

#1- Lottery limited to 15-16 academic year (MS3) plus Periods 1 & 2 in 16-17 (MS4)

-Allows for continued changes to curriculum for 2016-2017 without currently enrolled students.

-Capacity issues - for most courses, there is enough space for 230 students, but up to half of those spots are already filled by MS4 students. Change will help maximize available clerkship slots in 15-16. Periods 1 & 2 16-17 added for capacity buffer.

#2 - Additional change, for the most part, students will be scheduling clerkships in period only, no site selection - exceptions include MS3 Period 1 & 2 and first two rounds (regardless of period). Question - how should students be placed in specific site placements? At Medical School level or at clerkship level? Dr Nixon indicated challenges of late add/drops. Deb Egger-Smith shared worry of having 30+ students emailing her asking for sites or sharing preferences. Leslie Anderson questioned if the survey to students was not done every deadline, but rather bi-annually. Dr Power shared that Family Medicine is already "assigned," as is PCS (and Sub-I). Steve Richardson shared that there is a Google Doc for the students where they can discuss and trade site selection and negotiate other schedule changes. Dr Duffy shared that major purpose of removing site selection of the Lottery is to take emphasis off of site; to that end, site placements should be made as late as possible. With the exception of concerns about individual students emailing preferences, clerkship coordinators did not voice particular concerns about managing site placement internally, as long as it could be done 6-8 weeks prior to clerkship start dates to accommodate onboarding.

#3 - Medicine 1. Not by design, but by programming necessity (MEdis) - the students will be pre-scheduled. Preferences for semester and site will be solicited by survey; placements made by Brooke Nesbitt prior to the Lottery. There will be time for changes or petitions after placements made, but still before Lottery. Students will enter Lottery with Med 1 placement on their schedule.

****PAUSE** (couple weeks)**

Dr Pereira and Brooke Nesbitt will review student schedulings and consult with those who need improvements. Will also look for opportunities to fill any unfilled clerkship spots.

Phase B- electives. Sites visible. End of March.

MS4 Lottery -

In October/November of MS3, students will complete another Lottery to schedule 16-17 Periods 3-8 (MS4). \

Discussion - Clerkship Modifications - presented by Dr Pereira

See attached Handout - Current State of Clinical Education

Credits - required, elective

Time for training

Additional responsibilities during clinical years

National trends for additional curriculum

UMN Medical School priorities for additional curriculum (workgroup areas)

*Note - the LCME does not require specific clerkships in particular disciplines, however it does indicate through the standards that there should be clinical experiences in those areas; clearest way to meet this standard is to have a required clerkship.

Goals -

1. Responsible use of existing clinical capacity
2. Creation of time in MS4 for additional curriculum (ex. capstone course, boot camp)
3. Ensure foundational clerkship completion in MS3 year for common base for students in advanced clerkships.

Proposed modifications

1. Convert to 4- and 8-week block lengths only for required and elective courses, thus eliminating overlap courses which limit student enrollment and flexibility.
2. Distinguish MS3 foundational required clerkships (max 40 weeks) from MS4 advanced required clerkships.
3. Suggest selective clerkships, that is, several paths through which students can meet requirements. Maintain these selective clerkships as required, but students need to select a subset of them, depending on specialty choice.

Proposed calendar (16-17 dates, but could not be implemented until following year).

Dr Prunuske asked why 2-week electives would be eliminated and when shorter vacations could be fitted in. Those short electives are often used to investigate potential interests without taking longer periods. Dr Pereira countered that feedback from students and courses has also indicated that many two week periods are shortened further by orientation, illness, etc. Dr Watson added that discussions may include whether some two-week options, that often become shadowing opportunities, could be inserted in MS2 to maintain opportunities for career exploration.

Maros Cunderlik asked what would happen to current 3-week electives, such as Medicine specialties. Response from Dr Acton is that likely they would become 4-week electives. CEC would need to review and discuss what would happen to 3- and 6-week electives.

Dr Brooks asked if 8-week clerkships would be discipline-specific or could they integrate two or more disciplines (examples include General Surgery plus a sub-specialty or Neuro plus Psych becoming Clinical Neuroscience - done at MCW). New MS4 electives could be designed that way to better reflect service lines.

Dr Watson asked for feedback to understand what clerkship directors knew of their specialties at the national level. Dr Acton shared that nationally, most surgical clerkships are 8-week or 12-weeks (12 weeks include sub-specialty). There are also an increasing number of boot camps in Surgery across medical schools. Deb Egger-Smith shared that Dr Yamamura in OB has statistics that most OB clerkships are 6+ weeks. Dr Brooks suggested looking at newer schools to see what they have designed originally. CMU? FAU? Dr Henry shared that in EMMD, schools are working together to create a core curriculum that all schools with core clerkships would implement. Dr Specker shared that nationally, Psychiatry clerkships are mostly required and are between 4-6 weeks.

Drs Brooks and Power shared that in Family Medicine, the national trends are towards continuity, but that clinical capacity (and ability to compensate preceptors) becomes an obstacle.

Dr Specker also suggested that modifications or redesign consider the balance of outpatient and inpatient experiences. Most of required clerkships are inpatient; should modification of those experiences included balance of setting. Dr Acton shared that while the OR is a magnet to students, there is definitely benefit to spending time in Outpatient Surgery or surgery sub-specialty clinics. Dr Prunuske added that outpatient experiences in one discipline, like Surgery, may have more application to other career interests, than an exclusively inpatient experience.

Dr Prunuske also referenced the priority of integrating basic science into clinical training. Changes the landscape of both scheduling and clerkship design.

Maros Cunderlik (MS3) indicated that his interest and preference is towards inpatient, but that he knows he would benefit from more outpatient experience.

Dr Acton shifted conversation towards foundational vs. advanced clerkships. If MS3 foundational clerkships are limited to 40 weeks, which courses should be included (and at what lengths)? Dr Prunuske asked if only the asterixed clerkships (including FMCH, with modifications to length of Psych and Peds) that would be 40 weeks right there.

Dr Brooks reminded group that LCME looks for experiences, not necessarily independent and/or required clerkship experiences. For example, "preventive medicine" is on their list, but no independent required clerkship exists. Dr Watson asked if tradition is limiting ambulatory experiences in MS3-4 to generalists. Ryan Dean shared his experience in Neurology within an ALS-focused clinic. a model of interprofessional care and chronic disease management. Other potential ambulatory experiences could include Obesity clinics, etc. May also have significant opportunities for interprofessional experiences.

Dr Fallert asked if core clerkships in Pediatrics and Internal Medicine are exclusively inpatient. For the most part, Primary Care Selective accounts for the outpatient experience in those disciplines; Pediatric sites may have some outpatient experiences. Dr Prunuske reflected that the numbers of students going into Primary Care (decreasing) may be an indication that the current design is not working.

Dr Pereira solicited feedback from Emergency Medicine....Dr. Henry stated that is committed to keeping EMMD as a required rotation, though potentially open to it being an MS4 rotation, while still maintaining the opportunity the opportunity for interested students to take it early on. Dr Watson clarified that that opportunity is parallel with goal to NOT have students taking foundational rotations in Periods 6-7-8.

Dr Duffy added desire for students to have more preparatory experience prior to MS3 Period 1, building upon the current POCC experiences. Dr Acton shared that doing Inpatient Surgery POCC in the afternoon is not the most preparatory due to Surgery schedules. Steve Richardson asked if a more organized effort by the Medical School to provide shadowing experiences so that students can have pre-clinical exposure that fits clinic and preceptor schedules.

Next meeting: February 5, 2015