Clinical Education Committee
December 2, 2016
Minutes

Review of Minutes: from November Approved

Introduction of new members

Guest Brad Benson regarding charge of the CEC by Education Council

Dr. Benson shared that he wanted CEC to be a successful, efficient and effective meeting. There are five committees that are advisors to the dean. Education Council (EC) owns the curriculum and the outcome of the medical school and advises the dean most closely about curriculum. EC gives vision and oversight not management. Then EC makes sure that the leadership has the resources to make that happen. CEC, SFC and CUMED will check in with EC every six months to make sure that everything is in line between the committees and have objective measures in place to keep them on track.

Two things that EC is focusing on right now: The next AAMC visit is in 2020. Another thing that they're looking at is the graduation questionnaire. Students are less satisfied and more burned out with their medical education. These are the big picture things that EC is hoping that the CEC should be thinking about while making curriculum decisions. Making sure that students are more satisfied with their education should be a core value that we need to continue to think about.

Dr. Fiol asked if there was a way to continue communication between this committee and EC. Dr. Murray is serving as the liaison to EC and she could bring back the charge on things that are particularly relative to CEC. This can be an agenda item going forward. Dr. Ercan-Fang inquired on what is causing the results of the survey. Dr. Benson and the EC are doing a lot of analysis on this and they think there are many different factors, one of which being attending burnout and lack of connection between learners, physicians and the community. Dr. Kim explained another item that causes burnout in the first and second years would be the lack of connection with their physician identity. Dr. Kim and his team are bringing together focus groups of students to explore this. Dr. Pereira explained that data shows that longitudinal experiences help to raise satisfaction and lessen empathy loss and that the medical school is moving towards all students having some sort of longitudinal experience within their four years. Dr. Hobday expressed that the lane cohorts throughout their 3rd year and then the intercessions will provide a time to build connections between students. Dr. Murray expressed her hope that we will engage on issues of burnout and engagement to work towards better outcomes for our students in the graduation questionnaire.

Annual Clerkship Review (ACR) - reintroduce CEC Presentations

Dr. Murray explained that in the past the ACR was a presentation to the group about how the clerkships had been going over the past year. She then stated the need to figure out what will be most helpful to share and what colleagues would like to know (common struggles, common challenges, etc.). She wants to make this experience as valuable as possible for the group.

Dr. Fiol explained his process for doing the clerkship review. One of the challenges he expressed was the difficulty in reaching the 10 sites. Dr. Olson added that another challenge is standardizing across sites and expressed the need to analyze what variation is and is not okay. The students clearly share what different sites do and do not do so to make sure it is the same is very important. Dr. Nixon said that this committee is a good place to make sure that the experiences that students get on an LIC is comparable to the experiences that the block students are getting too as we continue to add LIC opportunities. Dr. Ercan-Fang explained that they do try to replicate the curriculum as much as possible. Dr. Nixon expressed that there needs to be regular check ins with these clerkships though to ensure that they continue to be equivalent experiences.

Dr. Ercan-Fang expressed another challenge is to integrate the curriculum and to incorporate some of the information that students learn in the first two years of medical school. She would like to build on that education but doesn't know exactly what they have learned in their pre-clinical years.

Dr. Baker said that RPAP does a survey with students after their time on RPAP and that might be an important part of presentation to the committee. Dr. Olson added that as we continue to build on MSPE writing and recommendations, we need to think more holistically about students and that we evaluate them on many different criteria instead of ranking students. Dr. Baker expressed the challenge of how to assist students who might need more one-on-one help and that an LIC may be a way to bring everyone into the same playing field.

Dr. Murray said it might be more helpful to do theme-based ACR presentations where multiple clerkships speak on a theme of the context of their clerkship instead of having each clerkship share individually on all of their information from the ACR. Dr. Nixon agreed that would be a good idea. He expressed that one way to group themes would be around EPAs to ensure that all of them are addressed across the clerkships and to avoid redundancy. This would help to better integrate the curriculum between pre-clinical and clinical years. Dr. VanDen Hoogenhof expressed concern that we don't really get student feedback on EPAs. Dr. Murray asked if Dr. Pereira had an idea about how soon we will be moving towards EPAs so that we can center around a specific goal. Dr. Pereira expressed that this is part of the goal of the educational retreat to discuss these shared principles. Likely one of these will address standardized outcomes demonstrated by the EPAs and the pathways to get to these outcomes. Administration is aiming towards this in the next 2-3 years. One question about this is how to do this in concert with grades and students anxiety about the match. Dr. VanDen Hoogenhof

expressed that the shared competencies are the PCRS which is what the students must meet by the time they graduate. Dr. McCarthy said one challenge will be to engage faculty so that they understand the objectives. Right now from her perspective, the faculty are still not developed in that area.

Dr. Hobday said that in block clerkships there is a disconnect between block rotations and longitudinal physician development. She wondered if there may be two levels of how we give feedback to students? One for the clerkship and one overall that they can take along with them as they continue on in their medical career. EPAC students get these larger picture feedback from a committee and it has worked well for them, but could potentially work on block clerkships. Dr. Olson explained that when grades don't matter it completely changes the discussion about competence. He suggested if there is a two level system, directors would need to figure out a way to work on learner handoffs. He also expressed that it would be helpful to know what the student needs to work on before they start the course. He also questioned if we can standardize that. Because our medical school product is ultimately residency, students are going to continue to care about grades because that is how they are going to match. EPA's are in direct opposition to grades, so until we decide we're going to change grades, this may not work. Nicole (student rep) acknowledges that the grades are very important especially for competitive specialties. She also stated that the group was underestimating students by assuming that they don't want to be competent physicians. Once people shift their mindset, students will likely be okay with what they are doing. Students do adapt. Dr. Olson expresses the concern about how to handle the transition and how to report on competencies for a residency application system. Dr. McCarthy expressed concern for folks who are going into competitive specialties and the impact on their potential to match. Dr. Baker explained that for RPAP and MetroPAP, they are mostly going into primary care which is not very competitive, though they have had some who go into more competitive fields and they have been very successful. Though the transcript looks the same as every other student.

Dr. Nixon expressed that it would be nice to do longitudinal competency. Students will need to be more confident to express the things that they need to work on at the beginning of the clerkships. He would also like to see less of a reliance on shelf scores for assigning the grades. Physicians would need to get better at assessing their other competencies and preparing faculty to give meaningful feedback.

Dr. Murray wondered if everyone routinely review their clerkship feedback from the students as a part of their annual process. Many agreed. Also asked if everyone has a strategy of disseminating that information to the faculty at their sites. Again many agreed. She summarized that there is a lot of interest in thinking creatively about meaning making, relationship building, burnout, increase in empathy; ensuring successful coordination between sites; a shared understanding of what the outcomes are; integration of previous curriculum; assessment feedback supporting longitudinal development of professionals but doing no harm to them as they continue into residency. One proposal is that we take ACR and rather than having it clerkship by clerkship, address these themes. She wants to set up that discussion with

engaging questions on that theme and or set of proposals for the group to respond to with the goal to come up with an action plan going forward. Dr. Fiol talked about the need to prioritize these areas and have people with expertise speak to that. Dr. Kim expressed that there are some programs that give one grade for the entire 3rd year instead of grades for individual clerkships.

Dr. Van Den Hoogenhof and Dr. Pereira have been meeting with DIOs of institutions and have asked to share the clerkship review data with them to make sure that they can start working to make these experiences better with the students. Dr. Pereira asked if this would be okay to share with the DIOs so they can support their faculty. Dr. Murray expressed that the directors would also need to share it with the site director at that site so that the communication doesn't go on above their heads. Dr. Pereira expressed that the information flow needs to be from clerkship directors to site directors before this is shared with DIOs.
There was confusion on who the DIO's are and what they do. Dr. Van Den Hoogenhof explained that although the DIO's are in charge of GME, they are also unofficially in change of UME. DIO = Designated Institutional Official and they report compliance to the ACGME. Dr. Pereira explained that they are responsible for education broadly for those institutions. Dr. Van Den Hoogenhof explained that the sites are now asking to get comparative evaluation information from other sites. Dr. Fiol expressed concern that they would need to have contact with their site directors first. Dr. Van Den Hoogenhof expressed that they will likely not zero in on one clerkship but to look at across clerkships how to make their site better as a whole, not just for one individual clerkships. Dr. Pereira said they mostly want to get an idea about their learning environment instead of individual departments. Dr. Kim suggested that we invite the DIOs here for a meeting. Dr. Murray is going to pull themes together and work with Dr. Acton to structure the ACR differently.

<u>Curriculum Integration</u>
Dr. Murray would like the group to think about how integration between clinical and basic science would look like. Dr. Fiol said he was concerned that we couldn't push too much on students at the same time. Dr. Olson suggested that faculty help students organize information through clinical information from the very start instead of separating them out and that there shouldn't be a division between basic science and clinical at all. Instead faculty should teach facts in a clinically applicable way. Dr. Henry expressed that this is in some ways this is already happening within the first 2 years. Dr. Murray doesn't know what types of educational strategies are being used in basic science to help incorporate those into the 3rd and 4th year.

Dr. Pereira expressed that there have been dyads in teaching within the first 2 years where the clinician is paired with a basic scientist to help bring in clinical correlation, though it has had varied success. BlackBag is our learner management system so everyone can know what students are learning before they get to their course. Most of the HHD courses in the 2nd year are taught by and facilitated by physicians so they get a lot of clinical correlation, though much of their information is from foundational scientists instead of clinicians. Dr. Murray wondered how much of that learning is case based. Dr. Pereira said that there is a small minority. Nicole

said that 2nd year was significantly more, though there wasn't as much. Maybe 1/10 in the first year and ¼ in the 2nd year is case based learning. Dr. Olson expressed that many physicians are saying that information is not important, so it becomes a challenge. Nicole has said that many residents still remember their foundational sciences and ask the students to teach them the basic foundations.

Dr. Nixon has been a part of a group who is looking at this nationally. Basic science physicians broke their field down to the top 10 things that students needs to know about their specialty and then a harm statement where if students don't know these things, they could cause harm to a patient. Basic scientists and clinicians don't talk to each other and schools should have a meeting that brings these groups together to work on specific ideas. Dr. Murray expressed that clinicians need to start working on how to integrate working on basic science foundations into the clinical years as well as working together with basic science colleagues to work on integrating clinical experience into the basic science.