

## **Agenda**

### **Clinical Education Committee**

**August 3, 2018, 0700-0830, Mayo B646**

#### Open

June minutes approved (Ercan-Fang) – Approved in advance

New members and new committee administrator (Dr. Pereira) Lora Wichser, Psychiatry Clerkship Director (adult psychiatry)

- Dr. Wichser shared that she graduated from the University of Minnesota Medical School and did her residency here as well. She graduated in 2017 and is interested in working with medical students around wellness, especially in how that relates to assessments and clerkships. She wants to focus on how to make the clinical experience purely exciting for students rather than exciting and terrifying.

ICU Sub-internship Director Ronald Reilkoff (adult pulmonary-critical care)

- Dr. Reilkoff shared that he completed Medical School at North Dakota and did his residency on the east coast. He came to Minnesota in 2016 as the ICU Director at Southdale where he worked with medical students in their Sub-I rotation and became interested in this work.

Beth Cliffe, REACH Coordinator

Alexandra (Alex) Behrend, EPAC and Pediatrics Coordinator

Sarah Dohm, CEC administrator

Dr. Pereira announced that today is Brooke Nesbitt's last day in the Medical School. Brooke shared that she will be working in CFANS as the Department Administrator for Animal Science.

#### 12-month work plan review (Dr. Ercan-Fang)

- Dr. Murray shared that there are a number of opportunities for members to volunteer to participate for September and October in the work plan. In September we will focus on clerkship director support and onboarding. In October we will focus on LCME preparation.

#### Reports

Ed Council Reports from [June](#) and [July](#) (Dr. Ercan-Fang)

- In the June meeting, Dr. Michael Kim presented COSSS and SSC updates. See linked meeting notes.
- In June Taisha Mikell provided a BA/MD program update. See linked meeting notes.
- Dr. Ramaswamy expressed concern over the 50% success rate that was reported for the BA/MD program and asked what the plan is going forward. She asked if new students will be brought in next year and if there is a plan to ensure this program works for the current students
  - Dr. Ercan-Fang responded as she attended the 4 hour meeting with the group where students were brought in for the committee to meet with. She noted that the primary focuses were concrete remediation plans and decreasing extracurriculars for students. They are trying to find funding for students to help offset students' need to work. Dimple Patel and Taisha Mikell are conducting a root-cause analysis to determine which factors have correlation.
- Dr. Ramaswamy asked how the students' course load compares to other undergraduate students.
  - Dr. Ercan-Fang noted that these students complete their coursework in 3 years so they do the same course load in a shorter amount of time however she wasn't clear on all of the specifics.
  - Dr. Pereira added that she didn't have the specific details either but they do have more courses than average.
  - Dr. Ercan-Fang added that the existing remediation plans are challenging and may not be realistic for students.
- Dr. Ramaswamy asked if the program is recruiting students for next year.
  - Dr. Ercan-Fang responded that, yes, the next cohort has been recruited.
- For the July meeting, Dr. Ercan-Fang shared that Ed Council had a special meeting due to the recent student death. The meeting focused on mental health and suicide prevention. See linked meeting notes.
  - Dr. Wichser mentioned the need to address tunnel vision for students and it would be useful for students to have one number to call when looking for support. Dr. Wichser added that solutions need to be shared across clerkship sites since the recent suicide occurred while the student was in their third year completing clerkships.
  - Dr. Gleich added that this tragedy could be a trigger for discussion of practicing physician mental health. Dr. Gleich noted that physicians seem to be at a higher risk compared to other professions. He asked if this is a continuum of risk through Medical School or if there is a sense that there are different issues arising for practicing physicians. He noted that when

students leave Medical School we should do more to consider their continued mental health and asked if there were plans for the group to consider where that work leads.

- Dr. Pereira noted that Dr. Rothenberger's position was developed to focus on faculty wellness and recognizing that it is a continuum. She shared that student data shows that burnout in the first two years is largely due to a disconnect between content and their purpose as a physician. She noted that in years 3 and 4 the focus is on environment as that relates to burnout. Dr. Rothenberger wants to look at the continuum from students, residents, and faculty. He is working with GME and Dr. Nelson and would like to include teaching programs across the Twin Cities.
- Dr. Ercan-Fang added that the continuum begins in college and that Medical School admissions and competition is very challenging starting in undergrad.
- Kevin O'Donnell added that students face hurdles getting into Medical School and the pressure of residency and matching hang heavily on students' minds. He added that the stigma does exist.
- Dr. Jewison added that medical students are not the only students to face this. He shared that student athletes are similarly under a lot of pressure and there is work being done to provide more psychological support. He added that his department has planned burnout conversations included in Grand Rounds.
- Dr. Ramaswamy supported recognizing that burnout begins in undergrad and continues through the continuum. She asked what we are doing in the admissions process to determine resiliency in Medical School candidates.
- Dr. Pereira replied that 2 years ago the Medical School shifted to multiple mini interviews which is a more systematic and fair way to look for qualities that we'd hope to see in our students. She added that the toxic environment is more of the focus.
- Dr. Skarda shared that studies show that medical students skew to more suicides. She added that environment should be the focus.
- Dr. Reilkoff shared that from his personal experience environment is a huge factor and matching oneself to the right fit for practice, medical school, or residency is important.
- Dr. Jewison added that the multiple mini interview process has been a significant improvement and shows how applicants work together, communicate, and deal with stress.
- Dr. Ercan-Fang wrapped up the discussion and suggested there be more time to continue this discussion in the future.

### Clerkship director of the month (Dr. Reilkoff)

- Dr. Reilkoff has been in the ICU Sub-Internship Course Director role for 4 weeks. In the upcoming year there is discussion around shifting some ICU sites and adding in new sites based on student experience and exposure. In the next few months he will be working on down-time curriculum. His hope for the next year is to ensure that students complete their ICU Sub-Internship with the necessary experiences to feel competent in this area. He wants students, at the end of this rotation, to intuitively know the first and second steps they should take and, while in those steps, know when to ask for help.
  - Dr. Pereira added that this course was developed to address gaps of knowledge students had when entering residency. In a national survey of program directors the biggest student challenges found were ability to know when to ask for help, communicating in an interprofessional team, and prioritization of tasks in a busy environment, which are the primary goals of the ICU Sub-Internship clerkship.

### Discussion

#### Recommendations of Tuition Allocation Task Force (Dr. Ercan-Fang)

- Members of the task force are Dr. Hutto, Dr. Murray (Chair), Dr. Nikakhtar, Kevin MacDonald, Dr. Calhoun, and Dr. Pereira. See link for recommendations.
  - Dr. Nixon asked for the rationale for having .25 FTE come from the University and having the other .25 supplied from the department instead of allocating a straight .5 FTE since the money is coming from the same place.
  - Dr. Ercan-Fang thought the money came from the department, not the Medical School via the department.
  - Dr. Nixon shared that the medical school designates money to the department, which the department uses at their discretion. The additional .25 would come from a larger pot of money for teaching. Dr. Nixon recommended that, if .5 is the recommended FTE, this should be combined and earmarked for the director's salary.
  - Dr. Murray shared that the task force made the recommendation in this way because the jump from .2 to .5 would be a bit of a shock. The alliance recommended .25 for administrative responsibilities associated with clerkships and .25 for scholarship and direct teaching. Dr. Murray added that the task force is very open to feedback about how this breakout is done.

- Dr. Nixon added that the line items should be explicitly broken out considering that some clerkship directors are based externally from the U of M.
- Dr. Ercan-Fang confirmed that, as an affiliate course director, she is impacted if the U of M doesn't dictate where money goes.
- Dr. Skarda expressed concern over funds not supporting medical students for things such as parking and meals while on long shifts.
- Dr. Howell appreciated that the task force recognized how much work is involved in running a clerkship. Dr. Howell stated that he could use help using some of these funds for outside sites who would be fantastic for students but they need a catalyst to make this relationship beneficial to the sites themselves. He asked if there was a distinction for how we could potentially use funds for this purpose.
- Dr. Murray responded that the purpose of the task force was to begin conversations with transparency. With transparency, the group can be on the same page about where tuition allocation dollars are spent.
- Dr. Jewison asked if there would be a monthly or yearly report where departments have to show where funding was spent by category. He also asked what potential push back the task force foresees.
- Dr. Skarda added that the U of M should be aware that other medical schools are approaching doctors. She supports funding for students to improve culture and making sure student needs are met while in clerkships.
- Dr. Pereira clarified that the task force is asking for transparency around tuition allocation.
- Dr. Nixon stated that MERC money is another source of funding. This funding should be transparent and each institution can share how they are using this money to support education.
  - [Here](#) you can see the MERC reports.

Learning Environment [Executive Summary](#) and [Best Practices: Family-Centered Rounds](#)

(Dr. Watson, Dr. Prekker)

- Dr. Watson shared that Family-Centered Rounds (FCR) is a way to bring a team focus to teaching sites comprised of medical students, residents, faculty, nurses, and other staff. FCRs are meant to be a reverse site visit concept that assures an excellent learning environment. Student interactions in FCR are meant to be meaningful and this process provides continuous feedback in key moments of patient care.

- Dr. Prekker works with pediatric patients at a county hospital. FCR is a multidisciplinary rounding model that involves planned, purposeful interaction involving families, doctors, students, and staff. There is a complete case presentation and discussion with family involvement in the decision making process. When doing FCR, someone is establishing discharge criteria, someone is writing goals on patient board, someone is writing orders, and the nurse is going through and asking for clarifications. There is work being done during FCR and it is educational. That education doesn't look like didactic learning that some students are used to. A lot of the learning comes from modeling communication, professionalism, interactions with families, and team building with a multidisciplinary team. FCR is not just moving table rounds or hallway rounds and going in front of the patient.
- FCR provides immediate feedback so faculty can see how students are learning to interact with families. As soon as the team leaves the room, you can have a conversation with students about areas where you noticed them struggling and offer feedback on how you would approach the situation. There are barriers such as addressing sensitive topics, managing a large team without intimidating the family, and using interpreters however the benefits outweigh the barriers.
- Dr. Ercan-Fang asked how they deal with students making mistakes and giving incorrect information during FCR.
  - Dr. Prekker stated that there are awkward moments. The goal is to make the learner feel comfortable with awkward encounters and set up learning with the expectation that it's okay if you don't know all the answers and that the team supports you. Families seem to be forgiving and are okay in these situations as long as they see that the student might not know the answer but, as long as the attending has a calm and confident presence and provides feedback, it is okay to redirect the information. Setting expectations is important. Some conversation about the family and plan before going in the room is okay.
- Dr. Skarda asked about what happens when team members disagree and how that is handled.
  - Dr. Prekker shared that she tries not to argue in front of families. The team should be somewhat on the same page before going into the room. If a learner has a recommendation that the attending may not agree with but it is reasonable, you can let the learner drive the ship and then you can take the rest of the discussion outside the room.
- Dr. Fallert shared that Family Medicine uses FCR in clinical setting. He asked FCR translates to efficiency in a hospital setting.
  - Dr. Prekker shared that studies show FCR takes a little bit longer to do at the bedside. It takes more time to accomplish up front but saves time later. Having everyone there at the same time for that 15 minutes means everyone is on the same page and understands what the plan is. The resident has written orders at the bedside so there are less resident calls to clarify questions and that the nurse doesn't understand what you're talking about. The hard part is not saving attending time but it does save resident time with that afternoon clarification.

- Dr. Nixon asked how FCR works with students earlier in the third year who don't have as much experience presenting at the bedside.
  - Dr. Prekker responded that students can do it. Things do take more preparation earlier in the year. Learners should watch what FCR looks like before they need to lead structured family conversation or a SOAP presentation. Early in the year more senior residents model what it looks like so they can see this example and watching YouTube videos helps too.
  - Dr. Nixon added that he has been doing a mix of letting students present in the old way so they get that down and then they do FCR at the bedside.
  - Dr. Prekker added that new admissions in the afternoon are a good time to sit down and say that you will practice presentations.
- Dr. Prekker added that she does FCR most of the time but there are times when she doesn't. FCR doesn't need to be performed the same way with every family but, instead, can be patient specific.