

**Clinical Education Committee  
May 1, 2015  
Minutes**

**Attendance**

<b>MEMBER</b>	<b>CLERKSHIP/ROLE</b>	<b>ATTENDANCE</b>
James Nixon	INMD 6805-6806-6807 Essentials of Clinical Medicine 3A-B-C; Process of Care Clerkships	X
Ray Christensen	Rural Medical Scholars Program	
Keith D. Henry	EMMD 7500 Emergency Medicine	
David Power	FMCH 7600 Family Medicine	X
Chris Fallert		X
Briar Duffy**	MED 7500 Medicine I MED 7501 Medicine II	<i>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>Murray @ 8:30, Sara Duxbury</i>
Sheila Specker	ADPY 7500 Psychiatry	<i>X, Anne Edvenson</i>
Robert Acton	SURG 7500 Surgery, CEC Chair	<i>Mitch Gmyrek</i>
Cornelius Lam	NSU 7200 Neurosurgery	<i>Rachel Radman</i>
Edward RG Santos	ORSU 7200 Orthopaedic Surgery	X
Jennifer Hsia	OTOL 7200 Otolaryngology	
Paul Gleich	UROL 7200 Urology	X
James Pacala	FMCH 7700 Primary Care Selective – Fam Medicine	X
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>X, Sara Duxbury</i>
Kathy Brooks	INMD 7200 Rural Physician Associate Program (RPAP)	<i>X, Bill Fricke</i>
Jacob Prunuske	Duluth Faculty Representative	<i>X, Paula Guisfredi</i>
Stephen Richardson	MS4 Student Representative	X
Ryan Dean	MS4 Student Representative	X
Maros Cunderlik	MS3 Student Representative	
Anna Gregoire	MS3 Student Representative	X
Michael Kim	Assistant Dean for Student Affairs	X
Kathy Watson	Senior Associate Dean for UME	X
Majka Woods	Assistant Dean for ACE	X
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
Brad Clarke	Curriculum Specialist	X
Julie Ansell	UME, Clinical Education - Project Specialist	X
W. Scott Slattery	Director, Learner Development	X
**chaired meeting		

**Minutes** - not enough directors at this time to approve. No edits from members present.

## **Announcements**

CEC Schedule changes: CEC will remain on first Friday of the month, but moving up to 7:00am, per requests. SFC moving to different Friday. Joint SFC/CEC quarterly meetings. Watch for annual calendar with minutes. NO JULY MEETING. Yes June meeting with breakfast.

MEDS: Best Practices in Medical Education Day - If you have not yet signed up, please do so. Day includes well-renowned guest speakers and UMN session presenters. Please encourage your faculty and residents/fellows to come. Attendance has increased each year! Next MEDS workshop is coming up in MERSC series. Plans are to continue to offer with interest.

Late grades: With the PeopleSoft upgrade, there are new processes and timelines for entering grades (for transcript). There will be a delay for the entry of some spring grades; this is not due to the clerkships or coordinators, but fully due to the upgrade shutdown. The registrar will be contacting some courses that have a handful of grades that would be late.

## **Student Comments**

Student Council has not met since the last CEC meeting, so there are no new issues to present. Today is final CEC meeting for MS4 representatives - thank you! Graduation is Friday, May 8 at Northrup.

## **Updates**

BlackBag - Clerkships are working closely with Adam Maier to convert and configure their clerkship sites in BlackBag to be ready for use in 2015-2016.

Thank you to Dr Michael Kim, new Assistant Dean for Student Affairs for years of excellent service as PCS Course Director (Pediatrics, Medicine/Pediatrics).

## **Discussion**

Clerkship Redesign - handouts include rationale for redesign and calendars (current MS3-4 calendar, proposed calendars for MS3 and MS4 17-18). There are 56 required clerkship credits and ~50 weeks in each clinical year for instruction. Goal includes having foundational clerkships (4- and 8-weeks in length) and advanced clerkships that allow for some student choice. Students would enter MS3 calendar at one of the points in the bottom table (rationale handout). Sequence would be consistent, but starting points would vary, to provide directors with a more homogenous group of students (previous courses, point in career).

No change to starting time for clinical rotations, due to need for USMLE study break. There are intersession weeks that are dispersed throughout the year for institutional assessments, reflection sessions with faculty advisors, project work, etc.

Dr Power shared potential struggle of students who would start with Family Medicine clerkship - no previous rotations, no EMR training. Dr Pereira noted that time between now and proposed 17-18 calendar would allow for preparation for this model. Dr Nixon and Dr Pacala expressed enthusiasm for calendar, but Dr Pacala expressed concern that model takes a step away from Primary Care. Students could complete foundational clerkships, and then select not to take Primary Care Selective. Dr Kim noted that many of the foundational clerkships do include ambulatory experiences, like Pediatrics (primary care). Dr Pereira asked for any suggestions about how to retain Primary Care experiences. Dr Pacala responded that integrating primary care experiences into other foundational clerkships is one option. Students would need to accrue a certain number of weeks of Primary care experience throughout their career. Dr Pereira added that there are resource limits in Primary Care Selective; if there is not enough capacity for all to take Primary Care Selective, what are creative ways to maintain or increase the experiences based on same amount of resources. Dr Prunuske added that having all students take FMCH clerkship in third year, provides an opportunity to introduce primary care ambulatory care to students who may have otherwise pushed FMCH clerkship into their later fourth year. Dr Specker commented that the selectives do allow adherence to certain "experience" expectations, with flexibility in which courses students take to meet those expectations. Dr Nixon added that almost all Year 1-2 students on both campuses get primary care experience in their clinical courses. An option may be to investigate increasing

the amount of primary care experiences in those early courses. Dr Brooks, while analyzing the impact on RPAP, notes that changes to inpatient/outpatient balances may be difficult to implement in a program that has a focus on primary care.

Heather Peterson shared that current schedules where periods cross semesters are out of compliance with federal financial aid regulations. Proposals for new calendars can and should ensure that periods are in compliance with university schedules and federal regulations.

Dr Power noted that many medical schools are making changes to clerkship lengths, Step 1 registration timelines, etc. that allow for more flexibility in experiences in third year.

\*\*Dr Pacala also asked if basic science redux is not included in intersession weeks, does that have to be integrated into now shorter 4-week clerkships.

Anna Gregoire asked if students with specialty interests (or potential interests) would have input into where on the sequence they start. Dr Pereira responded positively that students could have opportunity to state preferences (versus the lottery) before being scheduled into a "track."

Dr Pacala inquired about the Medicine Sub-Internship in Critical Care (that replaced Medicine II). With Medicine at 12 weeks, are there opportunities for ambulatory experiences? Dr Duffy shared that the charge, in the shift to Medicine 1 at 8 weeks, was to extend the foundation inpatient internal medicine experience. That mission would need to be re-addressed, before changing the focus of Medicine 1. Dr Pereira added that there is less value in short bursts of ambulatory primary care than in a longer longitudinal experience in ambulatory primary care.

Ryan Dean shared that one of the advanced electives could be "required" to be in primary care. Also, students interested in primary care could re-visit the same setting for each of their electives, even if not back-to-back. Dr Nixon added that could be extended into early years, too.

Anna Gregoire shared her perception from the flip-side - as a student more connected to primary care, her 4-week experience in the ICU, though uncomfortable, will help learn and appreciate the other side of medicine. The same may be true for students not committed to primary care when they are in their ambulatory primary care rotations.

Dr Power added that the current LIC experiences, including UCAM, provide longitudinal primary care experiences. Those experiences should be maintained (filled) with options for expanding. Dr Pereira noted that there is awareness of and commitment to maximize the current capacity, as well as the struggle to add capacity. There is not a consensus to just deal with the capacity that we have now, but use that capacity appropriately while continuing to seek opportunities for more experiences. Dr Nixon also wanted to recognize the improvements made in the MS1-2 ECM process of care clerkship on the TC campus - all students now get 8 half-days in clinic, systems are in place to manage and track clinic placements, and students express gratitude to their sites following the experience.

Dr Watson asked for comments and feedback from Surgical directors. The proposal to integrate two weeks of surgical sub-specialties into the longer Surgery clerkship. Dr Santos (Ortho) expressed satisfaction with the proposal, while noting that at least one site only hosts the four-week rotation.

Steve Richardson (MS4) shared that, in his experience, during his primary care experiences, the experiences are so varied that it can be frustrating for students to work with a different preceptor every four hours, following different guidelines for notes, etc. Such focus on certain details as an MS4 took away some of the experience of the overall patient care.

Dr Specker asked if there was still attention in the new schedule for MS4s for interview and Step 2 exams. Dr Pereira noted that there are 12 weeks worked into the schedule for these events; capacity in the MS3

year for foundational clerkships would need to support that break. Ryan Dean expressed support for this notion given the logistical work of arranging flights, interviews, exam dates.

Final thoughts for today on this topic - committee support for general outline.

#### Four Habits Model

Pressure on providers to have increasingly better communication skills. The Step 2 CS exam now has an increased focus on communication skills. The Four Habits Model is an easy rubric for clerkships to integrate a consistent approach to patient communication. \*see handout

Dr Brooks shared that this model is used during RPAP. Anna Gregoire shared that it works well for students to see this rubric and get feedback from direct observation about what they are doing well/not well relative to rubric. Dr Nixon added that a consistent model should be used across all years both campuses. Currently, ECM on TC campus uses a different model, but could easily transition. Dr Prunuske added that it is a good model, but may not be applicable in all courses (like during L&D or surgical sub-internships). Ryan Dean noted that it is a rare occurrence if he is directly observed during his patient interviews now. Even without direct feedback, it would be helpful to have this rubric for him to determine if he has deviated from the skills/behaviors he was taught in ECM. Dr Fallert emphasized the need for application across more than just primary care experiences; different specialties can review and determine application within their courses. Steve Richardson further emphasized the need for students to learn the different interview and exam behaviors within each specialty (how to structure an appointment in that field).

Dr. Watson asked for next steps options to implement this across campuses and clerkships. Ryan Dean offered that it would be helpful to introduce this within 1st and 2nd years and then continue to reinforce this throughout the rest of the medical school career. Anna Gregoire shared that it would be helpful to include this in the mid-clerkship feedback. Dr. Howard shared that it would be essential to do faculty development on this type of model. Dr. Specker offered that this would help to give more specific feedback to students. Dr. Prunuske shared that this model offers a more fluid evaluation of communication rather than a "check box" method of giving feedback on things like OSCE's. Many shared that there should be one method that we all agree on. Dr. Pacala shared that this should somehow be combined with the UMP communications course. He also offered that the course directors could do some teaching on what types of communications are important in each specialty field on each clerkship. Dr. Gleich said that he would like to see more of the first and second year students, but it is challenging for those students to talk to specialty patients because they don't know enough yet. Students need to be able to see the types of communication that go on even in their first and second year patient experiences. Steve Richardson expressed need for instruction on the structure of communication to patients in each specialty. Ryan Dean added the integration to how to deal with a difficult patient and with being culturally competent in patient care. In conclusion, Dr Watson suggested that a proposal go to all committees/directors that this is the framework that should be named/used for common language for things being taught to students now, just in a variety of models. Establishment of this as a consistent model within the Medical School will help to connect if there are slightly other versions used in our clinical affiliates.

**Next meeting: June 5, 2015**