

JOINT MEETING
Clinical Education Committee
Committee on Undergraduate Medical Education Duluth
Scientific Foundations Committee

April 1, 2016
7:00 – 8:30 am
Mayo B-646 & by Polycom

Minutes

2015-2016 Scientific Foundations Committee Members		
MEMBER	COURSE/ROLE	ATTENDANCE
Steve Katz	Chair (INMD 6814 Physiology)	x
Sharon Allen	INMD 6803/6804/6805 ECM 1, ECM 2, ECM 3A	
David Baldes	INMD 6815 Human Behavior	
H. Brent Clark	INMD 6819 HHD – N & P	x
Greg Filice	MS 2 ID Thread	
Glenn Giesler / Matthew Chafee	INMD 6813 Neuroscience	/ x
Bob Kempainen	INMD 6808 HHD – C & R	
Robert Morgan	INMD 6809 HHD – R, D & O ³	x
Brian Muthyala	INMD 6803/6804/6805 ECM 1, ECM 2, ECM 3A	
Kaz Nelson	INMD 6819 HHD – N & P	x
Catherine Niewoehner	INMD 6810 HHD – R & E-R	
James Nixon	INMD 6803/6805/6806/6807 ECM 1, ECM 3A/B/C	x
Jan Norrander	INMD 6801 Human Structure and Function	
Deborah Powell	INMD 6817 Principles of Pathology, MS2 Pathology Thread	
Michael Ross	INMD 6816 Human Sexuality	
Michel Sanders	INMD 6802 Science of Medical Practice	
David Satin	INMD 6803/6804/6805/6806/6807 ECM 1, ECM 2, ECM 3	
Peter Southern	INMD 6812 Microbiology	x
Heather Thompson Buum	INMD 6811 HHD – GI & Heme	x
Tony Weinhaus	INMD 6801 Human Structure and Function	
Kevin Wickman	INMD 6818 Principles of Pharmacology	
Mary Ramey	MS2 Lab Med/Path Coordinator	x
Nicole Cairns	MS2 Student Representative	x
Blake Stagg	MS1 Student Representative	x
<i>Mark Rosenberg</i>	<i>Vice Dean for Medical Education</i>	x
<i>Bob Englander</i>	<i>Associate Dean for UME</i>	x
<i>Jeffrey Chipman</i>	<i>Assistant Dean for Curriculum</i>	x
<i>Anne Pereira</i>	<i>Assistant Dean for Clinical Education</i>	
<i>Michael Kim</i>	<i>Assistant Dean for Student Affairs</i>	x
<i>Suzanne van den Hoogenhof</i>	<i>Interim Assistant Dean for Assessment & Evaluation</i>	x
<i>Brad Clarke</i>	<i>Director of Curriculum</i>	x
<i>Jim Beattie</i>	<i>Director of MEDS / FCT Course Director</i>	
<i>Leslie Anderson</i>	<i>Chief of Staff, Medical Education</i>	
<i>Scott Slattery</i>	<i>Director of Learner Development</i>	x
<i>Heather Peterson</i>	<i>Medical School Registrar</i>	
<i>Brian Woods</i>	<i>Lead Course Manager</i>	x

Guests: Pat Schommer, Mary Tate

The meeting was called to order at 7:00am.

Welcome from Dr Bob Englander, new Associate Dean for Undergraduate Medical Education.

Dr. Englander is coming to us from the Association of American Medical Colleges (AAMC), where he led national efforts around competency-based medical education. He worked on the Education in Pediatrics Across the Continuum (EPAC) project, which allowed him to interact with leaders here at the U. He has also been a pioneer in helping develop the Core Entrustable Professional Activities (EPAs) for Entering Residency, outlining clear expectations for learners and teachers to be sure medical students enter residencies with skills to succeed.

Dr. Englander started his career as a pediatric intensivist at the University of Maryland, a position that allowed him to develop his clinical passion as well as his interest in medical education. He served as education director for the division of critical care medicine before becoming Associate Program Director for the Residency Training Program and Director of Undergraduate Medical Education for the Department of Pediatrics.

From Maryland, Dr. Englander moved to the University of Connecticut School of Medicine and Connecticut Children's Medical Center. As Associate Residency Program Director he helped usher in competency-based graduate medical education. He also became involved in efforts to improve quality and patient safety for the inpatient services, eventually becoming Vice President for Quality and Patient Safety.

While at Connecticut Children's Medical Center, Dr. Englander participated in the Pediatric Milestones working group, helping usher in a new understanding of competency development for learners across the continuum.

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Introductions

Questions for Dr. Englander:

Dr Katz shared that there is an LCME accreditation survey beginning soon - will you be overseeing the preparation and coordination of the self-study? Yes, Dr Englander shared that he wants, by January, to have a project plan in place for implementation over the following three years.

Dr Acton referenced the clerkship design changes and shift to competency-based education - what is the big picture vision for these changes and integration of the two? Dr Englander wants to start with a set of guiding principles, then a design that fits in with those guiding principles. 1) We must agree on the outcomes (by the end of the core clerkships) as defined by CEPaERs, and 2) set up design for implementation, and 3) how do we assess competency? This will position students for a better transition to residency.

Dr Fiol referenced the new Clinics & Surgery Center and changes to the M Health clinical enterprise. Do you have any recommendation or new ideas for integrating the clinical clerkships with the M Health enterprise? Dr Englander shared that we need to expand our thinking and continue to build our partnerships with our clinical affiliates. Let's move from the student as burden misconception to student as value truth. Goal is to shift to where clinical practices are contacting US to set up student rotations.

Dr Englander's question to the groups: Are there any urgent issues that he should be focusing on in the next 30 days? 6-months?

6 months: Clinical capacity

6 months: Increase in Step 2 failures (locally and nationally)

Diversity & Inclusion

See attached draft proposal for Promotion of Inclusion and Diversity in the Medical School.

Definitions of diversity - see Medical School Diversity Statement and AAMC Statement on the Learning Environment

Dr Johns shared that he was a member of the team that wrote the MS diversity statement and reflected on how the medical school did not accurately reflect the diversity of our communities. How are the conversations about student diversity paired with efforts around faculty diversity (which is led from Faculty Affairs). Mary Tate added that the school is working with HR to work on increasing diversity of staff. Really, we all own this issue and the efforts needed; many staff have taken Office of Equity & Diversity workshops and extended trainings.

Dr Prunuske asked if there was data on how well (or not well) the diversity of the student body or faculty assembly represents the diversity of the state. Dr Kim shared that there is admissions data available that could be used to make this reflection.

Dr Nikakhtar noted that most of the student concerns and comments documented in packet reference racial and ethnic diversity, but does not seem to include other groups, such as sexual orientation and gender identity. Nicole Cairns (MS2) shared that the PRIDE group is working with AD Patel from Admissions about option to self-identify as GLBTQ on the admissions application.

Dr Jewison shared his personal experiences in different parts of the country, through the Teach for America program, and how that improved his views on diversity. The solution starts with increasing the diversity in the applicant pool. How are we marketing Minnesota as a school that would be a good place to go? He also prompted the group to think about diversity that is easy to “see,” but also the diversity that isn’t apparent - like SES, GLBTQ, etc.

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Mary Tate shared that nine students from (Student National Medical Association) SNMA went to the national conference and UMMS took home several prestigious awards. She also noted that SNMA is active in recruitment to UMMS (recruitment fair). Dr Johns added that the students can be the best representatives to promote the school.

Dr Thompson Buum shared the value in providing time for students to share stories and learn about each other, to realize the non-apparent diversity amongst the class. Nicole Cairns shared that there is a Facebook page for students to share their stories. Several members of the group suggested this be created for the faculty!

Dr Murray questioned if she knew enough about the learning environment for students as it relates to working with faculty and behavior as it relates to diversity. Mary Tate noted the Board of Regents’ and LCME’s codes of conducts or statements on behavior and reporting.

Please see handout for the LCME accreditation standards (3.3 and 7.6) for guidance from LCME on responsibility of the school. Final page lists other resources from UMN or AAMC.

Dr Englander thanked the group for having the discussion today. Diversity is both a strategy and a goal. Appreciation of diversity is critical to the performance of teams. While there is room for improvement in training our students to provide patient care to a diverse population, the inclusion of GLBTQ in our school and community was a selling point in Dr Englander’s desire and choice to come to UMN.

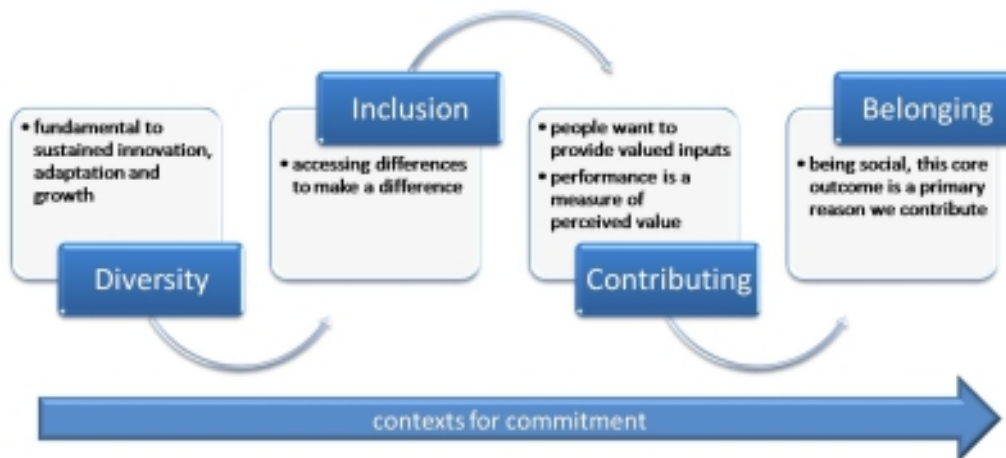
The meeting was adjourned at 8:30am.

Submitted BWN 4.1.16

Draft Proposal - March 31st, 2016

Strategic Plan for Promotion Inclusion and Diversity in the Medical School

1. Identify areas of need with stakeholders
2. Solicit commitment from key stakeholders
3. Assess strengths, weaknesses, opportunities and threats toward improving the current learning environment
4. Set diversity and inclusion goals that align with organization mission, vision, and values
5. Set clear and realistic objectives, supporting tasks, and action steps required to achieve goals
6. Establish roles, responsibilities, and decision-making channels



From www.ugmconsulting.com

Student Concerns

During the Dean's Forum hosted by Dean Jackson on January 29th, 2016 concerns were raised by students. These students reported that, although the diversity of the student body has had improvement in recent years, they did not feel the overall learning environment was appropriately welcoming and inclusive. A subsequent Dean's Forum was established that created a panel of Medical School leadership to address these concerns more specifically. The panel including:

Dimple Patel, Associated Dean of Admissions, Dr. Clifford Steer, Associate Dean for Faculty Affairs, Dr. Michael Kim, Assistant Dean for Student Affairs, Dr. Anne Pereira, Assistant Dean for Curriculum, and Mary Tate, Director of Minority Affairs and Diversity.

The panel responded to questions that were submitted by students for the forum. Dane Thompson, Executive President of the Medical School Student Council, and Amy Feng, President of the SNMA selected questions from the submission to present to the panel.

The questions submitted highlight the concerns of the students and are:

Student Questions Submitted for March 11th, 016 Dean's Forum (red indicated questions selected for the Forum by Student Council and SNMA)
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What efforts are being made to ensure SES diversity in the medical school? It seems that there are few students that come from a lower SES background. Of those that are seen as racially and ethnically diverse it seems that many come from physician or dual physician households or high SES background. I think that there is an aspect of diversity that our school is lacking.

What efforts are in being put in place to significantly increase the diversity of incoming classes? Will you attract more out of state students to accomplish this? Have you considered accepting stellar underrepresented students before they take their MCAT, even as early as high school like in Medical Scholars programs found in many private medical schools?
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What are you doing to facility conversations with students when they experience racism and prejudices directed against diverse pt populations from authority figures during clinical clerkships. Keeping in mind that students are at a disadvantage and high stakes setting current anonymous feedback system is often not empowering when advocating for pt diversity. Additionally this responsibility disproportionately falls on students from diverse backgrounds as they are the ones most likely to recognize descrimination and have a personal investment in addresses such inequalities.

What can be done to highlight diversity within the formal curriculum, particularly to increase awareness of the specific and unique health challenges faced by diverse communities (along racial and economic lines) and perpetuate the notion of community-based medicine and health?
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How can we ensure that cultural competency is taught longitudinally throughout the medical school curriculum, not just during Essentials of Clinical Medicine, but also during the clinical years? Also, what are your thoughts on teaching medical students about the different ethnic populations that we serve, for example Somali, Hmong, and American Indian communities?
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It is my understanding that there are initiatives to increase the diversity of the medical school faculty, however, are there initiatives in place to increase the diversity of the medical school staff?

As we build a more diverse student body, how do we create space for students to share their stories? An auditorium of 170 students is a difficult place to share personal stories and some people do not get lucky with their faculty advisor/WLC groups and are essentially "stuck" with people who are either unwilling to share, or those who create an environment where sharing personal stories and having difficult conversations is not easy.

How does the medical school plan to celebrate diversity in more ways than just in terms of the students' racial or ethnic background?
What is the medical school leadership doing to help students who are also parents?
A high percentage of students in our class seem to have at least one parent who is a physician. In what way does this support diversity initiatives?
Recruiting diversity to the medical school is only one part of the solution. Once you are able to get faculty/students to matriculate to the medical school, what are you planning to do to ensure this is a safe, welcoming environment for these individuals? What support services will you offer to make their transition to the medical school as smooth as possible?
How can we improve training on working with specific immigrant communities in the Twin Cities before getting to years 3 and 4?
What efforts are being taken to improve the unwelcoming and discriminatory environment for underrepresented students in the medical school?
what plans do you have to increase diversity training within the medical school curriculum in order to teach medical students about the experiences faced by minority communities (beyond just the medical field)?
What does affirmative action mean for the admissions committee?
What has the Medical School done to recruit and retain faculty from diverse backgrounds?
How can we make clinical reviews less subjective so that students can be graded more fairly across sites? It seems faculty and residents can say anything as they are subjective reviews. And that may have a disproportionate impact on students of color.
Thank you SO much for incorporating a race-centered discussion as part of our ECM curriculum this year. It was absolutely invaluable as a conversation-sparker and eye-opener among classmates. This was evidenced by how alarmed students were when one of our physiology professors addressed race-based corrections and dismissed the state of Minnesota as "too politically correct" for not using race-based corrections. Further research and conversation brought to light just how detrimental race-based corrections can be in providing respiratory healthcare to patients in need. I'm wondering how you will help us to continue to engage in conversations, spread the word, find new prompts to further study race, etc, so as to eliminate race-based medicine from our practices. (Or to at least critically examine its role in our healthcare system and to identify where it is appropriate (if at all) versus where it is not appropriate.)

Other Student Concerns

Other concerns have been brought directly to Mary Tate, Dr. Scott Slattery in the Office of Learner Development, and to Dr. Michael Kim. The concerns fall into the following categories:

1. Microaggressions directed at or overheard by students who were affected by the statements
2. Difficulties navigating accommodations prescribed by the Disabilities Resource Center
3. Lack of ability by students to help improvement the learning environment
3. Perception that certain groups of students are experiencing increased academic difficulties

The Case for Inclusion and Diversity

(From Diversity and Inclusion in Academic Medicine: A Strategic Planning Guide, Second Edition, AAMC 2016)

The Accreditation Case

Several *LCME* accreditation elements (formerly standards) relate to diversity in a medical school setting. These include diversity in the academic and learning environment, Element 3.3 (formerly IS-16 and MS-8), and cultural awareness in curricular content, Element 7.6 (formerly ED-21). To achieve and maintain accreditation, each medical education program must meet these *LCME* accreditation standards.

3.3 Diversity/Pipeline Programs and Partnerships

A medical school has effective policies and practices in place and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community.

These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

7.6 Cultural Competence/Health Care Disparities/Personal Bias

The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction about:

- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
- The basic principles of culturally competent health care
- The recognition and development of solutions for health care disparities
- The importance of meeting the health care needs of medically underserved populations
- The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensionally diverse society.

The Case for Excellence

There is persuasive evidence that recruiting a diverse student body and faculty has a strong, positive effect on the quality of medical education that is provided to learners. The positive educational outcomes include helping students break down stereotypes and racial biases; challenging assumptions; broadening perspectives about racial, ethnic, and cultural differences; and broadening students' understanding of the effects of language and culture on medical care—that is, achieving cultural competency. The climate enhanced by a diverse learner and teacher body ultimately increases students' awareness of health and health care disparities in nearby populations and increases students' interest in service to underserved communities and

overall civic commitment. These “added educational values” strengthen medical education and better prepare graduates to deliver health care services to an increasingly diverse population. More important, these educational benefits accrue for both minority and nonminority students.

In a survey conducted at Harvard Medical School and the University of California, San Francisco, Medical School, students confirmed that concrete benefits accrue from a diverse student body. Students reported that contact with diverse peers led to a more balanced exchange of information in classroom discussions, more serious discussions of alternative viewpoints about disease and treatments, greater appreciation of inequities in the health care system, and more cultural sensitivity. According to the survey’s authors, “Students regularly educate one another on important issues, such as differences among the cultures and how best to respond to those differences.” Furthermore, students “established close collegial and personal friendships with students of different races and ethnicities, and such ties contributed greatly to their understanding of medical practice and, ultimately, better trained them for service in a multicultural society.”

A dividend of the diversity rationale is that diversity enhances the educational climate, and educational outcomes are directly improved as a result. Numerous studies have now demonstrated that for both medical students and residents, when diversity is integrated within the educational climate, assumptions are challenged, perspectives are broadened, and more socialization across a variety of racial and ethnic groups occurs, resulting in intellectual and cognitive benefits for all learners. Greater diversity also helps ensure a more comprehensive and inclusive research agenda. These dividends can collectively drive academic institutions toward achieving excellence, which in turn will lead to improvement in health care equity through research and patient care for the populations served.

Medical School Diversity Statement

The University of Minnesota Medical School is committed to excellence in fulfilling its mission. We uphold that an environment of inclusiveness, equal opportunity, and respect for the similarities and differences in our community fosters excellence, and that institutional diversity fuels the scholarly advancement of knowledge. An atmosphere where differences are valued leads to the training of a culturally competent healthcare workforce qualified to meet the needs of the varied populations we serve.

The Medical School, as part of the University of Minnesota, shall provide equal access to and opportunity in its programs, facilities, and employment without regard to race, color, creed, religion, national origin, gender, age, marital status, disability, public assistance status, veteran status, sexual orientation, gender identity, or gender expression.

The Medical School seeks to attain a diverse learning environment through the recruitment, enrollment, hiring, and retention/graduation of students, faculty, and staff who are underrepresented in medicine and may also be underrepresented in Minnesota.

We strive especially to have our learning community better reflect the demographics of the state by increasing the representation of African-Americans/Blacks, Hispanics/Latinos, Native Americans, Native Hawaiians/Pacific Islanders, Native Alaskans, Hmong, individuals from rural backgrounds, first generation college students, or those from economically disadvantaged backgrounds.

AAMC Statement on the Learning Environment

We believe that the learning environment for medical education shapes the patient care environment. The highest quality of safe and effective care for patients and the highest quality of effective and appropriate education are rooted in human dignity.

We embrace our responsibility to create, support, and facilitate the learning environment shared by our patients, learners, and teachers. In this environment, our patients witness, experience, and expect a pervasive sense of **respect**, **collegiality**, **kindness**, and **cooperation** among health care team members. This includes all professionals, administrators, staff, and beginning and advanced learners from all health professions. This includes research as well as patient care environments.

We affirm our responsibility to create, support, and facilitate a learning environment that fosters **resilience** in all participants. It is our responsibility to create an atmosphere in which our learners and teachers are willing to engage with learning processes that can be inherently uncomfortable and challenging.

We affirm our commitment to shaping a culture of teaching and learning that is rooted in respect for all. Fostering resilience, **excellence**, **compassion**, and **integrity** allows us to create patient care, research, and learning environments that are built upon constructive **collaboration**, mutual respect, and human dignity.

For more information and to view a library of resources, visit **[aamc.org/learningenvironment](https://www.aamc.org/learningenvironment)**.

Resources to Learn More

1. Free online 30 minute module from AAMC:

https://www.aamc.org/members/leadership/catalog/178420/unconscious_bias.html

2. The implicit association test that is referenced in the AAMC video can be directly accessed here:

<https://implicit.harvard.edu/implicit/takeatest.html>

3. University of Minnesota Office for Equity and Diversity (OED) Workshops

<https://diversity.umn.edu/>

- Link to the 2016 Medical School Hippocrates Café presentation:

<https://mediasite.ahc.umn.edu/Mediasite/Play/d678b163301d4ce48f8be5205f9c37611d>