2015 MEC Retreat Summary: **Ultrasound**

Alan Chiem and Randolph Steadman

1. Ultrasound is the standard of care for many presentations, and thus ultrasound education should be a core feature of the DGSOM curriculum.

2. Both focus groups agree that US curriculum needs to be expanded to cover all four years of medical school.

3. Integration into the third year can be accomplished via training of faculty champions, a focused ultrasound block, and/or through regular ultrasound boot camps.

4. While there is tremendous support to establish scan portfolios for all medical students, making this (i.e., platinum level) optional for select students, at the discretion of the College chairs, may be an appropriate start.

5. US education can follow AAMC Core EPAs 10 and 12, while more specific ultrasound EPAs can be developed for advanced students or for GME level training.

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2015 MEC Retreat Summary: **Authentic Clinical Experience**

Tomer Begaz and Denise Sur

**General:** There was consistent strong support for the concept, and recognition of need for better early authentic experiences for our students, noted in both groups. The importance of AUTHENTIC ROLES was cited – the "karate kid" analogy – students play vital but circumscribed roles initially that provide a foundation for developing more complex/comprehensive clinical acumen later.

**Benefits:** Groups cited numerous benefits of working in the clinical arena, such as teaching humility, a team approach to care, respect for and understanding of the roles of other members of a care team, early development of skills in patient interaction, maintenance of core values as medical school progresses. Early meaningful clinical experiences can appeal to different learning styles. Reps of Drew, stressed the importance of setting as they have found their grads continue to work with the underserved patients with whom they trained.

**Challenges:** One member asked the interesting question: While clinicians accept that more clinical exposure is important, what is the evidence for this? Any new curricular piece requires the work to develop curricula and manage them. The "devil is in the details" – implementation is key to making this work. RESOURCES came up a lot – administrative and training will be a big undertaking. More EALCE could potentially take time away from the foundational science curriculum and the groups want to be careful that these are not de-emphasized. Finally, any curricular change will prompt concern from students about the effect on their board scores.
Themes/New Ideas:
In addition to discussion of the 7 pathways in the proposal, members of the retreat groups talked about some complimentary ideas

- Multidisciplinary/care partner rotation: students would rotate with other parts of the patient care team. For example, students would rotate with nursing and do blood draws, place IV’s etc. Respiratory therapy, etc. This is already done successfully in EM rotations, but the vision is more longitudinal. It can become known that there is always a student for certain hours at certain nurse’s stations, and they have designated responsibilities. Would improve relationship with nursing. While students may need some guidance, in a short period of time, this could be offset by adding value.

- Similar to health coach/motivational interviewing, there was interest from psychiatry to train students in mindfulness, sleep hygiene, etc. education to give to patients. This would have additional benefits to students but comes at the same challenges of resources (physical space, training, etc.) that are listed above.

- There was interest in embedding students in a medical home longitudinally, where their authentic role would evolve over time but their home would remain.

- The themes of providing appropriate place for students to process their experiences, and measure outcomes

With regards to the question of EVOLUTIONARY vs. TRANSFORMATIVE change, there were mixed responses. Roughly half of those that responded to this question were in each group. Themes discussed for each were:

**EVOLUTIONARY**
Evolution is easier than transformation.
It was noted that we spend enormous resources creating proxies for authenticity, and it can be hard to convince students that these proxies are valuable – we could easily take some of those resources and instead use them to provide ACE. (“Proxies” included PBL, much of doctoring 1 and 2, etc.)

**TRANSFORMATIVE**
Some group members felt that “you can’t keep adding stuff” to a curriculum – at a certain point in the evolution of a curriculum it is time to step back, see what works, what needs to be changed, and reorganize things. We are talking about adding ACE in the early years, which would necessitate taking some time away from the foundational sciences, and this would be a great opportunity to create a curriculum that does that, and also re-emphasized the foundational sciences in a meaningful way in the later years.
2015 MEC Retreat Summary: Entrustable Professional Activities (EPA)

Ed Ha and Jessica O’Connell

1. Standardized checklist
   a. The use of this by faculty will require significant faculty development

2. Procedures
   a. Includes activities like checking a blood pressure and other vital signs
   b. The key procedures that every student should complete will need to be thoughtfully composed
   c. Issue of how procedures will be entrusted and remediated, and how many of each of the procedures a student must perform successfully for eventual entrustment
   d. Simulation should be used for instruction and remediation

3. Master clinicians
   a. Protected time and compensation vital to:
      i. Move from a process of recruitment to a process of selection
      ii. Provide master clinicians with the time needed to teach most effectively
      iii. Provide students with uniform exposure to the best and most effective teachers
   b. Longitudinal relationship with a small group of students would be very effective for instruction and mentorship
      i. Summative assessment for each group of students could be performed by the master clinician for a different group of students and vice versa to preserve the safe environment for students.
   c. The master clinicians also need to be master “observers” with significant faculty development for this purpose to ensure accurate and uniform formative/summative feedback
   d. This concept should be balanced with an expectation for a baseline of teaching by all UCLA faculty consistent with citizenship

4. Other EPAs that should stand alone
   a. Professionalism/humanism EPA
      i. While this should exist as a thread through all of the other EPAs, stating it explicitly as a separate EPA to emphasize its importance should be considered
      ii. Observable behaviors should be defined to be included on checklists
   b. Interpersonal communication EPA
      i. This should also exist as a thread through all of the other EPAs given it is inherent to the successful completion of each of the other EPAs
   c. Practice-based learning
      i. One of the goals should be that students learn to consistently ask for help when they do not feel comfortable in their abilities, and to help students self-assess
      ii. This should exist as a thread through all of the other EPAs

5. Entrustability and level of training
2015 MEC Retreat - May 13, 2015

a. The entrustability decision for each of the EPAs needs to be viewed from the perspective of a developing medical student and when in that development would be most ideal for the achievement of entrustability

6. Needs Assessment
   a. Identify those EPAs where there is the greatest current gap between ideal and actual
   b. Identify those EPAs deemed to be most important
      i. Session 1 group's discussion identified EPA #1 as most important

7. Evaluation
   a. A new clinical evaluation form for the tiered grading system should include the EPAs
      i. Clear and specific anchors should be delineated for use by the evaluators.
   b. Student buy-in is crucial
      i. At present, students focus more attention on the step I USMLE examination because the internal OSCEs are very low-stakes
      ii. Standard for “passing” OSCEs should be raised
      iii. Consideration for moving USLME step I to after the clinical clerkships to emphasize the importance of clinical skills over pure knowledge

8. An integrated curriculum
   a. Requires coordination between different curricular pieces
   b. Requires communication between the medical school and the clinical departments

2015 MEC Retreat Summary: **Strategy for Moving Ahead**

Tom Drake and Mark Noah

Each session was opened with a request for participants to express and whether incremental reform or transformation is needed, and related issues. Discussion comments fell into 3 broad categories – support for the values of early clinical experience, rationale for change, and practical aspects/concerns about implementing change. Consistent with reports from the other sessions, participants valued close contact of students with clinicians and the clinical setting throughout training. They also agreed with the concept that clinical exposure along with basic science in the early years would enhance student learning and their preparation for the "3rd year" experiences. Concerning the rationale for change, the comments here were mostly with respect for transformative change, and there was more questioning or uncertainty expressed in general than strong advocacy for this path. There was not a clear understanding of the compelling need for transformative change. As put by one comment- No "burning platform" for creating urgency for educational change. Nevertheless there was interest in change and desire to understand this more fully from different perspectives, including what has compelled other schools to take this route, and evaluating our reasons from the perspective of clearly defining what do we want our graduates to do/be (put as the UCLA “brand” or “product”) to meet their needs.
A good amount of discussion focused on practical aspects of curricular change. Quite a number of comments related to the expectation that increased clinical exposure and contact time would likely be resource intense and require increased investment in people (faculty), training and support. Individuals’ time and training to improve quality were noted. Logistics at multiple levels are generally more complicated with more personalized instruction/learning settings. For potential new approaches, scalability was notes being critical given the size of the classes. Along with all this were comments that cultural change in the institution and faculty and student buy-in would be necessary for change to be successful.

Transcribed notes from the sessions grouped as above.
Value of early clinical experience: Comments were positive that this
  • Expanded view of curriculum (process/instructors)
  • HBD prep for “wards”; negative impact of USMLE; draws attention
  • Students don’t see practice in clinical setting for what taught
  • Impact of clinical exposure to improve HBD learning
  • Clinical tie-in improves basic learning; this could change impact of the 3rd year
  • Personal attributes needed in physicians- need to start early- compassion and emotional intelligence (teachable or can these be developed?)
  • EPAs; adaptive curriculum; culture
  • Critical thinking skills – sufficient?
  • Interdisciplinary aspect important

Rationale for change:
  • We could do better
  • UCLA brand
  • "students do well regardless“ vs not really prepared
  • Rationale for change – what is driving?
  • Peer institutions/residency expectations/drivers – schools doing different things- why?
  • ID specific Q's – what to focus on for graduate needs
  • Not preparing students for the future
  • What is the problem with the current curriculum? Is this the time to do more?
  • Is there a problem with students/training? World has changed- moving the goal; Future expectations of graduates/practitioners
  • What is the UCLA “product”? Need to envision to decide what to do.
  • No “burning platform” for creating urgency for educational change

Practical aspects
  • Human resources- mentors- #/quality/training
  • Dept responsibility
  • Organizational support- ability to change
  • Practical aspects: logistics/people availability/continuity/responsibility of Departments
• Culture changes needed- mentors/quality (change in faculty/instructors); organizational support-$$
• Are students prepared? Value of 4th year? Should it be a “rotating internship”? Scalability is an important aspect for feasibility of proposed changes
• Duration of training- fixed/flexible; ? necessary consequence
• Need for faculty buy-in
• Fragmentation of experience is a current problem
• Pacing of learning (ie possible value of an adaptive curriculum).
• Need for remediation vs changed admission policies
• “Tracks”- some do well- eg Surg- others not; some need transformation, others reform
• Clinical exposure in first 2 years: good, but time value/quality
• Preceptor quality (need to pay); ?quality of current preceptor feedback- student experience is variable
• Time to view interviews (new technology possibilities?)
• Watching full interview/exam: time intensive and need “master clinicians”
• Logistics of student time allocation and possible need to pay students
• “Family” setting; group; various experiences
• Resource intense
• Level of engagement needed- watching vs active (eg scribe)