



### Implementing a Strategic Plan at an AMC

In practice, medical education is not always an equal partner in the enterprise of the academic medical center (AMC), as the AMC's mission, finances, and governance are often distinct from those of its affiliated medical school. Richard M. Schwartzstein, MD, and associates report on the efforts of Boston's Beth Israel Deaconess Medical Center (BIDMC) to conduct an institutional strategic review of its educational mission, the recommendations engendered by this review, and the results that followed.

The director of graduate medical education (GME) was charged with the responsibility of directing a strategic analysis of all medical education at BIDMC. A coordinating committee provided oversight of the review process. Four national experts were invited to a visiting committee to provide an external perspective. Subcommittees were formed for finance, undergraduate medical education, and GME. Self-study surveys were conducted as well.

Using recommendations from the visiting committee and results of the self-study, the coordinating committee identified six key needs: faculty development across departments; teaching incentives for faculty; improved educational space; more formal teaching, increased direct observation, and increased feedback for medical students; centralized allocation of educational funds; and centralized educational administration.

At the core of the organizational changes and program recommendations was a vision to place BIDMC in a strong position relative to curricular innovation, professionalization of the teaching faculty,

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and a greater focus on the full spectrum of medical education. The AMC created the position of vice president for education, charged with oversight of all educational aspects at BIDMC. New programs were established, including a "core faculty" model, a longitudinal "principal clinical experience" for third-year medical students, a simulation and skills center, an annual "education week," Web-based modules for the ACGME core competencies, offices of educational technology and educational research, and faculty scholarship. BIDMC is currently working on a hospital-wide faculty survey about perceptions of the new financing schemes for medical education.

Schwartzstein RM, Huang GC, Coughlin CM. *Development and implementation of a comprehensive strategic plan for medical education at an academic medical center.* Acad Med 2008;83(6):550-559.

### Survey of Publications and Presentations Arising from Students' Required Research

Mayo Medical School (MMS) has had a required research experience since the schools' establishment in 1972. Each student obtains a research project mentor, who supervises project design, approves the student's research proposal, sponsors the project when presented to the research coordinating committee, supervises the research, and evaluates the student's performance. Students are required to write a "medical communication report" organized as a standard research manuscript before graduation; most students base this report on their work during the required research experience. The report requirement is fulfilled by a published article, a copy of a manuscript submitted for publication, or a manuscript draft. Liselotte N. Dyrbye, MD, and co-workers conducted a study to determine students' research productivity and to examine whether this research productivity has varied depending on the duration of the

research experience, which was initially 21 weeks but was shortened to 17 to 18 weeks and then to its current 13 weeks.

The investigators conducted a retrospective cohort study of all 1105 medical students who graduated from MMS between 1976 and 2003. Independent variables were year of graduation, gender, duration of required research experience, and type of project; dependent variables were number of published research reports, number of published research abstracts, and number of extramural research presentations.

Overall, among the 998 MMS graduates who participated in the required research program, there were 554 research reports and 258 abstracts published during the 26 years of the program, and there were 416 extramural research presentations. The graduate was the first author on 65% of the research reports and 73% of the abstracts. There was no difference among the three duration groups in the proportion of graduates publishing a research report or abstract or presenting at a scientific meeting; however, there was a statistically significant difference with respect to first authorship, with more graduates in the 21-week group being first authors.

The authors state that their results suggest that a required research curriculum enables most students to implement their research studies, analyze results, and report their findings. Further study is needed to explore whether conducting this research leads to the acquisition of knowledge and skills that students would not have obtained elsewhere in the curriculum.

Dyrbye LN, Davidson LW, Cook DA. *Publications and presentations resulting from required research by students at Mayo Medical School, 1976-2003.* Acad Med 2008;83(6):604-610.

### Preparing Students to Care for Publicly Insured Patients

Patient, provider, and health system factors all contribute to health disparities. When the College of Human Medicine (CHM) at Michigan State University redesigned its curriculum, report Jane L. Turner, MD, and Lynda Farquhar, PhD, it focused on provider factors, as these are most easily addressed by medical educators. CHM's goal in the "Contract for Social Commitment" was to produce a physician graduate who has the

knowledge, skills, and attitudes to care for patients insured by Medicaid and others who suffer from disparate health care.

Learning objectives for students included, among others:

- ❖ To identify and understand the relationship between health conditions and poverty;
- ❖ To know the conditions that illustrate health disparities;
- ❖ To recognize barriers to access to health care;
- ❖ To be able to work effectively with individuals from all types of backgrounds;
- ❖ To work with other professionals to promote the welfare of economically disadvantaged patients.

Course directors worked in committees to tie assignments in individual courses with those in other courses for horizontal and vertical integration. Faculty development included course orientation sessions and a program discussion guide. One-fourth of the preclinical courses were modified, adding components relating to understanding access and barriers to health care, working with interpreters, and communicating effectively with individuals of varied backgrounds.

In evaluation, students who experienced the revised curriculum performed slightly better than previous students on key skills related to the project, but the differences were not statistically significant. Student satisfaction remained the same or improved slightly, but again, the differences were not statistically significant. Most students indicated that they had meaningful learning experiences with their economically disadvantaged patients; however, some felt that the program was driven by political correctness and was too heavy-handed.

Turner JL, Farquhar L. *One medical school's effort to ready the workforce for the future: preparing medical students to care for populations who are publicly insured.* Acad Med 2008;83(7):632–638.

#### **Development and Assessment of an NIH-Funded Research Ethics Training Program**

Through 2007, the NIH T15 Short-Term Courses in Research Ethics program supported 26 training programs. James M. DuBois, PhD, DSc, and colleagues describe

the content, format, and outcomes of one such training program, supported by the NIH for four years, between the Center for Health Care Ethics at Saint Louis University (SLU) and the continuing education department at the Missouri Institute of Mental Health (MIMH).

The Ethics in Mental Health Research (EMHR) training course was developed jointly by SLU and MIMH to provide mental health researchers across the country with access to an effective, theoretically grounded course in research ethics tailored to their special needs. The goals were to be accomplished with course materials tailored to mental health researchers, a train-the-trainer program to prepare participants to use the course materials at their own institutions, and an evaluation of the program. Educational objectives were:

- ❖ Increasing knowledge of ethical and regulatory issues in mental health research;
- ❖ Heightening ethical awareness in behavioral health research;
- ❖ Improving the ability to focus on all salient aspects of a moral situation;
- ❖ Fostering moral motivation by promoting self-reflection; and
- ❖ Facilitating ethical action by providing investigators with the proper resources.

The course had a special emphasis on consumer perspectives and on systematic case discussion and moral development, as opposed to rote knowledge. Internet-based video streaming technology was used to combine the strengths of a traditional classroom-based program with the broad dissemination possibilities of a Web-based course.

The course was delivered in nine two-hour sessions. Cases discussed at each session were designed to promote sustained critical discussion rather than merely illustrating principles. Course materials included a textbook, instructional DVDs, and a Web site ([www.emhr.net](http://www.emhr.net)).

The training program had several strengths, observe the authors. First, trainees were generally very satisfied with the overall program. Second, by incorporating mental health services consumers in the development team, the program allowed participants to share their views on what is ethical, moral, and respectful in mental health research. Third, the program produced a

number of enduring resources, which have been used in further training programs.

DuBois JM, Dueker JM, Anderson EE, Campbell J. *The development and assessment of an NIH-funded research ethics training program.* Acad Med 2008;83(6):596–603.

#### **Uncovering the 'Hidden Curriculum'**

Most multicultural training models concern educational outcomes for individual trainees who have received units of cultural competence training designed for individual consumption. Because of this, when deficiencies in such programs are discussed, they generally relate to what is lacking in the isolated, individual trainee, rather than focusing on institutional factors that may actually contradict the multicultural lessons and activities and undermine their intended effects. Jann L. Murray-Garcia, MD, MPH, and Jorge A. Garcia, MD, MS, discuss the educational impact of the institution's learning environment on the multicultural education of its physician trainees, with a goal of enabling medical educators to ask: "What is the 'institutional curriculum' of our training program regarding issues of race and difference?"

The model the authors used involved the intersection of three areas: the paper curriculum, the curriculum in action, and the students' experience. These three areas and their intersections yield seven specific regions. Ideally, the intersection of the three would indicate a congruence among the curriculum that was planned, what was taught in formal curricular activities, and the informal relations and discussions with faculty, resources available to trainees, the mode and timing of public leadership of administrators, formal written policies regarding patient care, and the processes students see daily. In reality this ideal is not always realized, for a number of reasons—this represents the hidden curriculum.

The authors note that the most difficult task for an institution is to commit the institutional energy and resources to an ongoing process of organizational critique and recreation, consistent with the institution's mission.

Murray-Garcia JL, Garcia JA. *The institutional context of multicultural education: what is your institutional curriculum?* Acad Med 2008;83(7):646–652.