I. Welcome

Dr. Todd Larabee, President of the Faculty Senate for 2012-13, called the meeting to order.

II. Approval of Minutes from December 11, 2012 Faculty Senate Meeting

Minutes from the December 11, 2012 Faculty Senate Meeting were unanimously approved.

III. Update on Concealed Carry Issue on CU Grounds – Nichole Reisdorph, President-Elect for Faculty Senate

Dr. Reisdorph attended a meeting this morning between Chad Kautzer (who is a leader in an effort to petition President Benson to lobby the State of Colorado Legislature to return authority about concealed carry on University grounds to the CU Board of Regents) and President Benson. To date, there have been more than 850 signatures of faculty members who are in support of this petition (of note, no faculty are allowed to use their official position to lobby this effort). President Benson says he doesn’t know how the Board of Regents members feel about this issue, but he does not want to take action at this time. He said he would be having a meeting over the weekend with the Board of Regents and would feel them out. A state legislator will be introducing legislation this session about this issue, and President Benson wants to wait and see what happens.

Comment from a Senator: As a reminder, hospitals are private entities, and concealed weapons are not allowed in any of the hospitals on our campus.

IV. Graduation Questionnaire – Celia Kaye, Sr. Associate Dean for Education and Maureen Garrity, Associate Dean for Student Affairs

Dr. Garrity gave a presentation (with Power Point slides) of results from two sources of data; a graduation questionnaire for the Class of 2012 (conducted nationwide) and data from the evaluation office from 2009-12. The graduation questionnaire has been given to all US medical students since 1978, and it was substantially revised in 2012 to include more specific questions about mistreatment. From 2007-2011 about 20-25% of CU medical students reported mistreatment – this is higher than the national average. Mistreatment mostly occurs in the clinical setting (usually by either clerkship faculty or residents and interns). On the new 2012 questions, 43% of students reported public humiliation, 23% were
the subject of offensive sexual remarks, 5.2% reported being physically harmed (i.e. hitting, slapping, kicking), 11% report being denied opportunities due to gender, and 6% report being subjected to unwanted sexual advances. All of these are higher than the national average. There was fairly equal reports of mistreatment by faculty and by residents and interns. About 50% of the time, the person being reported to have done the mistreatment was only accused one time, showing that this is not just a problem of a small number of frequent offenders.

Dr. Kaye then spoke, and she started by saying that nobody intentionally mistreats students or wants students to be mistreated. She said she does believe this data, and it is not the case that the students are simply too sensitive or interpreted the question wrong. Some individual reports of mistreatment are shocking. She said we have been working over several years to try and tackle this problem. Examples include that a letter of offer for new faculty now have a professionalism clause, a teacher-student contract has been created, the Professionalism First campaign has been in effect over a year, online modules for professionalism have been created. She said although there is a third party anonymous reporting system, there have been a small number of reports compared to the number of reports on the graduation questionnaire. This is likely due to students being scared of retaliation.

Dr. Kaye said the literature shows that 60% of people who mistreat and are told about it will not do it again (may have been secondary to stress, etc.). There is a need to change the culture at CU School of Medicine. It isn’t OK to allow this mistreatment to happen, and we need a zero tolerance policy. This doesn’t mean if mistreatment occurs a person will be fired; it means if you see this mistreatment happen you confront your peer about this, say “we don’t do this at the University of Colorado School of Medicine”.

The topic was then opened for discussion.

*Question from a Senator:* What are the current remediation steps for housestaff or faculty?

*Dr. Kaye:* When a block director is made aware of mistreatment, the faculty member is confronted. However the problem is mistreatment is underreported. Students don’t believe the reports are truly anonymous, and they fear retaliation. They’re only going to be completely honest at the graduation questionnaire when the threat of retaliation is gone. More personal interaction with offending faculty is needed, we understand the stresses that may cause faculty to do this.

*Comment from Dr. Lowenstein:* Should the senators take on this problem directly as its responsibility? For example should the Faculty Senate draft important principles of this change and present to Department faculty?

*Comment from Dean Krugman:* The silence in this room is common and understandable. It’s easier to remain silent, but I don’t think we can afford to ignore
There is a huge amount of giving from alumni of the 1950s and 1960s, but not nearly as much from alumni of the 1970s and 1980s. One alumnus from 1978 said it was a very abusive atmosphere in the late 1970s at the SOM to students. There has been a real financial and reputational hit to this school due to this problem. I don’t think we can leave this alone another decade. One way to approach this problem is to set a standard; to give immediate feedback to the offending party. When you see it, you have to say “That was inappropriate, stop it.” Probably 90% of people who behave this way never get this feedback and don’t even know it’s a problem. There are a very small percentage of these mistreatments which are actually felonies or misdemeanors, but the majority are misbehaviors. And misbehavior rates have been shown to be directly correlated with malpractice rates.

**Question from a Senator:** I’m concerned with underreporting. How do we better ensure anonymity?

*Comment from Courtney Holscher, Student Representative to Faculty Senate:* We can’t ensure anonymity completely. Students feel vulnerable and are not protected in this process.

*Dr. Kaye:* The problem is the event is usually recognizable by the faculty. If we wait too long then feedback isn’t timely. We need to change and address our colleagues that day.

**Question from a Senator:** Would it be better to intervene immediately or after grades are in?

*Dr. Kaye:* We do wait for grades to go in before turning over reports of mistreatment to block directors.

*Dean Krugman:* Students don’t report mistreatment even after grades are in for a particular block if they want to go into that field for fear of not getting a residency in that area.

*Dr. Lowenstein:* The biggest problem is silence. Peers need to step up on behalf of the students.

*President Larabee:* Real-time feedback is the best time for feedback.

*Senator Alison Heru (Psychiatry):* I have worked on this issue at a previous institution. If we are going to change behaviors we need a large-scale change, not a series of small changes.

*Dr. Kaye:* Again, this needs to be a culture change.

*Comment from a Senator:* We should make a small subcommittee to work on this within the Faculty Senate.
Comment from a Senator: We need to address this from the attending side; these statistics are shocking. Maybe we need repetitive messaging from the Faculty Senate or the Dean to the faculty and housestaff at large.

Dr. Lowenstein: This body can do something as the governing body of the School of Medicine.

Dean Krugman: Everyone in the clinical faculty knows someone who has done this over the years and have looked away when it happened. I’d welcome the involvement of the Faculty Senate.

Question from a Senator: Should we tie these behaviors to performance evaluations and promotion?

Dr. Lowenstein: We are making new stronger language in letters of offer.

Dean Krugman: Money is another way to help this problem. Changing incentive plans to include quality, safety, behavior, and academics in addition to production could help. We could remove offending faculty from teaching students.

Comment from a Senator: We should incentivize reporting, maybe a letter of appreciation in a faculty member’s file.

President Larabee: But the baseline should be zero tolerance. Are there any volunteers to be in a subcommittee for this project? If interested please send an email to me. And I will send out a reminder email soon to solicit participation in a subcommittee.

V. Update on Plans for Longitudinal Integrated Clerkships – Brenda Bucklin, Assistant Dean for Clinical Curriculum (Phase III)

Dr. Bucklin presented a set of Power Point slides to provide details which are in addition to Dr. Linas’ presentation from earlier in this year. A Carnegie Foundation Report from 2010 published in *Academic Medicine* said “medical training is inflexible, excessively long, and not learner-centered”. Longitudinal Integrated Clerkships (LICs) happen in the third year of medical school. Students in LICs participate in comprehensive care of patients over time, meet multiple times with faculty, and get an excellent longitudinal experience. Students do multiple clerkships simultaneously over the course of the year. The University of Minnesota introduced the first LIC in 1971, followed by more in the 1990s in Australia, Canada, South Africa, and the US. There has been a Consortium of Longitudinal Integrated Clerkships created in the last 10 years. The current environment of learning is fragmented, and there has been erosion of the relationship with patients, faculty, and the inpatient team. There has been a lack of opportunities for students to make diagnoses. Research over the last decade shows potential educational advantages with LICs. Students in LICs see more patients pre-admission and post-discharge,
and develop better long-term relationships with patients, have more longitudinal exposure to disease processes, and get better feedback and mentoring. There has been a lot of discussion at AAMC and LCME about LICs. There are some pilots in process here at the CU SOM. There is a 12 month block at Denver Health, and a 16 month rural block is being developed.

Question from a Senator: I have concerns about in-depth learning not occurring such as would happen in a 4 week block. What do you think about this?

Dr. Buckner: I visited a program in South Dakota where LIC has been done for 20+ years, I think it’s a good model. Many of these LICs have “immersions” in surgery, OB/GYN, etc. where they spend 2 weeks in intensive learning in a discipline. Also this model makes it less onerous on community preceptors, many of whom can’t do a solid month with a student as easily.

Question from a Senator: What about non-patient specialties such as pathology, radiology?

Dr. Buckner: There is flexibility in LICs to allow students to go to radiology, pathology, etc. when a patient of theirs is having one of those services utilized.

Question from a Senator: Do patients volunteer for this?

Dr. Buckner: In a sense, yes. They can sign up for this. Patients like having an advocate in the medical student.

Comment from a Senator: There are some specialties that are well-suited to this, others aren’t. Some skills need to be repeated day-in, day-out to learn these skills.

Dr. Buckner: We will be looking at outcomes. These are pilot programs at this point.

VI. Dean’s Comments

Dean Krugman had no updates today.

***Of note – Due to time limits, the GME Annual Report was postponed.

The meeting was adjourned at 5:55pm.

Respectfully submitted,

Bruce Landeck, MD
Faculty Senate Secretary