



47th Annual Meeting

June 16-18, 2021

"Virtual Pittsburgh" Meeting held virtually via

zoom

#ADMSEPAM21

Association of Directors of Medical Student Education in Psychiatry ADMSEP 2021 Annual Meeting Program



Association of Directors of Medical Student Education in Psychiatry

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If you are interested in applying for CME credits for this Annual Meeting Email: admsep.facdev@gmail.com

ADMSEP Council Includes:

President: Howard Liu, M.D., M.B.A. President Elect: Lisa Fore-Arcand, Ed.D. Past President: Benoit Dubé, M.D. Past President: Susan Lehmann, M.D. Past President: John Spollen, M.D. Secretary: Erin Malloy, M.D. Council: Lia Thomas, M.D. Council: Dawnelle Schatte, M.D. Council: Matthew Goldenberg, M.D. Council: Jeffrey Rakofsky, M.D. Administrative Director: Nancy Harker, B.S.

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Welcome to the Annual ADMSEP Meeting



Howard Liu, M.D., MBA President, ADMSEP

Dear ADMSEP Family:

I am thrilled to welcome you to our June 2021 annual meeting! Congratulations on your humanity, grit and creativity which have given hope to our medical students throughout the pandemic. I have personally enjoyed learning from your innovative curricula and deep insights at our Fall, Winter and Spring virtual meetings. As Andy Warhol once said, "They always say time changes things, but you actually have to change them yourself." I credit our incredible Council and Co-Chairs of Committees and Task Forces for stepping up in a thousand ways to reinvent ADMSEP in a virtual era. From our new Mentorship Program to our vibrant Education Scholars initiative, our members have continued to underscore the value of ADMSEP in supporting medical student educators in psychiatry.

The June 2021 virtual meeting is exciting and reflects lessons learned from a year of online teaching. I am so impressed by the work of our outstanding program chair, Dr. Matt Goldenberg, assistant program chair, Dr. Jeff Rakofsky, and our dedicated administrative team, Nancy Harker, and Ellie Corbaley. Our keynote speaker, Dr. Helena Hansen, is a national expert in blending anthropology and psychiatry and will speak to the role of structural competency in psychiatric education. Our workshops showcase active learning and our poster session will highlight cutting edge research on how to teach effectively. Themes of diversity, equity, and inclusion (DEI) are woven into our meeting along with a full spectrum of educational innovations.

If you are new to ADMSEP, we are so excited to meet you! Here are some reasons to join as a member:

- Support for educators and coordinators: via our active listserv, mentorship program and workshops
- Cutting edge teaching tools: from Clinical Simulation Initiative peer-reviewed online modules to resources on DEI, we have a full toolkit for 21st century medical education
- Networking: ADMSEP has always created time for renewing professional friendships and offers many committees and task forces to connect with mentors and sponsors (see page 21**)
- Scholarship: we have a flourishing Education Scholars Program for those who want to take a deeper dive into the science of medical education

In short, we look forward to welcoming you to our annual meeting! Thanks for an incredible year and see you at #ADMSEP21 on June 16-18!

Cheers, Howard Liu, M.D., MBA ADMSEP President 2020-21

ADMSEP Mission Statement

The Association of Directors of Medical Student Education in Psychiatry is an organization of psychiatric educators dedicated to the education of medical students in the behavioral sciences and psychiatry. The Association was formed in 1075 when a small ensure of manchine educators

formed in 1975 when a small group of psychiatric educators met in Chicago to discuss undergraduate medical education. The mission of ADMSEP is to:

- Champion excellence in medical student psychiatric education
- Support, develop, and disseminate research and innovation in teaching methods, content, and evaluation
- Develop goals and objectives for medical student psychiatric education
- Foster the professional development and career satisfaction of medical student psychiatric educators
- Provide support, guidance, and resources to medical students considering a career in psychiatry
- Collaborate with other psychiatric and medical education organizations to pursue common interests



Bridges over the rivers in Pittsburgh, PA

2021 Annual Meeting Goals

Educational Goal

To provide an update on current issues and innovative initiatives, methodologies and approaches to/in medical student education in psychiatry, in an environment of collegial sharing, support and inquiry.

Learning Objectives

By the end of the meeting, the attendee shall be able to:

- Design innovative methodologies of teaching medical students
- Apply the science of learning foundations to educational modalities
- Describe generational differences in medical education and apply that understanding to teaching
- Identify new approaches to faculty development
- Practice preparing scholarly work for publication using different research methodologies

Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and Association of Directors of Medical Student Education in Psychiatry. The APA is accredited by the ACCME to provide continuing medical education for physicians.

Designation Statement

The APA designates this live activity for a maximum of 11 AMA PRA Category 1 Credits (TM). Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CME Credit & Program Evaluation

An E-mail will be sent with the information for claiming CME Credits

Target Audience

This activity is designed for psychiatrists, behavioral health providers, medical educators, administrative staff, residents and medical students.

Disclosure Information

The following information has been disclosed for this meeting: Dr. Jeffrey Rakofsky, Consultant: 11 Ten Innovation Hub Grant/Research: Sage, Otsuka, Compass Other: FOCUS Journal, SMI Clinical Advisor. Dr. Howard Liu, MD, Consultant: Robert Wood Johnson Foundation. Employee: University of Nebraska Medical Center/Nebraska Medicine. Speaker's Bureau: Speaker for Medscape conference 2021. Other: Stipend for editorial work at Elsevier. Dr. Gaurava Agarwal, MD, Consultant: Vital WorkLife EAP Oscar Health. Speaker's Bureau: Otsuka Pharmaceutical/PsychU. Dr. Dawnelle Schatte, Employee: UTMB Other: My husband is the Chief Medical Officer of Stratus, a company that provides in-home EEG services. He also has an investment in Zeto, a tech company that provides EEG equipment. Neither has relevance to this talk about UME to GME transition information for clerkship directors and program directors. Dr. Arif Musa, Employee: WebMD payments made for physician education presentations. Grant/Research: Stryker Medical Student Grant from the J Robert Gladden Orthopaedic Society for research support. Southern California Clinical and Translational Sciences Team Building Award for research support. The remaining presenters and program planners report no relationships with commercial interests.

Participant List

To better assist with "Making Connections during this Annual Meeting, a separate list for all meeting registrants will be attached to your E-mail Address.

Meeting Plan for "Virtual Pittsburgh"

- 3 days of academic content, networking opportunities, and social events
- Academic events include: Large group events, concurrent workshops/discussion groups, and poster presentation sessions

Virtual Conference Center - A Zoom Link will be sent to all Registrants

1. Steelers Ballroom = Meeting Hub (Welcome for each day, Hangout, Always Available)

The All-Attendee Sessions will be held here including:

Town Hall

President's Address, Business Meeting

Keynote Address

Awards

Brief Oral Presentations

This will also be the ACCESS POINT to "Named Breakout Rooms" for:

Interest Group/Task Force Meetings

Poster Session Presentations

Informal Social Groups

2. Three Main Session Rooms

a. Allegheny (Concurrent Session - Unique Zoom Link)

- b. Monongahela (Concurrent Session Unique Zoom Link)
- c. Ohio (Concurrent Session Unique Zoom Link)

3. Breakout Rooms

These zoom rooms will be used in two ways.

1. Access from Steelers Ballroom for sessions mentioned above

2. The Three Main Session Rooms with unique Zoom Links for Concurrent Sessions will also have breakout rooms attached to enable small-group discussions within each concurrent session

Keynote Speaker: Helena Hansen, M.D., Ph.D., David Geffen School of Medicine

Subject: Structural competency as it relates to psychiatry and the importance of and strategies for incorporating SC into psychiatric education

Dr. Helena Hansen holds an M.D., and a Ph.D. in cultural anthropology from Yale University's NIH funded Medical Scientist Training Program. She is professor and chair of Research Theme in Translational Social Science and Health Equity at UCLA's David Geffen School of Medicine.

During graduate school she completed fieldwork in Havana, Cuba, on Cuban AIDS policy, and in Puerto Rico in evangelical Christian addiction ministries founded and run by self-identified ex-addicts. Her work has been published in both clinical and social science journals ranging from the Journal of the American Medical Association and New England Journal of Medicine to Social Science and Medicine and Medical Anthropology.



Helena Hansen, M.D., Ph.D.

After graduate school, she completed a clinical residency in psychiatry at NYU Medical Center/Bellevue Hospital, during which she also undertook an ethnographic study in the introduction of new addiction pharmaceuticals. She examined the social and political implications of clinicians' efforts to establish addiction as a biomedical, rather than moral or social condition, as well as the ways that neurochemical treatments may be reinscribing hierarchies of ethnicity and race. She completed a feature length visual documentary based on this work, "Managing the Fix," which debuted at the annual meeting of the American Psychiatric Association. Dr. Hansen is also leading a national movement for training of clinical practitioners to address social determinants of health, which she and Jonathan Metzl call "Structural Competency," and which is the subject of her second book, "Structural Competency in Medicine and Mental Health: A Case-Based Approach to Treating the Social Determinants of Health," with co-editor Jonathan Metzl. It was published by Springer Press in 2019. Her third book, "Whiteout: How Racial Capital Changed the Color of Heroin in America," with policy analyst, Jules Netherland along with historian David Herzberg, is forthcoming from UC Press.

Dr. Hansen is the recipient of the Robert Wood Johnson Health Policy Investigator Award, Kaiser Permanente Burche Minority Leadership Award, an NIH K01 Award, a Mellon Sawyer Seminar grant, the NYU Golden Dozen Teaching Award, the American Association of Directors of Psychiatry Residency Training Model Curriculum Award, and an honorary doctorate from Mount Sinai School of Medicine in New York.

2021 Pre-Meeting Schedule Tuesday, June 15, 2021

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4:00 PM - 6:00 PM (EDT) ADMSEP Education Scholars Workshop: (By Invitation Only) opening virtual session			
Scholar	Institution	Project	ADMSEP Mentor
Alexis Cohen-Oram, M.D.	University of South Florida	Clerkship Grading: CPX & Resident evaluation	Greg Briscoe, MD
Victoria Dinsell, M.D.	New York University School of Medicine	Residents & Teachers Program/Curriculum	Brenda Roman, M.D.
Rachel Russo, M.D.	University of Texas Southwestern Medical School	Imrpoving Psychiatry Clerkship Experience	Lia Thomas, M.D.
Neeral Sheth, M.D.	Rush University Medical Center	Substance Abuse Education in the Psychiatry Clerkship	Curt West, Jr., M.D.

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2021 Meeting Schedule Wednesday, June 16, 2021

12:00 PM-1:00 PM ET Virtual ZOOM Room Opens

1:00 PM-1:15 PM ET Brief Welcome

1:15 PM-2:00 PM ET Brave New World/How Can ADMSEP Prevent the Ship From Sinking in Rising Residency Applications TownHall

2:00 PM-2:45 PM ET Business Meeting and President's Address

3:00 PM-4:15 PM ET Concurrent Session #1: Off with the Rose-Colored Glasses Examining the Impact of Personal Privilege Workshop Session by reservation only

Concurrent Session #1: Delivering Difficult Feedback to Faculty Teachers Workshop

Concurrent Session #1: Building Better OSCE's – Virtual Innovations Workshop

4:30 PM-5:45 PM ET Making Connections with Other ADMSEP Members Breakout Rooms 2021 Meeting Schedule Thursday, June 17, 2021

10:30 AM-11:00 AM ET Virtual Room Opens

11:00 AM-12:00 PM ET Keynote Address: Dr. Helena Hansen

12:15 PM-1:30 PM ET

Concurrent Session #2: Evidence Based Advising and Tips: Improving longitudinal student advising

Discussion Panel

Concurrent Session #2: So you want to teach about Anti-Racism? How to avoid pitfalls Workshop

Concurrent Session #2: Do What You Do and Publish Too: Practice, Pearls and Pitfalls Workshop

1:45 PM-2:45 PM ET

Committees and Meetings of Interest Groups and Task Forces

3:00 PM-4:15 PM ET

Concurrent Session #3: The Psychiatrically Hospitalized Medical Student: Practical and Ethical Issues

Discussion Panel

Concurrent Session #3: Myth Behind the Manikin: Simulation-Based Learning has a Role in Psych Ed Workshop

Concurrent Session #3: Developing a Professional Brand: Five Reasons Not to go 100% Organic Workshop

4:30 - 6:00 PM ET Virtual Poster Sessions

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2021 Meeting Schedule Friday, June 18, 2021

10:30 AM-11:00 AM ET Virtual Room Opens

11:00 AM-11:20 AM ET ADMSEP Annual Awards

11:20 AM-12:30 PM ET Brief Oral Presentations

12:45 PM-2:00 PM ET

Concurrent Session #4: Strategies to Provide Meaningful Application Information to Program Directors Discussion Panel

Concurrent Session #4: Negotiation for Educators: Tools for Success from Clerkship to Career Workshop

Concurrent Session #4: Less Work and More (Role) Play: How (and Why) to Develop Successful Role-Play Workshop

2:15 PM-3:00 PM ET ADMSEP at the Museum: Art as a Teaching Tool

Town Hall — 1:15 P.M., Wednesday, June 16, 2021 "How Can ADMSEP Members Assist Students in the Brave New World of Psychiatry Recruitment?"

Anna Kerlek, M.D., Nationwide Children's Hospital Daniel Gih, M.D., University of Nebraska Medical Center Lia Thomas, M.D., UT Southwestern/ VA North Texas Greg Briscoe, M.D., Eastern Virginia Medical School Jessica Kovach, M.D., Temple University Brenda Roman, M.D., Wright State University Boonshoft School of Medicine

Background: The 2020-2021 psychiatry recruitment season was unlike any other that preceded it. The Coalition for Physician Accountability Work Group's recommendations for only virtual interviews sent the UME and GME worlds into a frenzy. Simultaneously, medical student interest in psychiatry is rising. Training programs are being overwhelmed with greater number of applications. Total applicants outnumber the available positions, increasing the number of applicants going unmatched. This past year approximately 200 MD seniors and 150 DO seniors did not match into first year residency positions.

Over the last ten years, the average number of applications per U.S. or Canadian applicant to psychiatry has doubled to reach 55.9 applications. Anecdotally, students are distressed as they are feeling pressured to apply to more programs than needed. This has potential secondary effects of increasing burnout, student debt loads (especially considering travel in non-pandemic years) and encouraging non- optimal fits with programs. These pressures could also affect learning opportunities in the final year of medical school. These trends and related conversations from educators have generated debate about how to best manage the surge. Last year, ADMSEP and AADPRT issued joint recommendations about the recruitment season in response to the pandemic and application numbers. ADMSEP members in the Dean's offices, clerkship directors, advisors, program directors and administrators have an important role in providing accurate advice moving forward.

Objectives: By the end of this discussion, participants will be able to: 1) Examine the 2020-2021 residency recruitment season, 2) Identify recent trends in application numbers, and 3) Generate advising guidance to faculty and staff in undergraduate medical education for upcoming recruitment.

Methods: First, the group intends to have short, focused presentations on application trends from the Electronic Residency Application Service (ERAS) 2021 Preliminary data counts, published literature, and selected comments from social media sites. Second, we will switch to an engaged town hall setting by panelists from their roles on campus and various organizations answer questions from the audience under a major topic area. There will be space for discussion, and potential for live polling from the audience through the chat. As the number attendees are not known, a moderator will be utilized to ensure a successful discussion group. An additional perspective from the Recruitment Committee of AADPRT will also be included.

Results: The presenters would like to continue working towards collaborative ways to best help students while maintaining our psychiatric education mission, galvanizing stakeholders, and moving our field forward.

Discussion: ADMSEP members are often in position to advise medical students applying to psychiatry. Thus, it is important to provide recommendations that reflect current data and support matching success.

References:

1. Association of American Medical Colleges. Preliminary Data As of 11/9. https://www.aamc.org/media/6231/ download. Accessed 15 Nov 2020.

2. Special Joint Statement on 2020 Recruitment from AADPRT and ADMSEP: https://www.aadprt.org/application/files/1015/9009/1630/admsep_aadprt_statement_5-17-20.pdf

3. Additional Joint Statement AADPRT/ADMSEP Statement on Guidelines for Virtual Recruitment: https://www.aadprt.org/application/files/8816/0017/8240/admsep_aadprt_statement_9-14-20_Rev.pdf

4. Ray C, Bishop SE, Dow AW. Rethinking the Match: A Proposal for Modern Matchmaking. Acad Med. 2018;93(1):45-47.

5. Weissbart SJ, Kim SJ, Feinn RS, Stock JA. Relationship Between the Number of Residency Applications and the Yearly Match Rate: Time to Start Thinking About an Application Limit? J Grad Med Educ. 2015;7(1):81-85.

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President's Address and Business Meeting

2:00 P.M., Wednesday, June 16, 2021

President, Howard Liu, M.D., M.B.A.

Election of Officers:

President: Lisa Fore-Arcand, Ed.D.
Vice President: Erin Malloy, M.D.
Secretary: Lia Thomas, M.D.
Councilor Year 3: Matthew Goldenberg, M.D.
Councilor Year 2: Jeffrey Rakofsky, M.D.
Councilor Year 1: Lindsey Pershern, M.D.
* New Treasurer Position: Lorin M. Scher, M.D., FACLP 3-Yr term, not in the leadership progression

Membership vote on update to ADMSEP Bylaws that include addition of a new treasurer position

Concurrent Session 1 • Workshop (pre-registration was required - limited capacity) 3:00 P.M., Wednesday, June 16, 2021 • limit 30

Off With the Rose-Colored Glasses: Examining the Impact of Personal Privilege and Empathy in the Learning Environment

Sheritta Strong, MD, University of Nebraska Medical Center Linda Love, EdD, University of Nebraska Medical Center Katrina Cordts, Ph.D., University of Nebraska Medical Center Lloyda Williamson, MD, Meharry Medical School

Background: There are some preconceived biases that exist within our psyche that are not readily accessible. Implicit biases are implicated in healthcare and in the learning environment⁽³⁾ and decrease our ability to empathize. The automaticity of our brain promotes these unconscious biases ⁽¹⁾. Our unique lens contributes to our identity, which is intricately shaped by various factors ⁽⁴⁾. It also effects the way we perceive our patients and learners. To have advantages in society by virtue of belonging to a certain group based on one's status, is the definition of privilege ⁽⁵⁾. Homiphily, the human tendency for people to seek out or be attracted to those like themselves, can elevate a sense of isolation in underrepresented individuals ⁽²⁾. Reflecting upon our own lens, we are better able to understand our interactions ⁽¹⁾. In this interactive workshop, we will identify our own privilege to help us understand and effectively disrupt the effects of biases.

Objectives: After participating in this session, participants will be able to:

- Review the complexities of our identities
- Analyze our own privilege and how it shows up in daily encounters
- Explore the impact of biases on our patients and our learners
- Describe ways to increase empathy and mitigate bias using case-based scenarios

Methods: After the introduction and background of the activity, this three-part workshop limited to thirty participants will examine their own privilege by engaging in personal reflection activities and the discussion of case-based scenarios. This workshop can be easily delivered in person or virtually using breakout rooms for smaller group activities. Screen sharing by the workshop facilitators would be used to demonstrate activities and links to pdf's can be included in the virtual chat function.

Format: Introduction (15 minutes): In a safe environment, a review of participants' baseline experiences and a brief awareness demonstration will take place to show the automaticity in our brains. The participants will be encouraged to lean into the discomfort and reflect individually. Sharing of personal reflections won't be required. Part I (25 minutes) –Examining Privilege as a Way to Increase Empathy: A 5 min video will demonstrate privilege. Next, participants will reflect individually on their own privilege. Discussion will ensure in small groups, with participants and session leaders sharing insights. Part II (25 minutes) –Case-Based Scenarios: Discuss scenarios and use tools to use to mitigate the bias. Wrap-up (10 minutes): Final group and individual insights will be shared especially how this activity can enhance our interactions with our learners. Session leaders will provide general insights with the group.

References:

1. Castillo-Page, Laura et al. Chapter 2: The Inconvenient Truth About Unconscious Bias in the Health Professions. Diversity and Inclusion in Quality Patient Care. 2019; 5-13. 2. Ellis, Josh et al. "Interviewed While Black." NEJM. NEJM. org on November 11, 2020. 3. Holm, Amanda et al. "Recognizing Privilege and Bias: An Interactive Exercise to Expand Health Care Provider' Personal Awareness. Academic Medicine. (2017);92(3):360-364. 4.Tatum, Beverly. "The Complexity of Identity: "Who Am I?" Readings for Diversity and Social Justice: An Anthology on Racism, Sexism, Anti-semitism, Heterosexism, Classism and Ableism (pp. 9-14). New York: Routledge. 5. Zhou, Stephanie. "Underprivilege as Privilege." JAMA. (2017);318(8):205-206.

Concurrent Session 1 • Workshop 3:00 P.M., Wednesday, June 16, 2021

Delivering Difficult Feedback to Faculty Teachers

Rachel Russo, MD, University of Texas Southwestern Medical Center Kathlene Trello-Rishel, MD, University of Texas Southwestern Medical Center J. Chase Findley, MD, McGovern Medical School at UTHealth Gayle Ayers, DO, University of Texas at Austin – Dell Medical School

Background: Medical schools rely on monitoring feedback from students' evaluations as the most common method to help faculty improve their teaching.(1) However, studies looking at student feedback alone have found that student evaluations do not consistently improve teaching.(2,3) Evaluation by fellow faculty (peer review) has been shown as a valid way to enhance faculty teaching skills.(4,5) We looked at presentation of direct feedback from students and peer review in our clerkship and found direct feedback from students and peers was impactful. However, despite feedback and faculty development activities, in some cases a teacher will continue to get poor reviews or have issues with professionalism or boundaries, and in these instances' direct delivery of this difficult feedback by the clerkship director is required. We aim to provide an opportunity for administrative leaders in education to reflect, share, and discuss how to improve ways of delivering difficult feedback to instructors.

Objectives: Upon completion of this session, participants will be able to:

- Describe methods of improving teaching via faculty feedback, peer review, and faculty development.
- Discuss case vignettes and a role play exercise to highlight challenges and potential solutions for coping with an underperforming teacher
- Reflect on the cases above to build morale and develop individualized tools for improving faculty teaching

Methods: Brief didactics followed by a majority of time spent on skill building exercises.

Format: In this 75-minute workshop we will use: - 15 minutes of review of the literature and our data - 50 minutes of skill building exercises to include 20 minutes of case-based discussion in small groups of cases depicting failing teachers, 10 minutes of small group interactive discussion of ways to improve faculty lectures, and 15 minutes of large group discussion - 10 minutes of wrap up and questions

References:

1. Kelley M Skeff; Evaluation of a Method for Improving the Teaching Performance of Attending Physicians. The American Journal of Medicine 75 (1983) 465-470. 2. Debra K Litzelman et al; Beneficial and Harmful Effects of Augmented Feedback on Physician's Clinical-teaching Performances. Academic Medicine 73 (1998) 324-332 3. LuAnn Wilkerson and David M Irby; Strategies for Improving Teaching Practices: A Comprehensive Approach to Faculty Development. Academic Medicine 73 (1998) 387-396. 4. Lori R Newman et al; Developing a Peer Assessment of Lecturing Instrument: Lessons Learned. Academic Medicine 84 (2009) 1104-1110. 5. Maryellen Gusic

Concurrent Session 1 • Workshop 3:00 P.M., Wednesday, June 16, 2021

Building Better OSCE's: Virtual Innovations

Erin Malloy, MD, University of North Carolina School of Medicine Kelly Cozza, MD, Uniformed Services University of Health Sciences F. Edward Hebert School of Medicine

Background: The use of Observed Structured Clinical Examinations (OSCE's) in assessment of clinical skills in psychiatry has grown in recent years. Advantages of OSCE's include standardization of assessment, reliability of direct observation, potential for reduced bias in grading compared to clinical encounters (1), consistent resources, and capacity to meet educational needs not readily available through real patient encounters. For many schools, OSCE's have been a key element of the assessment of clinical skills for students in their clinical years. The COVID-19 pandemic has created challenges for clinical courses, limiting opportunities for direct observation of students with real and standardized patients due to safety concerns. Virtual OSCE's have been developed to address these challenges (2,3). Transitioning from in-person OSCE's to virtual formats requires time and effort for careful adjustments to create authentic encounters that allow for reliable assessment of clinical skills.

Objectives: Upon completion of this session, participants will be able to:

- Evaluate strengths and challenges of several virtual psychiatry OSCE formats in experiential and descriptive formats
- Improve knowledge base related to necessary considerations of OSCE development in both face-to-face and virtual formats evidenced by crafting a list on worksheets
- Utilize an algorithm to identify assessment needs, available resources, and communications processes to begin developing (or adapting) a psychiatry OSCE via virtual means, using a worksheet
- Discuss and take steps to create a plan for evaluation/assessment of the OSCE as means to measure clinical skills

Methods: This session can be delivered virtually or in-person. To best meet participant needs, use of insession polling will identify participant familiarity with components of OSCE development to set a "community baseline" for further discussion. Two brief presentations of virtual OSCE innovations will highlight key decision points in developing virtual OSCE's: the Uniformed Services University of the Health Sciences (USUHS) SOM 4-station Psychiatry Virtual OSCE and the University of North Carolina SOM Virtual Observed Evaluation OSCE. Facilitated small group breakouts will allow participants to use a worksheet as a base to reflect on their own goals, needs, and resources to enable them to begin to develop an action plan for development/adaptation of an OSCE at their institution. Share-back after the small groups will enable participants to learn from others. Ideas will be collated visually and also incorporated into a resource list that will be shared with the participants.

Results: USUHS preliminary results: Since April 2020, USUHS has completed 112 four-station Psychiatry virtual OSCEs. There have been no significant technical difficulties. Students have performed at the level of their non-virtual peers or better, and there has been just one OSCE "pass but with concerns" outcome (1 student provided NO safety assessments in any of the 4 stations, and will be required to complete a 4-week clerkship-level remediation). Initial student feedback on the "TeleOSCE" has been favorable. This format has also allowed faculty from across the globe to participate in the assessment of students. UNC SOM preliminary results: Since July 2020, students successfully completed the virtual psychiatry OSCE. All OSCE's were completed and recorded without significant technical difficulties in the CAE LearningSpace virtual platform. Performance of the first cohort of 44 students was higher than that of the prior in-person OSCE's, no failures. No grade complaints.

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Discussion: The need for reliable and accurate assessments of clinical skills for medical students will continue to grow, in this era of pandemic-related limitations in directly observed clinical encounters and heightened import of assessment given the upcoming shift to Pass/Fail USMLE Step 1. We have a great need to share our experiences in assessing clinical skills during clerkship. Working to develop expertise in synchronous, distributed, "live" assessment is a necessity. Sharing experiences in virtual assessment of clinical skills such as OSCE's can engage educators in a process for developing and/or adapting OSCE's to virtual means, based on their own goals, needs, and resources. Discussion of an ongoing development of next steps during this workshop will contribute to our growing Psychiatry clinical education resources.

Format: This session can be delivered virtually or in-person. To best meet participant needs, use of in-session polling will identify participant familiarity with components of OSCE development to set a "community baseline" for further discussion. Two brief presentations of virtual OSCE innovations will highlight key decision points in developing virtual OSCE's: the Uniformed Services University of the Health Sciences (USUHS) SOM 4-station Psychiatry Virtual OSCE and the University of North Carolina SOM Virtual Observed Evaluation OSCE. Facilitated small group breakouts will allow participants to use a worksheet as a base to reflect on their own goals, needs, and resources to enable them to begin to develop an action plan for development/adaptation of an OSCE at their institution. Share-back after the small groups will enable participants to learn from others. Ideas will be collated visually and also incorporated into a resource list that will be shared with the participants.

References:

1.Hodges BD, Hollenberg E, McNaughton N. et al. The Psychiatry OSCE: A 20-Year Retrospective. Acad Psychiatry 38, 26–34 (2014). doi 10.1007/s40596-013-0012-8 2.Lara S, Foster CW, Hawks M, Montgomery M. Remote Assessment of Clinical Skills During COVID-19: A Virtual, High-Stakes, Summative Pediatric Objective Structured Clinical Examination. Acad Pediatr. 2020 Aug;20(6):760-761. doi: 10.1016/j.acap.2020.05.029. Epub 2020 Jun 5. PMID: 32505690; PMCID: PMC7273144. 3.Cozza, KL and Hamaoka, DA. Clerkship Virtual and Simulation COVID "Pivot"—Psych TeleOSCE and Return to LIVE Instruction in The Show Must Go On: Lessons Learned- Building COVID Virtual Curriculum. Presented at the ADMSEP Virtual Quarterly Fall Meeting, October 14, 2020. 4. Vitiello E, Doctor D, Lindner S, Dallaghan GB, Malloy EM. A Novel Approach to Standardization and Resident Involvement in the Psychiatry Clerkship OSCE. Accepted on November 11, 2020 for publication in Academic Psychiatry.

Concurrent Session 2 • Discussion Panel 12:15 P.M., Thursday, June 17, 2021

Evidence Based Advising and Tips: Improving longitudinal student advising

Daniel Gih, MD, University Nebraska Medical Center Alexandra Fiedler, University Nebraska Medical Center Jody Glance, MD, University of Pittsburgh School of Medicine/WPIC Michael Miller, MD, University of Texas Medical Branch at Galveston Dana Raml, MD, University Nebraska Medical Center

Background: Interest in psychiatry residency training has increased creating greater competition for residency positions. With this growth, past practices and advice given to students need updating and calibration with current trends. Therefore, using data from match trends and program director surveys may provide a better path for student and faculty advisors alike. This workshop will update participants' understanding of the competitive environment for students applying for residency, clarify differences between psychiatry and other fields, and generate approaches to student advising using existent data. As the match process represents a significant step towards practice in the specialty of choice, an advisor's ability to positively influence a student's residency placement and career is important.

Objectives:

1.Understand current match data and program director surveys for students entering psychiatric residency 2.Review current and ideal state for longitudinal student advising 3.Discuss strategies to enhance current advising practices 4.Apply advising strategies using presented data to various student scenarios Methods:

First, didactic portion will be minimal and limited to focused presentations on match trends, program director surveys and current student advising practices. Of note, preliminary statistical analyses have been conducted using the NRMP Program Director Surveys over the past decade; they will serve as major discussion points. Second, small group learning will be utilized to have at least two concurrent breakout groups led by members of the presentation team. Presenters will facilitate peer to peer discussion and feedback incorporating ERAS and NRMP data with common student scenarios. We will discuss strategies to promote longitudinal advising best practices, and successful matching. Following the case discussions, the large group will reconvene to recap key takeaways. Moreover, live polling will help capture participant reactions and conclusions.

Format:

Part 1 Background information Brief presentation 1: Introduction and Review Match Trends (Daniel Gih) - 10 min Brief presentation 2: NRMP Program Director Surveys 2008-2018 (Alexandra Fiedler) – 10 minutes Brief presentation 3: Longitudinal student advising: preparing for success and challenges (Raml/Miller/Glance) – 15 minutes Part 2:Case scenarios (30 minutes) Participants will practice applying match data, program director surveys and advising best practices to three student advisee scenarios Part 3:Wrap-up (10 minutes) Summarize key tactics for effective student advising

References:

1. Association of American Medical Colleges. Preliminary Data As of 11/9 of each season. https://www.aamc.org/ media/6231/download. Accessed 15 Nov 2020.

2. American Association of Medical Colleges (2019). Apply Smart: Data to consider when applying to residency. Retrieved from https://students-residents.aamc.org/applying-residency/filteredresult/apply-smart-data-consider-when-applying-residency/.

3. American Psychiatric Association (2019). Guide to Applying to Psychiatric Residency. Retrieved from https://www. psychiatry.org/residents-medical-students/medical-students/apply-for-psychiatric-residency.

4. National Resident Matching Program, Results and Data: 2019 Main Residency Match®. National Resident Matching Program, Washington, DC. 2019.

5. National Resident Matching Program, Data Release and Research Committee: Results of the 2018 NRMP Program Director Survey. National Resident Matching Program, Washington, DC. 2018.

Concurrent Session 2 • Workshop 12:15 P.M., Thursday, June 17, 2021

So you want to teach about AntiRacism? How to avoid pitfalls implementation

Kristin Escamilla, MD, University of Texas at Austin Dell Medical School Sarah Baker, University of Texas Southwestern Medical Center Pierre Banks, University of Texas Medical Branch Premal Patel, University of Texas Medical Branch Rachel Russo, MD, University of Texas Southwestern Medical Center Kathlene Trello-Rishel, MD, University of Texas Southwestern Medical Center

Background: Recent national events have served as a catalyst for the necessary and urgent integration of Antiracist teaching within medical education. However, many faculty are not knowledgeable about this topic and have no experience teaching or discussing it. Despite this lack of expertise, it is crucial that faculty begin and continue this important work for trainees, patients, and colleagues, without causing harm to anyone in the process. This workshop will provide an introduction to AntiRacism, including pitfalls to avoid, for the implementation of this vital topic into medical education.

Objectives: Upon completion of this session, participants will be able to:

- Identify specific examples of anti-racism curricular interventions to implement
- Recognize established and emerging frameworks to facilitate implementation
- Describe how to avoid common pitfalls during implementation
- Evaluate effective strategies to prevent, minimize and mitigate unintentional re-traumatization of participants of color
- Develop practical approaches to responding to an array of participant reactions, including fragility, insensitivity, and anger.

Methods: The workshop will begin with an overview of AntiRacism, including examples of implementation undertaken at the presenters' home institutions and in the literature. Then, small groups will be asked to brainstorm and explore implementation ideas that will be shared with the large group. Presenters will then discuss strategies for responding to challenging scenarios, including skepticism, fragility, and microaggressions, that may arise during implementation of these activities. Case scenarios will then be discussed in small groups so that participants can explore how they might respond to various participant reactions. The large group will then have time to debrief, with further discussion of implementation strategies and possible challenges.

Format: 5 minutes: Introduction, 10 minutes: Didactic in large group on the principle of AntiRacism and examples of curricular integration, 15 minutes: Brainstorm implementation ideas in small groups, 10 minutes: Large group debrief on implementation ideas, 10 minutes: Didactic in large group on responding to injury and pushbacks, 20 minutes: Review cases on responding to injury and pushback in small groups, 10 minutes: Large group debrief on responding to injury and pushback, 10 minutes: Q&A, Closing remarks, and Feedback survey

References:

 Ahmad, N. Jia; Shi, Marc MSc The Need for Anti-Racism Training in Medical School Curricula, Academic Medicine: August 2017 - Volume 92 - Issue 8 - p 1073 doi: 10.1097/ACM.0000000000000000806
 Yousif, H; Ayogu, N; Bell, T. The Path Forward. An Antiracist Approach to Academic Medicine. The New England Journal of Medicine: October 2020 – 383:e91 doi: 10.1056/NEJMpv2024535

Concurrent Session 2 • Workshop 12:15 P.M., Thursday, June 17, 2021

Do What You Do and Publish Too: Practice, Pearls and Pitfalls

John Spollen, MD, University of Arkansas for Medical Sciences Richard Balon, MD, Wayne State University School of Medicine Lia Thomas, MD, UT Southwestern Medical Center/ VA NTHCS Jeff Rakofsky, MD, Emory University School of Medicine

Background: Academic psychiatrists are faced with many pressures – one of them being the ever-present reminder of promotion. Promotion is often tied with publication, but how do people with little research training or experience do it and where does one find the time? Educators are often unsure of where to start in research and publications and are often unable to sustain projects to completion and publication. In this workshop, we will present an expanded view of educational research and scholarship with examples of published projects to stimulate participants. Then we will discuss barriers to successful implementation of educational research and scholarly projects and present proven strategies for successfully overcoming obstacles.

Objectives: At the end of this workshop, participants will be able to:

- 1. Describe an expanded view of research and scholarship in medical education.
- 2. Identify potential challenges to engaging in educational scholarship and ways to overcome them.
- 3. Define a specific project they will accomplish in the coming year.

Methods: We will use a mix of short didactic presentations followed by extended breakout sessions using a think/pair/share methodology to increase understanding of a broader view of educational research and scholarship, as well as effective strategies to overcoming barriers to successful endeavors in educational research and scholarship.

Format: Introduction and Objectives (5 minutes) Didactic Presentation on Expanding Views of Educational Research (10 minutes) Breakout Session 1: Think/Pair/Share on Possible Projects Based on Expanded View (20 minutes) Brief Audience Response on Barriers to Doing Educational Research (5 minutes) Didactic Presentation on How to Make it Work Despite Barriers (10 minutes) Breakout Session 2: Think/Pair/Share on Personalized Plan for Success (20 minutes) Wrap up and Conclusions: (5 minutes)

References:

1. Boyer, E. L. (1997). Scholarship reconsidered: Priorities of the professoriate. Princeton, N.J.: Carnegie Foundation for the Advancement of Teaching.

2. Arnold, L.L Preface: Case Studies of Medical Education Research Groups.Academic Medicine. 79(10):966-968, October 2004

3. Before You Send Out that Survey: The Nuts and Bolts of Implementing a Medical Student Survey Study. Rakofsky JJ, Beck Dallaghan GL. Acad Psychiatry. 2017 Jun;41(3):391-395.

Committees, Interest Groups, and Task Force Meetings (Everyone is welcome to join us!) 1:30 P.M., Thursday, June 17, 2021 • Breakout Rooms out of the Main Room

Awards Committee:

Faculty Development Committee:

Membership Engagement Committee:

The Membership Engagement Committee works to make all ADMSEP members feel welcome. We do this by highlighting members in the ADMSEP newsletter. We create personalized outreach to fellow members with individualized emails and old school hand written postcards. Our committee also identifies potential new members and provides outreach to areas underrepresented in ADMSEP. We have a relatively low time commitment throughout the year and a lot of flexibility. If making connections with others is your strong point, come join us!

Contact: Peirce Johnston, johnstpw@ucmail.uc.edu or Dana Raml, dana.bell@unmc.edu for more information

Clerkship Administrator Committee:

The Administrator's (Coordinators) Committee is a group of hard-working individuals from all forms of programs, University Programs to community campus/hospitals. We welcome any administrator to the group whether you are just starting out in the role or experienced. We try and discuss tips and tricks that will be helpful to all, concerns about procedures we all face, and network with others that know our specialty. We look forward to welcoming new members and catching up with returning members, and seeing and learning new or different ways to view and improve our work life.

Contact: Callie Langenderfer, langend8@msu.edu or Kristi Rowell, Kristi.D.Rowell@uth.tmc.edu for more information

Clinical Simulation Initiative Committee:

The Clinical Simulation Initiative (CSI) Committee serves to assist our members to plan, design, develop, and distribute medical student educational electronic modules for featuring on the ADMSEP website. Our modules are free, open-access interactive online educational tools and provided just-in-time education and training during the 2020 pandemic with over 150,000 views in 112 countries. The development of these educational tools requires a number of diverse talents and interests (e.g., designers, acting talent, reviewers, content experts) — just let us know how you would like to contribute. There is a place for everyone. Contact: Derrick Hamaoka, <u>derrick.hamaoka@usuhs.edu</u> or Mary Steinmann, <u>Mary.Steinmann@hsc.utah.edu</u>

Research Committee:

DEIA Task Force:

The DEIA Task Force of the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) enhances the organization's mission to promote excellence in behavioral sciences and psychiatric education for medical students by encouraging a focus on diversity, equity, inclusion and antiracism in all organizational activities. If interested in getting involved in creating DEIA milestones in ADMSEP and in the creation of curriculum/content, please join our lunchtime session!

Contact: Lia Thomas, Lia.Thomas@UTSouthwestern.edu or Matt Goldenberg, matthew.goldenberg@yale.edu

MSPE Task Force:

The ADMSEP MSPE Task Force continues to work on issues related to the UME to GME transition, especially as Step 1 moves Pass/Fail reporting in January 2022. Several members of the task force hosted a workshop at AADPRT and are developing a Program Director survey as a needs assessment, and other members are working on a scoping review and presenting Strategies to Provide Meaningful Application Information to Program Directors in a Step 1 Pass/Fail World at this ADMSEP meeting.

Contact: Dawnelle Schatte, <u>daschatt@utmb.edu</u> or Jeffrey Rakofsky, <u>jrakofs@emory.edu</u> for more information

Concurrent Session 3 • Discussion Panel 3:00 P.M., Thursday, June 17, 2021

The Psychiatrically Hospitalized Medical Student: Practical and Ethical Issues for Clerkship Directors

Kirsten Wilkins, MD, Yale University Matthew Goldenberg, MD, Yale University Mario Fahed, MD, University of Connecticut

Background: More than 25% of US medical students experience depression, and over 10% report experiencing suicidal ideation. Students who require inpatient hospitalization may receive that treatment at academic medical centers affiliated with their medical schools, including on units that serve as training sites for medical students and residents. A student's hospitalization on a unit in which a classmate may be working requires clerkship directors to weigh issues of patient privacy versus student educational experience.

Objectives: At the end of this discussion group, participants will be able to:

- 1. Cite the epidemiologic prevalence of depression and suicidal ideation among medical students
- 2. Discuss ethical considerations in the management of a medical student's psychiatric hospitalization on a unit that serves as a medical student training site.
- 3. Identify LCME standards and school policies relevant to student-patient privacy.
- 4. Consider whether and how consideration of a student's psychiatric hospitalization may differ from a medicalsurgical admission.

Methods: Over the last few years at our institution, we have had multiple medical students admitted for inpatient psychiatric treatment at our academic medical center's hospital. The site where they are hospitalized is used as a primary training site for clerkship students and residents. As clerkship directors, we have had to make decisions about how to manage these situations. In this discussion group, presenters will first share data on the prevalence of mental health disorders and treatment seeking among medical students. Next, a de-identified case will be shared of a medical student requiring inpatient psychiatric admission. Whether in person or via virtual platform breakout rooms, presenters will alternate buzz groups and large group discussion to engage participants in consideration of the various practical and ethical issues medical student educators must consider in such a scenario.

Format: Introduction (brief presentation of data on medical student mental health): 10 mins. Case presentation: 5 minutes. Buzz groups/large group discussion: Buzz group #1 ("What are the key ethical dilemmas in this case?"): 5 minutes. Large group debrief: 7 minutes. Buzz group #2 ("What are the roles/duties of the clerkship director, unit attending, and student affairs officers in this case?"): 5 minutes. Large group debrief: 7 minutes. Buzz group #3 ("What are the relevant LCME/school policies to consider in decision-making in such a case?"): 5 minutes. Large group debrief: 7 minutes. Buzz group #4 ("How does psychiatric admission of a medical student differ from medical/surgical admission?"): 5 minutes. Large group debrief: 7 minutes. Large group debrief: 7 minutes. Large group debrief: 7 minutes. Large group bebrief: 7 minutes. Large group #1 ("How does psychiatric admission of a medical student differ from medical/surgical admission?"): 5 minutes. Large group debrief: 7 minutes. Large group #2 ("How does psychiatric admission of a medical student differ from medical/surgical admission?"): 5 minutes. Large group debrief: 7 minutes.

References:

1. Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis. JAMA. 2016;316(21):2214-2236.

2. Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree; March 2018. https://lcme.org/publications/. Accessed October 10, 2019.

3. Dent GA. The student becomes the patient. Virtual Mentor. 2012;14(9):701-704. 4.Goldenberg MN, Wilkins KM. A medical student is psychiatrically hospitalized. Academic Psychiatry. 2020;44:629-631.

Concurrent Session 3 • Workshop 3:00 P.M., Thursdsay, June 17, 2021

The Myth Behind The Manikin: Simulation-Based Learning Has a Role in Psychiatric Education

Kristin Escamilla, MD, University of Texas at Austin Dell Medical School Sarah Baker, University of Texas Southwestern Medical Center Kathlene Trello-Rishel, MD, University of Texas Southwestern Medical Center Brian Fuehrlein, MD, VA Connecticut Healthcare System Nicholas Ortiz, MD, Dell Medical School at The University of Texas at Austin

Background: Computer-enhanced manikin (CEM) simulation has been widely adopted in other fields of medicine but is rarely used in psychiatry education despite student preference and evidence supporting its effectiveness (1-4). Additionally, there is wide consensus that management of substance use disorders is not adequately addressed in medical education, with consequences for attitudes and treatment of this stigmatized population (5-6). In response, educators at Yale, UT Southwestern, and Dell Med received an ADMSEP Grant to develop a novel case that addresses attitudes and clinical skills necessary for physicians practicing within the current opioid epidemic. Our workshop will familiarize educators with critical aspects of CEM, review the newly created case, and provide recommendations for implementing this novel learning tool into existing curricula.

Objectives: After participating in this session, participants will be able to:

- List three benefits of the use of CEM in medical education
- Describe the logistics and identify challenges in the creation and implementation of a CEM case
- Develop a CEM case for future use within psychiatric education

Methods: First, there will be a brief didactic presentation on basic concepts surrounding CEM technology. Next, attendees will be led through a specific example of a fully developed and implemented CEM clinical scenario. Participants will then share their experiences with the use of this technology at their respective institutions and how it could be utilized further. Finally, in small groups, participants will brainstorm ideas for new case creation and implementation of their new case. Facilitators will work closely with each small group to guide participants through the components of creating an effective clinical scenario, logistics of CEM implementation, and engage in discussion around planning future clinical cases at their institutions.

Format: Didactic background component (15min), Group activity – Participants will run through a CEM case currently being implemented at participating institutions (15 min), Large group discussion – Participants will be encouraged to discuss logistical considerations necessary for CEM implementation as well as previous challenges faced when initiating CEM-based learning at their home institutions (15 min), Small Group Work and Discussion -Participants will be divided into small groups. Each group will be encouraged to develop a novel CEM case for psychiatric education. Each group will then present their new case to the larger group for open discussion and sharing of ideas (25 min), Conclusions and Questions (5 min).

References:

1. Abdool PS, Nirula L, Bonato S, Rajji TK, Silver IL. Simulation in undergraduate psychiatry: exploring the depth of learner engagement. Acad Psychiatry. 2017; 41(2): 251-261.

2. Scalese RJ, Obeso VT, Issenberg SB. Simulation Technology for Skills Training and Competency Assessment in Medical Education. JGIM 2008; 23: 46-49.

3. Cook DA, Hatala R, Brydges R, et al. Technology-enhanced simulation for health professions education: a systematic review and meta-analysis. JAMA. 2011; 306(9): 978-988.

4. Issenberg SB, Mcgaghie WC, Petrusa ER, et al. Features and uses of high-fidelity medical simulations that lead to effective learning: a BEME systematic review. Med Teacher. 2005; 27(1): 10-28.

5. Ram A, Chisolm MS. The Time is Now: Improving Substance Abuse Training in Medical Students. Acad Psych. 2016; 40: 454-460. (6)Miller NS, Sheppard LM, Colenda CC, Magen J. Why Physicians are Unprepared to Treat Patients who have Alcohol- and Drug-related Disorders. Acad. Med. 2001; 76.

Concurrent Session 3 • Workshop 3:00 P.M., Thursdsay, June 17, 2021

Developing a Professional Brand: Five Reasons Not to go 100% Organic

Dana Raml, MD, University of Nebraska Medical Center Linda Love, EdD, University of Nebraska Medical Center Jeana Benton, MD, University of Nebraska Medical Center Sheritta Strong, MD, University of Nebraska Medical Center

Background: When we think of "brands" we often think of big business, like Coca-Cola or Ford. Businesses and organizations carefully nurture their brands because of the power that experiences and feelings have in growing relationships and ultimately, the bottom line. The same is true for your personal professional brand. Your brand is what people think about you: whether you agree with it, recognize it, or not. Whether you are a junior or senior faculty member, paying attention to your brand can slip off the radar. This is especially true following the events of 2020; with COVID changing the way we practice medicine and educate students, and the Black Lives Matter Movement renewing focus on diversity. This workshop offers an intentional guided structure to consider your current brand, and the intersection of your passion areas, your skills, and your organization's needs. We'll examine common derailers of brands, and develop an action plan to move beyond relying on a 100% organic career path.

Objectives: After participating in this session, participants will be able to:

- Examine your current brand
- Align your brand with your career goals
- Develop mechanisms to communicate your brand
- Design/redesign strengthening brand strategies

Methods: This workshop focuses on five key way faculty can practice intentional brand development—all of which are relevant for all ranks and years of service. Engaging with the larger psychiatry community, faculty will examine a series of data points and make decisions about inequities, gaps, or skills that can be addressed for maximum career performance. A major emphasis will be alignment between personal and organizational goals. Participants will use reflection, critical thinking, and problem-solving to fine-tune their career brand. This workshop may be completed either in person, or via zoom. Zoom break out rooms will be used for small group discussions and zoom polling will be used to generate large group themes. We are confident in our ability to execute this workshop effectively through zoom and make appropriate modifications based on the number of participants in attendance.

Results: Examining personal professional brands and how they work in tandem with organizational brands can be notably revealing, particularly for faculty who have relied on a serendipitous strategy for their career. Professional brands exist whether faculty are aware of their impact or not. Developing the professional practice of regularly examining the effectiveness and breadth of a brand can help both individuals and organizations yield better long-term impact.

Discussion: Carefully and intentionally nurturing a personal brand can seem an unnecessary chore for some, or too much self-promotion for others. But, by honing specific intentionality, reflection, and planning habits, faculty can truly be at the helm of creating a personally rewarding career. Developing a personal brand is not a "one and done" proposition. It is a practice that will require recalibration, pivots, adaptability, accountability, hand-offs, and hand-ups over the course of a career. When this kind of clarity is evident, the larger organization wins too, with more fulfilled employees and smarter strategies for helping people grow.

Format: This session is interactive throughout. Each section is 15 minutes.

• Crowdsourcing your brand Faculty will live text 3-7 trusted colleagues with the following question: I am in a workshop about my professional brand and we are crowdsourcing data. Can you text me 3-5 words you think describe my "brand"?

• Mirror, Mirror Small group: With a critical eye, pull up your website with your department profile or biography. What you think of your picture and the words offered. What does your profile say about your values?

• Brand Bumps Large group: Sometimes our brand gets lopsided. What are threats to your brand? How has COVID impacted your brand trajectory?

• Your Bosses Thoughts Small group: Do you know what s/he thinks your brand value is? Does your actual work reflect who you want to be?

• Wait, what? Large group: Evaluate brand gaps and action steps for aligning with your desired outcomes. Look at the composite of data gathered. What is your assessment?

References:

Borman-Shoap, E., Li, S. T. T., St Clair, N. E., Rosenbluth, G., Pitt, S., & Pitt, M. B. (2019). Knowing Your Personal Brand: What Academics Can Learn From Marketing 101. Academic Medicine, 94(9), 1293-1298.

Chapleo, C., & Simpson, L. (2019). 10 Measuring higher education brand performance and brand impact. Strategic Brand Management in Higher Education.

Chu, F. Y., Dai, Y. X., Liu, J. Y., Chen, T. J., Chou, L. F., & Hwang, S. J. (2018). A Doctor's Name as a Brand: A Nationwide Survey on Registered Clinic Names in Taiwan. International journal of environmental research and public health, 15(6), 1134.

Humphries, L. S., Curl, B., & Song, D. H. (2016). # SocialMedia for the academic plastic surgeon—elevating the brand. Plastic and Reconstructive Surgery Global Open, 4(1). Jones, R. (2017). Branding: a very short introduction. Oxford University Press.

Concurrent Session 4 • Discussion Panel 12:45 P.M., Friday, June 18, 2021

Strategies to Provide Meaningful Application Information to Program Directors in a Step 1 Pass/ Fail World

Dawnelle Schatte, MD, University of Texas Medical Branch J. Curt West, MD, USUHS David Schilling, MD, Loyola University Chicago Stritch School of Medicine Ellen Gluzman, MD, Temple University Lewis Katz School of Medicine Biana Kotlyar, MD, Rosalind Franklin University of Medicine and Science

Background: The USMLE has announced that sometime after January 1, 2022 Step 1 will move from a threedigit score to pass/fail reporting. This has caused a stir in the medical education community and a call to use this as an opportunity to develop better ways for residency program directors (PDs) to holistically review student applicants. As clerkship directors (CDs), we serve a unique role in providing PDs with descriptions of student performance. Some CDs have focused on increasing the breadth of multiple small-stakes assessments to demonstrate student competency in standardized encounters. Other CDs have focused on facultydevelopment to improve reliable clinical evaluation and descriptive narrative feedback in workplace-based assessment. Other CDs have coached students themselves to put forth their best application packet possible.

Objectives: At the end of this discussion group, participants will be able to:

- 1. Identify literature on opportunities and challenges as Step 1 moves to Pass/Fail
- 2. Describe ways to improve the quality and reliability of clinical evaluations
- 3. Describe the potential role for multiple small stakes assessment in clerkship evaluation
- 4. Enhance coaching of students for application to psychiatry residency

Methods: In this discussion group, faculty from five different schools will discuss methods that may enhance the quality of information clerkship directors can deliver to program directors to enhance the evaluation for fit for a residency program. The discussants are members of the ADMSEP MSPE Task Force Gap Analysis workgroup.

Format: Speaker 1- 15 minutes: Dr. West will review what has been done in the literature and at USUHS to improve the quality and reliability of clinical evaluation. Speaker 2-15 minutes: Dr. Schilling will discuss the potential merits of multiple small-stakes assessment in the psychiatry clerkship, and potential ways that information may be useful to program directors in evaluating applicants. Speaker 3-15 minutes: Dr. Guzman will present resources for coaching students to communicate an useful and accurate application, including improving the personal statement to help PDs understand he applicant. All Discussants (lead by Drs. Kotlyar & Schatte) 30 minutes: the group will discuss the methods and potential bias presented, as well as suggestions from the attendees. We will brainstorm what might be the most efficient and descriptive methods for clerkship directors to assist the program directors in identifying applicants who are the best fit for their program.

Concurrent Session 4 • Workshop 12:45 P.M., Friday, June 18, 2021

Less Work and More (Role) Play: How (and Why) to Develop Successful Role-Play Exercises

Thomas Mitchell, MD, Yale University Matthew Goldenberg, MD, Yale University Kirsten Wilkins, MD, Yale School of Medicine

Background: Communication skills are increasingly viewed as important in medicine and have become a more explicit part of medical school curricula. Yet, these skills are difficult to acquire through passive learning, instead requiring more active and experiential practice, which allows for deeper processing and mastery. Interacting with standardized patients (SP) to teach clinical skills is a well-established method, but SP programs can be logistically and financially challenging to implement. Alternatively, role-plays in which learners assume the roles of both physician and patient can be a flexible and accessible way to incorporate active skills into a curriculum. However, role-play scenarios are often met with resistance from students, in part because of prior negative experience with poorly conceptualized scenarios. Additionally, there are novel challenges when facilitating interactive role-play exercises through virtual platforms.

Objectives: At the end of this discussion group, participants will be able to:

- 1. Understand the educational theory supporting the use of role-play exercises
- 2. Discuss the benefits and challenges of role-play exercises in medical education
- 3. Discuss challenges and solutions when facilitating role-play exercises through virtual platforms
- 4. List the key components necessary for a successful role-play activity
- 5. Describe a unique role-play scenario for use in the psychiatry curriculum at their institutions

Methods: Presenters will engage participants in an introductory discussion of prior experience with role-play exercises (including negative ones) before providing a brief overview of the educational theory that supports the use of role-play in medical education. Then, the group will discuss the benefits and challenges of using role-play exercises with students, including a solution-focused discussion of facilitating role-plays through virtual platforms. Through an interactive process, we will develop a "best practice" checklist for creating an effective role-play exercise. Throughout this process, presenters will also share experiences from our recently published curriculum that relied heavily on role-play exercises. Participants will then break into small groups to develop their own unique role-play scenarios using techniques learned that would be ready for use in the psychiatry curriculum at their institutions. Finally, highlights from these scenarios will be shared with the whole group.

Format: Introduction (discussing prior experience and an overview of educational theory): 10 mins Group discussion (benefits/challenges of role play, including virtual facilitation): 15 mins Small group exercise #1 (developing a "best practice" checklist): 10 mins Large group debrief (consolidation of "best practice" checklist): 5-10 mins Small group exercise #2 (developing unique role-play scenarios): 20-25 mins Large group debrief (presentation of scenarios; wrap-up): 10 mins

References:

Mitchell TO, Goldenberg MN. When Doctor Means Teacher: An Interactive Workshop on Patient-Centered Education. MedEdPortal. [In Press].

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Concurrent Session 4 • Discussion Panel 12:45 P.M., Friday, June 18, 2021

Negotiation for Educators: Tools for Success from Clerkship to Career

Howard Liu, MD, MBA, University of Nebraska Medical Center Nutan Vaidya, MD, Rosalind Franklin University of Medicine and Sciences Linda Love, EdD, University of Nebraska Medical Center

Background: Negotiation is a critical skill in every phase of an academic career. Despite the importance of maximizing resources in times of scarcity, many faculty are undertrained in the skills needed to succeed in negotiation (Sarfaty 2007). This is especially true for women physicians, where compensation studies have documented an ongoing disparity in pay for equal work. Salary studies over 2 decades indicate a persistent gender gap in salaries. Female doctors earn 27% to 36% less than their male colleagues, and this gap may be widening (Choo 2019, Asgari 2019). It is important to recognize that negotiation is not confined to salary and funding alone (Khashab 2012). For medical educators, it can include support for travel to key academic conferences, allocation of support staff, access to mentors, and protected time for scholarship. These factors play a huge role in an educator's resilience and ability to thrive in academia.

Objectives: At the end of this discussion group, participants will be able to:

1. Recognize common vocabulary in a negotiation such as BATNA, reservation point and aspiration point

2. Recall practical steps to prepare for a negotiation

3. Apply negotiation principles to a case study or a current negotiation dilemma facing educators in the early, mid or late career

Methods: This workshop will leverage the experience of 3 ADMSEP leaders who have negotiated in multiple roles as clerkship director, chair, senior associate dean, assistant vice chancellor, director of faculty development, and state workforce director. The facilitators include a past ADMSEP President, the current ADMSEP President and a current Director of Faculty Development. In part 1, facilitators will first present key principles for success in negotiation. These will include the concept of value-based negotiation, review of key concepts, discussion of common pitfalls to avoid and advice on practical steps to prepare for a negotiation. In part 2, attendees will work in small groups to role play either a fictionalized case study or a real life negotiation dilemma. Facilitators will work with the participants to apply the concepts and principles of part 1 to the case study or current dilemma. In part 3, each small group will share their insights with the large group.

Results: Elements of this workshop have been previously presented at ADMSEP and the American Academy of Child & Adolescent Psychiatry and were well received. This workshop was accepted in 2019 but was not presented due to cancellation of the live ADMSEP meeting.

Discussion:

As ADMSEP continues to attract early career and senior faculty, negotiation is a key competency. There is an extensive body of literature on successful negotiation in the business world, and it is key for medical educators to benefit from these skills as academic health centers are tightening their budgets during COVID. For early career faculty, the initial stage is identifying an initial leadership role and accessing mentorship and sponsorship to nurture growth. For mid-career faculty, the dilemmas are often about maintaining the resources needed for ongoing success while considering new leadership roles. For senior faculty, the negotiation may be about finding a new role in the department or the medical school that enhances career vitality. The principles are equally applicable to program goals. It is critical for clerkship directors and pre-clinical educators to have sufficient support staff and protected time to continuously refine the curriculum.

Continued on the next page

Format:

This workshop can be presented live or virtually using Zoom. 15 minutes: In part 1, facilitators will first present key principles for success in negotiation. These will include the concept of value-based negotiation, review of key concepts in negotiation, discussion of common pitfalls to avoid and advice on practical steps to prepare for a negotiation. If this is presented live, presenters will work from a handout. If this is presented virtually, presenters will utilize slides and a PDF. 50 minutes: In part 2, attendees will work in small groups (or breakout rooms via Zoom) to role play either a fictionalized case study or a real life negotiation dilemma that they currently face. Facilitators will work with the participants to apply the concepts and principles of part 1 to the case study or current dilemma. 10 minutes: In part 3, each small group will share their insights with the large group. They will receive a PDF handout with a summary of key principles.

References:

Sarfaty S et al. Negotiation in Academic Medicine: A Necessary Career Skill. Journal of Women's Health 2007;16(2):235-244. Choo EK, Bangsberg DR.

Equity in Starting Salaries: A Tangible Effort to Achieve Gender Equity in Medicine. Academic Medicine 2019 January; 94(1):10.

Asgari MM, Carr PL, Bates CK. Closing the Gender Wage Gap and Achieving Professional Equity in Medicine. JAMA May 7, 2019;321(17):1665-1666.

Khashab M. The Art of Salary Negotiation in Academic Medicine: Lessons from a 32-year Career. Gastrointestinal Endoscopy 2012;75(4):857-860. Sidhu SA, Jeffrey J. Contract Negotiation for Academic Psychiatrists. Academic Psychiatry 2016;40:835-838.

11:20 AM, Friday, June 18, 2021 • Steeler's Ballroom – Meeting Hub Words Will Never Hurt Me: Improving Implicit Bias in Clerkship Narrative Evaluations

Neeta Shenai, MD, University of Pittsburgh School of Medicine (Presenter)

Neil Munjal, University of Pittsburgh School of Medicine Jody Glance, MD, University of Pittsburgh School of Medicine/WPIC Jason Rosenstock, MD, University of Pittsburgh School of Medicine/WPIC

Background: Narrative language from clerkship evaluations is quoted in the Medical Student Performance Evaluation (MSPE) letter and are an influential component of residency applications. Language carries the potential for bias and can significantly affect recruitment and promotion. Prior studies have shown underrepresented minorities (URM) and women to be more commonly described by their personal attributes rather than competency-based language (Low et al, 2019). For example, women were more likely to be described as "compassionate" or "sensitive" than their male counterparts. (Rojek et al, 2019). We aim to improve the language in the narrative component at our institution to more competency based through a brief training to faculty.

Objectives:

1) Use a natural language processing approach to identify and quantify the use of biased language in evaluations of different student cohorts. 2) Demonstrate the feasibility of measuring change in the use of biased language through a brief faculty training session.

Methods: Faculty who serve in our clerkship sites will be offered a brief training on utilizing more competency-based language. Of the faculty that attend the training, pre- and post- training narrative evaluations will be analyzed from academic years 2018 to 2021. Using vector-based word representation techniques of natural language processing we will generate quantifiable word and document vectors demonstrating various aspects of bias for each evaluation. Controlling for the grade received, we will independently evaluate the difference in bias between groups using the two variables of URM status and gender. Categorical measures will be evaluated using the Pearson's chi-squared test and ordinal variables using the Mann-Whitney-Wilcoxon test. This process will also generate a list of frequently used biased descriptors. A report will be provided to faculty outlining specific personal attributes descriptors versus competency-based language used in their evaluations.

Results: Fifteen faculty are primarily involved in providing evaluations for the psychiatry clerkship. By the time of the presentation, anonymous data of the faculty report described above will be presented.

Discussion: Disparities in clerkship grades in URM and women have been well described. Training of faculty and residents to standardize narrative comments in clerkship evaluations to a competency-based framework is essential in reducing implicit bias. Using a natural language processing pipeline to demonstrate and quantify bias in free-form evaluations is feasible.

References:

Daniel Low, Samantha W. Pollack, Zachary C. Liao, Ramoncita Maestas, Larry E. Kirven, Anne M. Eacker & Leo S. Morales (2019) Racial/Ethnic Disparities in Clinical Grading in Medical School, Teaching and Learning in Medicine, 31:5, 487-496, DOI: 10.1080/10401334.2019.1597724. Rojek, A.E., Khanna, R., Yim, J.W.L. et al. Differences in Narrative Language in Evaluations of Medical Students by Gender and Under-represented Minority Status. J GEN INTERN MED 34, 684–691 (2019). https://doi.org/10.1007/s11606-019-04889-9

Brief Oral Presentation

11:20 AM, Friday, June 18, 2021 • Steeler's Ballroom – Meeting Hub

Psych Sibs: The Development of a Mentorship Program for Fourth-Year Medical Students at UNC Chapel Hill Applying to Psychiatry

Surabhi Kasera, MD, University of North Carolina School of Medicine (Presenter)

Erin Malloy, MD, University of North Carolina School of Medicine

Background: The residency application season is a challenging time for fourth-year medical students. Additionally, recent data have shown that matching into residency programs has become increasingly competitive (1). Mentorship programs in medical schools have been widely studied in several contexts and have shown benefits in NMRP Match results and overall career development (2). These studies primarily show the efficacy of mentorship of students by faculty, however, there is limited data showing the efficacy of mentorship by recent medical school graduates (PGY1 residents). Prior to our initiative, there was no such near-peer mentorship program in the Department of Psychiatry at the University of North Carolina, Chapel Hill to assist fourth year medical students applying to psychiatry.

Objectives: The primary objective of this study is to create an effective mentorship program for fourth-year medical students applying to psychiatry residency programs. By connecting fourth-year medical students with resident mentors, we hope to use a systematic approach to assist students with each stage of the residency application process. The overarching goal is to allow students to better understand their own goals as they relate to careers in psychiatry, and help them achieve these. We hope to compare our results following one year of mentorship by residents to studies that have been completed in other settings that show the efficacy of faculty mentors.

Methods: During our first year of Psych Sibs (2019-2020), nine volunteers from the PGY1 class and five volunteers from the PGY2 class were selected as mentors. Nine fourth-year medical students expressed interest in having a mentor, and therefore each was assigned a PGY1 mentor, while five were also assigned to a PGY2. This year (2020-2021), seven volunteers from the PGY1 class were matched to nine fourth-year medical students. Matches were made based on commonalities in backgrounds and interests within psychiatry. Mentors were given established check-in points to discuss relevant application steps with their mentees. The following check-in points are being utilized: 1) following submission of ERAS application 2) beginning of interview season 3) middle of interview season 4) sending letters of interest and creating a rank list.

Results: We hypothesize that outcome measures will show efficacy of this program. We will utilize surveys and retrospective reviews to test this hypothesis. Surveys will be administered to students from both the 2019-2020 group as well as the 2020-2021 group. Outcome measures will include the following: satisfaction with mentorship assignment (based on subjective similarities between the student and mentor), amount of interaction the mentee had with their mentor, match data (including number of applicants who received their top three choices), and application process data (whether or not the applicant received advice on what programs to apply to, the interview day, post-interview communication, and creating a rank list).

References:

1) Association of American Medical Colleges. Results of the 2017 Medical School Enrollment Survey; Washington, DC; 2018. 2) Farkas AH, Allenbaugh J, Bonifacino E, Turner R, Corbelli JA. Mentorship of US Medical Students: a Systematic Review. J Gen Intern Med. 2019 Nov;34(11):2602-2609.

Laura Cardella, MD, University of Rochester School of Medicine and Dentistry (Presenter)

Wendi Cross, MD, University of Rochester School of Medicine and Dentistry Valerie Lang, MD, University of Rochester School of Medicine and Dentistry Chris Mooney, MD, University of Rochester School of Medicine and Dentistry

Background: The art and science of psychiatric interviewing is a knowledge and skill set that is best learned by practice and feedback. Psychiatry residents are entrusted with extensive teaching duties in medical schools, including providing effective feedback to medical students. Few residents enter postgraduate training with well-developed teaching skills or the understanding of their important role in medical student education.¹ In addition, there are very few studies in the "Residents As Teachers" literature that have used videorecorded encounters to assess acquisition of feedback skills, using objective measures and multisource feedback.²

Objectives: The purpose of this innovative project is to develop and evaluate psychiatric resident's skills providing feedback to medical students on their psychiatric interviewing skills using the novel approach of videorecording, multi-source assessment, and deliberate practice.

Methods: A "Residents As Teachers" program was implemented with second year Psychiatry residents to develop their feedback skills. The resident observed a psychiatric interview performed by a medical student during their psychiatry clerkship. The resident's feedback encounter with the medical student was videorecorded. After the feedback encounter, the resident was sent a private link of the videorecorded feedback encounter and completed a self-assessment. A faculty member viewed the videorecorded feedback, completed an assessment, and then met with the resident to provide in person feedback. In addition, assessments of the feedback encounter were collected from the medical student, which were de-identified and aggregated for each resident. The residents completed this experience at three time points during their second year to promote deliberate practice. Pre and post surveys of resident self-assessment of their skills, confidence and attitudes were gathered.

Results: The average feedback scores from all three sources for the residents improved over time, as determined by a repeated measures ANOVA. The differences between the first and third sessions and the second and third sessions were statistically significant, and showed that the greatest growth occurred between sessions two and three for all measures. 100% of residents also reported on the post-survey that three sessions "just right" for their learning. A large effect size (ES >1) was found pre-post self-report on several aspects of residents' attitudes about teaching (e.g. confidence with giving feedback increased significantly). In addition, residents reported an increase in the opportunities they were provided to learn how to give effective feedback, to practice teaching and giving feedback, and receiving feedback on their teaching and feedback skills. High baseline scores did not change over time for: residents' attitude about the importance of teaching.

Discussion: The results will be presented along with a discussion of the feasibility and potential limitations. One limitation of this innovation the need for audiovisual recording capabilities. However, given the advancement of technology, this limitation is becoming easier to overcome. The other potential limitation is faculty time and effort to organize, review videorecordings, and meet individually with residents to provide feedback. However, given the potential for significant enhancement of feedback skills of residents and thus future faculty, the investment will have a multiplicative long-term impact. While the target of this project was psychiatry resident teaching, there is potential for use in other training or continuing education programs. The methods of the program and assessments used are easily transferable to other training programs, including other non-physician training programs.

References:

1. Louie AK, Beresin EV, Coverdale J, et al. Residents as teachers. Acad Psychiatry. 2013;37(1):1 – 5. 2. Bree KK, Whicker SH, Fromme HB, et al. Residents-as-teachers publications: what can programs learn from the literature when starting a new or refining an established curriculum? J Grad Med Educ. 2014: 237-248. 3. Halman S, Dudek N, Wood T, et al. Direct observation of clinical skills feedback scale: development and validity evidence, Teaching and Learning in Medicine. 2016: 28:4, 385-394.

Brief Oral Presentation 11:20 AM, Friday, June 18, 2021 • Steeler's Ballroom – Meeting Hub Mental Health First Aid Training for All First Year Medical Students: Baseline Knowledge, Attitudes,

Anita Ukani, Wayne State University School of Medicine (Presenter)

Tiffani Strickland, MD, Sutter Medical Center of Santa Rosa Margit Chadwell, MD, Wayne State University School of Medicine Eva Waineo, MD, Wayne State University School of Medicine

and Training Impact

Background: Studies show medical students have a higher prevalence of anxiety and depression than age-matched peers and up to 11% admit to suicidal thoughts in the past year (1). Students unfortunately experience obstacles to seeking treatment. Recent studies have shown the importance of peer engagement to address mental health and support those experiencing distress (2). Mental Health First Aid Training (MHFAT) is an established course which teaches participants how to recognize and respond to a mental health crisis. Although one study demonstrates improvement in confidence and knowledge in UK students, little is known about impact of MHFAT on US medical students. Following favorable pilot group results accepted for ADMSEP 2020 and presented at AAMC Learn Lead Serve Virtual 2020, this study aims to evaluate the longitudinal impact of MHFAT upon a large cohort of first-year medical students, and its potential to aid wider efforts to improve peer support and mental health resources.

Objectives: 1. Understand components of MHFAT and its utility as a resource to guide student response to a mental health crisis 2. Evaluate the effect of MHFAT on student knowledge, confidence, and attitudes towards mental health crises 3. Assess potential for MHFAT to promote wellness and improve student health outcomes by enhancing peer support

Methods: MHFAT was administered over zoom to the entire class of first-year medical students as part of orientation curriculum at Wayne State University School of Medicine (WSUSOM). Surveys were anonymously administered to participants (n=290) before training (94% response rate) and immediately after training (71% response rate). Surveys assessed students' attitudes, confidence, and knowledge about mental health problems and ways to intervene. Respondents indicated their level of agreement with statements assessing each attribute (knowledge, confidence, or attitudes) on a 5-point Likert scale, with higher scores reflecting more positive outcomes. A combined mean percentage score for each attribute was calculated, and compared before and after training. We plan to survey students again 6 months after training (February 2020) to assess further impact of the training, including if students intervened in a mental health crisis and if they believed the training received proved helpful.

Results: When surveyed immediately following the training, participants reported an increase in mean percentage of self-reported confidence levels (51% before training, 85% after), and knowledge regarding mental health problems (46% before training, 77% after). A majority of students (78%) reported positive attitudes towards mental health crises at baseline, which further increased to 83% following training. Further, 81.95-94.14% of participants felt comfortable helping someone in a mental health crisis following training, compared to only 28.12-76.65% prior to the training. The range denotes comfort level across multiple crises, including substance use, psychosis, and suicidal thoughts. Almost 95% of students believed they will use the skills they learned in the future with a peer/friend or patient.

Discussion: This study demonstrated an increase in student knowledge, attitudes, and confidence in responding to a mental health crisis immediately following MHFAT. Following training, students felt more comfortable assisting in a variety of mental health crises common amongst their age group. Considering most medical students who experience mental health symptoms during training turn to a peer/colleague for support, empowering the student body to recognize and offer support to peers in distress may improve student health and wellbeing. Six-month follow up data will provide further insight into whether improvements were sustained and translated into informed interactions with both patients and peers.

References:

1) Dyrbye LN, Thomas MR, & Shanafelt TD. Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. Acad Med. 2006;81(4):354-373. 2)Moutier, C. Physician mental health: an evidence-based approach to change. J Med Regulation. 2018;104(2):7-13. 3)Davies EB, Beever, E, & Glazebrook C. A pilot randomized controlled study of the mental health first aid eLearning course with UK medical students. BMC Medical Education. 2018; 18:45.

Psychological First Aid in the psychiatry clerkship: Medical students supporting patients during COVID-19 lockdown

Timothy Kreider, MD, PhD, Zucker School of Medicine at Hofstra, Northwell (Presenter)

Xingyu Wei, BS, Zucker School of Medicine at Hofstra, Northwell Sarah Marks, MD, Zucker School of Medicine at Hofstra, Northwell John Young, MD, MPP, PhD, Zucker School of Medicine at Hofstra, Northwell

Background: Large-scale public health crises such as the ongoing coronavirus pandemic create significant disruption and unique challenges for the health care system and medical education, particularly for early learners (1). The potential roles for medical students during these challenging times are often overlooked, yet medical students can serve real and meaningful roles during a crisis (2-4), and with proper training and support can be a valuable resource to patient care (5-6). Historically, medical students have contributed in a variety of ways to emergency response efforts, such as during the influenza of 1918 (7), the September 11, 2001 terrorist attack (2), and 2010 natural disasters in Haiti (4) and Chile (6). In addition to documenting these important contributions from medical students, the literature also highlights the barriers to meaningful engagement. A key theme is the need for proper training, supervision, and support for the medical students on the front lines.

Objectives: In April-May 2020, the Zucker School of Medicine at Hofstra/Northwell, like other medical schools in the New York City area, suspended clerkships due to COVID-19 and moved all classroom learning to online platforms. Medical students were therefore removed from clinical care just when vulnerable patients were facing a public health crisis. We designed an elective experience to leverage the energy and skills of medical student volunteers, training and supervising them to provide support to vulnerable psychiatry outpatients in a clinic undergoing rapid transformation to virtual care. Methods: In April, we trained 3rd-year students in Psychological First Aid (PFA) and Skills for Psychological Recovery (SPR) using available online courses, and the students developed a telephonic intervention for psychiatry outpatients. We embedded each student in an ambulatory psychiatry treatment team providing telehealth. The students performed support calls to patients identified as high-risk, using the PFA intervention to assess and address COVID-related stress and other needs. Students had weekly group and individual supervision. These calls were a novel outreach provided on top of treatment-as-usual, during April-May. When the psychiatry clerkship resumed in June 2020, the intervention was adapted for use by clerkship students. The second cohort focused on SPR, as the impact of COVID-19 had moved out of the acute phase. The clerkship students were prepared and supported by the online module, an interactive didactic, and weekly group supervision.

Results: During the April-May elective, outreach was made to 414 patients by 9 students, and 139 patients received the full intervention. In June-July during the 6-week clerkship, 16 students completed 94 calls with 74 patients. Patient satisfaction with the calls, as expressed both to the students and in follow-up surveys, was high. The most frequently cited benefit of the intervention, beyond COVID information or specific PFA skills, was that the supportive call interrupted the isolation of quarantine. Participating student volunteers expressed high satisfaction with the project, describing it in focus groups as a way to make a meaningful difference for patients during a crisis that affects them all. Students described it as valuable for their professional development, regardless of future specialty (only half are applying in psychiatry). Finally, clinic administration and staff were very enthusiastic for the support, during a time of rapid change and uncertainty in the clinic.

Discussion: Medical students can be safely supervised to provide effective support to vulnerable patients during a public health crisis, using an evidence-informed model of disaster intervention (PFA and SPR) that has available online learning modules. Such work can be helpful to patients, valuable for the clinic, and meaningful for the students.

References:

1. Lim EC, et al. The challenges of "continuing medical education" in a pandemic era. Annals of the Academy of Medicine, Singapore. 2009;38(8):724. 2. Cushman JG, et al.. Two New York City hospitals' surgical response to the September 11, 2001, terrorist attack in New York City. The Journal of trauma. 2003;54(1):147. 3. Katz CL, et al. The medical student experience with disasters and disaster response. CNS spectrums. 2002;7(8):604. 4. Avashia YJ, Thaller SR. Postearthquake plastic surgery mission trip to Port-au-Prince, Haiti: a medical student's perspective. The Journal of craniofacial surgery. 2011;22(5):1549. 5. Chen E, et al. Involving Medical Student in Disaster Response: Ethics, Education and Opportunity. 2014. 6. Starr I. Influenza in 1918: recollections of the epidemic in Philadelphia. Annals of internal medicine. 1976;85(4):516. 7. Reyes H. Students' response to disaster: a lesson for health care professional schools. Annals of internal medicine. 2010;153(10):658.

Brief Oral Presentation 11:20 AM, Friday, June 18, 2021 • Steeler's Ballroom – Meeting Hub Evaluating the Efficacy of In-Person versus Online Training in Opioid Overdose Prevention and **Response Training**

Tabitha Moses, MD, PhD, Wayne State University School of Medicine (Presenter)

Jessica Moreno, Beaumont Health Mark Greenwalkd, Wayne State University School of Medicine Eva Waineo, MD, Wayne State University School of Medicine

Background: Over the past decade there has been a shift in medical education as more institutions are minimizing large lecture classes in favor of smaller group sessions. One result of this shift has been an increase in online education to replace larger lectures. Although there has been significant research into the efficacy of online education [1] there is minimal research on how traditionally smaller group classes and trainings can translate to this virtual format. These questions became even more pertinent with the Covid-19 pandemic and the need to reduce in-person education when possible. There is also a need to optimize online formats for these small-group classes and trainings. Given the interactive nature often necessitated by small group sessions, the efficacy of online formats is uncertain. In this study we aim to compare the efficacy of a synchronous online versus in-person Opioid Overdose Prevention and Response Training (OOPRT).

Objectives: The goal of this study was to examine the efficacy of OOPRT conducted via a synchronous online platform (Zoom) versus in-person training. Students in the Wayne State University School of Medicine (WSU SOM) Class of 2023 received the training in person during their first unit of medical school and students in the Class of 2024 received the training via Zoom during their first unit of medical school. Both trainings were 1hr and used the same curriculum delivered by the same trainer (JLM). We compared 3 primary outcomes between the two groups: 1) Effect of training on knowledge of and attitudes towards opioid overdose response, 2) Effect of training on attitudes towards patients with substance use disorders (SUDS) and harm reduction, and 3) Student engagement and opinions of the training itself.

Methods: This study evaluated effects of OOPRT in 2 cohorts of first-year medical students. In cohort 1 (Class of 2023), 50% of students (n=146) were assigned to receive OOPRT during year 1 (Sept. 2019) in a classroom setting in groups of 30-40 students. In cohort 2 (Class of 2024) all students (n=295) were assigned to receive OOPRT during year 1 (Sept. 2020) via Zoom in two groups (~150 per group). Students in both cohorts completed surveys at medical school entry and immediately post-training. The surveys evaluated student knowledge and experiences with SUDs using the Opioid Overdose Knowledge Scale (OOKS), Opioid Overdose Attitudes Scale (OOAS), Medical Conditions Regard Scale for SUDs (MCRS), and Naloxone Related Risk Compensation Beliefs (NaRRC-B) [2-5]. Independent t-tests explored differences between cohorts. RM ANOVA with cohort as the covariate was used to identify changes in response to training and the impact of training type on outcome measures.

Results: Of 430 students, 362 (84.2%) completed baseline and post-training surveys: 124 (34.3%) in cohort 1 and 238 (65.7%) in cohort 2; there were no demographic differences. RM ANOVA showed improved opioid overdose knowledge in all 4 OOKS subscales after training. Training improved self-rated competency, F(1,360)=1590.07, p<0.001, and readiness to intervene in an overdose, F(1,360)=15.50; p<0.001; and reduced concerns about managing overdose, F(1,360)=246.37, p<0.001. Attitudes toward patients with SUDs (total MCRS score), F(1,360)=22.55, p<0.001, and attitudes toward naloxone use and distribution (agreement with NaRRC-B statements) improved post-training. Only one outcome differed by training type: knowledge of opioid overdose signs, F(1,360)=12.83, p<0.001; cohort 1 improved more after training (6.15±1.71 to 8.67±0.95) than cohort 2 (6.34±1.67 to 8.13±1.48). Cohorts did not differ in opinions of training; 97.2% (n=352) enjoyed it and 99.4% (n=360) believed future classes should receive it.

Discussion: Medical students' attitudes and knowledge significantly improved after OOPRT. All 13 outcomes (overdose knowledge and attitudes, and attitudes towards patients with SUDs and naloxone use) improved after training; only one (knowledge of opioid overdose signs) showed a cohort difference. As each training was practically identical and provided by the same faculty member, this suggests a possible unique impact of the in-person learning format. There were no differences in enjoyment, indicating that if necessary, switching to virtual learning does not undermine the learning experience. Almost all students enjoyed training and believed future classes should receive it, thus virtual OOPRT may be useful in settings without a qualified trainer. Further studies are needed to explore if these results apply to other medical school classes where small group interactive discussion is preferred, to see if efficacy is equivalent when implemented online versus in-person.

References: 1. Tang B, Coret A, Qureshi A, Barron H, Ayala AP, Law M. Online Lectures in Undergraduate Medical Education: Scoping Review. JMIR Med Educ. 2018;4(1):e11. 2. Williams A V., Strang J, Marsden J. Development of Opioid Overdose Knowledge (OOKS) and Attitudes (OOAS) Scales for take-home naloxone training evaluation. Drug Alcohol Depend. 2013;132(1-2):383-386. 3. Berland N, Lugassy D, Fox A, et al. Use of online opioid overdose prevention training for first-year medical students: A comparative analysis of online versus in-person training. Subst Abus. 2019;0(0):1-7. 4. Winograd RP, Werner KB, Green L, Phillips S, Armbruster J, Paul R. Concerns that an opioid antidote could "make things worse": Profiles of risk compensation beliefs using the Naloxone-Related Risk Compensation Beliefs (NaRRC-B) scale. Subst Abus. 2020;41(2):245-251. 5. Christison GW, Haviland MG, Riggs ML. The Medical Condition Regard Scale: Measuring Reactions to Diagnoses. Acad Med. 2002;77(3).

1. Psychotropic Informed Consent: A Cross-specialty, Role-playing Skill Builder

Emily Diana, Uniformed Services University of the Health Sciences (Presenter) Kelly Cozza, MD, Uniformed Services University of the Health Sciences Derrick Hamaoka, MD, Uniformed Services University of the Health Sciences Matthew Goldenberg, MD, Yale University

Background: Informed consent (IC) is a fundamental practice for all physicians, regardless of specialty. According to the AAMC's core entrustable professional activity (EPA) 11, medical students should have developed IC skills prior to graduation, though many residents report learning this skill by observation while in residency. Objectives: By the end of this presentation, learners will be able to: 1. Illustrate the importance of utilizing an informed consent curriculum for medical student education 2. Discuss the academic and clinical impacts of an informed consent curriculum during clerkship rotations 3. Examine potential adaptations of an informed consent curriculum to be modified for different specialties or for pre- and post-clerkship students

Methods: USU Psychiatry clerkship students were given vignettes of patients needing psychotropic medication and asked to participate in weekly IC role-playing exercises. Survey results were obtained regarding utilization of the role-playing exercise. NBME scores were compared between academic years without an IC curriculum, with the first edition IC curriculum, and with an enhanced IC curriculum.

Results: Students overall felt the IC exercise improved comfort in providing IC on psychiatry and other services. The first cohort of students receiving the enhanced IC curriculum had a significantly higher pass rate for the NBME exam in comparison to those with no or first edition IC curriculum.

Discussion: Students engaged in IC role-playing exercises improve in academic performance and clinical shared decision-making abilities. This curriculum increases familiarity of high yield psychotropic drugs and may be adapted to teach medications and procedures for other specialties. In the future, this skill building exercise may include longitudinal assessment of students or residents over time to track proficiency in obtaining IC. References:

1. Paterick TJ, Carson GV, Allen MC, Paterick TE: Medical informed consent: general considerations for physicians. Mayo Clin Proc. 2008 Mar;83(3):313-9. doi: 10.4065/83.3.313. 2. Obeso V, Biehler JL, Jokela JA, Terhune K. Core Entrustable Professional Activities for Entering Residency—EPA 11 Schematic: Obtain Informed Consent for Tests and/or Procedures. Obeso V, Brown D, Phillipi C, eds. Washington, DC: Association of American Medical Colleges; 2017. 3. Nickels AS, Tilburt JC, Ross LF. Pediatric resident preparedness and educational experiences with informed consent. Acad Pediatr. 2016;16(3):298-304.

2. Building an ambulatory psychiatry clerkship: Barriers and opportunities learned from a pilot

Timothy Kreider, MD, Zucker School of Medicine at Hofstra/Northwell Anna Costakis, MD, Zucker School of Medicine at Hofstra/Northwell Fatima Nagaya, MD, Zucker School of Medicine at Hofstra/Northwell John Young, MD, Zucker School of Medicine at Hofstra/Northwell

Background: Psychiatry clerkships have historically been located in acute care settings, which are poorly representative of the experiences of most psychiatrists and psychiatric patients. Potential benefits of increasing student exposure to ambulatory psychiatry include improved recruitment to psychiatry and reduced stigma of our patients. Additionally, faculty and residents working in ambulatory settings may welcome more opportunities to teach. To capture such benefits, a number of clerkship innovations have included the ambulatory space, such as longitudinal integrated clerkships (1); less dramatic changes include adding a weekly ambulatory experience to a more traditional psychiatry clerkship structure (2). Our school has a 6-week psychiatry clerkship with two clinical rotations (4 weeks, 2 weeks) in acute and C/L settings. Ambulatory exposure has been limited to didactic and observational experiences. We aimed to develop and pilot a 4-week, immersive "ambulatory track" for the clerkship.

Objectives: The objectives of the pilot project were to design an ambulatory track (AT) for the psychiatry clerkship that addressed the following goals: Meet the same learning objectives as a placement on a general adult inpatient unit, including: Variety of psychopathology, Continuity of care, Active participation in care (i.e., not primarily "shadowing"). Involve senior residents (PGY3 and PGY4), who typically do not participate in the clerkship due to their ambulatory focus, as near-peer educators and supervisors Minimize demands on outpatient faculty, who do not have the same experience integrating clerkship students into their workflow as do inpatient faculty and who also face significant productivity pressures After the pilot the next steps were to refine the AT, further develop ambulatory faculty and senior residents as educators, and offer the AT to more students each cycle. The long-term goal is to make the ambulatory setting a significant part of our UME.

Methods: We chose a walk-in intake clinic within the outpatient department to be the core experience for the

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4-week AT. This clinic was chosen due to broad patient diversity, high likelihood for patient follow-up, and the availability of an enthusiastic faculty champion who committed to direct observation, feedback, and evaluation of the student as primary preceptor. In light of the intake clinic's focus on assessment, stabilization, and referral as well as service demands, we identified other teams within the outpatient department to also include in the AT. The result was a student schedule that varied in location and direct supervisor from day-to-day. The student was paired with a PGY4 resident, who directly supervised care and also facilitated coordination among the faculty and non-physician staff in the AT. Outcome measures were our routine clerkship indicators of meeting requirements (e.g., patient logs) as well as a daily tally of educational activities we created to assess the AT.

Results: According to routine clerkship forms – logging patient encounters by diagnosis, attesting to midclerkship feedback, and documenting direct observation of patient care by supervisors – the AT student met all minimum educational objectives. The AT student and 3 peers on traditional placements each completed a daily tally over the 4 weeks of patient encounters, supervised exams, oral presentations, bedside teaching, and other educational activities; there was variance between AT and other settings. Debrief interviews with the student, residents, and faculty identified areas of the AT to keep, remove, or modify in the next iteration; in particular, the number of areas within the outpatient department was reduced, and the value of the senior resident supervisor was found to be significant.

Discussion: The AT pilot underscored that success in this setting depends heavily on faculty enthusiasm and bandwidth, so scaling up will require faculty development and support. The similar value of the senior resident who was assigned to oversee the student, and the positive experience for this resident as a developing medical educator, suggests that senior residents can usefully be tapped to facilitate the inclusion of students in the clinic. This finding suggests an educational win-win opportunity for UME and GME as psychiatry clerkships move into the ambulatory setting: pair students not only with faculty preceptors but also with senior residents, thereby reducing burden on outpatient faculty and enhance the resident-as-teacher experience for senior residents. References:

1. Griswold et al. Psychiatry in the Harvard Medical School-Cambridge Integrated Clerkship: An innovative, yearlong program. Academic Psychiatry 2012; 36:380-387. 2. Gay et al. Enhanced ambulatory experience for the clerkship: Curriculum innovation at the University of Michigan. Academic Psychiatry 2002; 26:90-95.

3. A new model of The Longitudinal Integrated Clerkship (LIC) in Psychiatry: Kaiser Permanente Bernard J. Tyson School of Medicine (KPSOM)

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Background: Most Psychiatry clerkships take place in traditional block rotations within the third year of medical school. Students generally have limited continuity of with preceptors and patients. (LIC) is a model of clinical training increasingly utilized by medical schools across the United States and the world.1,2 Learning sciences, including spaced learning and interleaving, suggest that early and repeated clinical exposure may improve long-term retention of medical knowledge.3 Continuity over 6-12 months with preceptors and patients may lead to many benefits, including improved patient-centered attitudes in learners and improved clinical communication skills.4,5 Most LICs do include Psychiatry, but it usually takes place in an all-clinical year, primarily in the third year of medical school. KPSOM aims to reconstruct the psychiatry clerkship experience and expose students early and broadly to psychiatry experiences in a unique, integrated care delivery system.

Objectives: 1. To launch a medical school with the entire class pursuing their clinical clerkships in an LIC format in Years 1 and 2. Students will learn fundamentals of psychiatry as early as their first year in primary care setting. 2. To create a robust LIC Psychiatry clerkship in a team-based, integrated delivery system, concurrent with classroom-based teaching that will expose students to psychiatry in a collaborative, team-based model. Methods: KPSOM is a new medical school, founded in 2020, in Pasadena, California, embedded within the integrated care delivery system of KP. A unique feature of KPSOM that all our 50 students will complete their LIC into the first two years of medical school. In year 1, they will begin the first year of their Family Medicine/Internal Medicine Clerkship (FM/IM), paired with one preceptor for weekly half-day sessions. Psychiatric curriculum taught in the Mind and Nervous System Course via case-based clinical presentations is reinforced by learning activities in the FM/IM clerkship. Year 2 extends FM/IM and adds clerkships in ER, OBGYN, Pediatrics, Psychiatry, and Surgery, concurrent with a 35 week small group based clinical presentation curriculum. In Year2, students will have 40 half-day sessions in Psychiatry, including approximately 20 sessions with their preceptor in the outpatient setting. Students may select to follow a patient through multiple encounters in the KP psychiatry department. Results: Students have embarked on Year 1 of their FM/IM LIC and second year planning is well underway. The clerkship will be Honors/Pass/ Fail. The clerkship assessment system will include brief clinical observations, quarterly written and verbal RIME (Reporter, Interpreter, Manager, Educator) assessments, systems-based practice

and health systems science assessments, and observations by expert clinical assessors. Additionally, students in KPSOM will take the National Board of Medical Examiners (NBME) Comprehensive Clinical Science Examination (CCSE) twice in the second year of medical school. KPSOM is also using progress Observed Structured Clinical Examinations (OSCEs) and data will be available regarding progress in psychiatry content over the four years of school. Additionally, we will track NBME board scores, Honors grades in the psychiatry clerkship, interest in psychiatry as a career, and match data. Student satisfaction and preceptor satisfaction scores will be obtained. Discussion: In summary, KPSOM is the first school to embed all students in an LIC experience in the first two years of medical school. Students will be have early instruction in Psychiatry that is connected to clinical practice from day one. With this close connectivity between classroom and practice, our hope is that students will recognize the relationship between mental and physical health and consider psychiatric care part of comprehensive and preventative care delivery. Furthermore, as part of an integrated delivery system, students will participate in addressing care gaps and screening for patients with chronic mental illness, opportunities that often go unrecognized in other models of care. Capitalizing on the EHR-enabled communication across settings and providers, and through varied experiences, including inpatient and outpatient care, addiction medicine, consultliaison and telehealth, students will experience a unique, longitudinal, integrated practice of psychiatry **References:**

1. Mazotti, L., (2018). Diffusion of innovation and longitudinal integrated clerkships: Results of the clerkship directors in internal medicine annual survey. Medical Teacher, 2. Worley, P., Couper, I., Strasser, R., Graves, L., Cummings, B. A., Woodman, R., Stagg, P., Hirsh, D., & Consortium of Longitudinal Integrated Clerkships (CLIC) Research Collaborative (2016). A typology of longitudinal integrated clerkships. Medical education, 50(9), 922–932. 3. Taylor K, Rohrer D. The effects of interleaved practice. Appl Cognit Psychol 2010 Sept; 24(6):837-848. 4. Poncelet A, Hirsh D, editors. Longitudinal integrated clerkships: principles, outcomes, practical tools and future directions. Alliance for clinical education. New York: Gegensatz Press North Syracuse; 2016. 5. Griswold, T.,Psychiatry in the Harvard Medical School—Cambridge Integrated Clerkship: An Innovative, Year-Long Program. Acad Psychiatry 36, 380–387 (2012).

4. Adapting the standard psychiatric interview to a geriatric population

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Background: The population of the United States is aging, with the percentage of people over the age of 65 expanding rapidly. The most recent estimate from 2019 data is that 16.3% of the US population is over 65 (2). In parallel, the number of persons with dementia is increasing, expected to increase to 13.8 million by 2050 (1). A psychiatry clerkship is part of standard medical school curricula in the United States. Despite population trends, psychiatry clerkships provide limited exposure to geriatric psychiatry and common disorders in the elderly, such as dementia. Examples of elements of a geriatric psychiatry assessment that may be overlooked without specialized training include, but are not limited to, structured evaluation of cognitive domains, utilization of collateral informants, a focused physical exam and a more intensive review of medical history and data.

Objectives: Our objective was to compare the typical psychiatric intake interview with that used by experienced geriatric psychiatrists, and then use our observations to create an educational tool for medical students to use when performing a psychiatric interview with an older adult.

Methods: We reviewed the elements of a typical psychiatric interview used in adult patients and contrasted this with the content of psychiatric evaluations performed by experienced geriatric psychiatrists. We then used this information to develop an interview guide, targeted at students, which incorporates elements unique to geriatric assessments and emphasizes age specific manifestations of psychiatric disorders and symptoms.

Results: Several areas of the initial psychiatric assessment were identified as requiring adaptation to the unique concerns pertinent to the evaluation of older adults. This includes: 1) Role clarification and identification and interview of collateral informants. 2) Screening for common psychiatric disorders, tailored to recognize those that present differently at later life stages. 3) Gathering additional social history elements, especially social support and living situation, which has extra importance in the context of medical co-morbidity and disability. 4) Routine assessment of IADLs and ADLs. 5) Review of medical history with a detailed focus on current medications due to risk of adverse events and polypharmacy. 6) Focused neurologic exam to distinguish dementia subtypes and medical etiologies of psychiatric syndromes. 7) A detailed summary with the patient and family member to review the results of the examination and outline next steps.

Discussion: Use of a clinical interview guide will allow medical students to perform a thorough geriatric psychiatry assessment. This promotes awareness of mental health concerns common to elders as well as identifying

targets for biopsychosocial interventions. Also, a guide adapted to this population will facilitate consideration of behavioral and psychological phenomena as signs and symptoms of medical diseases as well as somatic presentations of mental illness. The initial psychiatric evaluation of geriatric patients hones skills that are integral to psychiatry specifically and geriatric medicine generally. References:

1. Alzheimer's Association. 2020 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2020;16(3):391+. 2. United States Census Bureau, (2020, April 29). Age and Sex Composition in the United States: 2019. Retrieved October 15, 2020, from https://www.census.gov/data/tables/2019/demo/age-and-sex/2019-age-sexcomposition.html

5. Two Approaches to Teaching Cultural Intersectionality & AntiRacism as it pertains to Race in The Psychiatry Clerkship

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Background: Amidst the national civil rights movement galvanized by the killings of Breonna Taylor, George Floyd, and Ahmaud Arbery, there is growing awareness of the need for enhanced teaching on racism, antiracism, and cultural intersectionality and humility within medical education. Educators at UTMB and UTSW developed two different approaches for teaching antiracism and cultural intersectionality, with the shared goal of creating a culture shift that would inspire trainees, faculty, and staff towards advocating for those facing healthcare disparities. By recognizing racism's influence on the personhood of others, we aimed to instill an approach to medical education and lifelong learning that is more inclusive and oriented toward moral action. Through recurring workshops at both institutions, attendees were encouraged to deepen their self-awareness and empathy skills.

Objectives: Objectives included reflection on one's own personal biases, being able to identify and understand the impact of microaggressions, and identifying discrimination as a social determinant of health.

Methods: UTMB psychiatry/neurology clerkship students completed a self-paced reading with an overview of cultural humility and then selected an additional reading from an unfamiliar culture from a provided list. They then participated in a 2-hour discussion utilizing vignettes led by faculty/residents. Those on non-psychiatry rotations completed the same reading/vignettes that incorporated more reflection questions in the absence of discussion. UTSW psychiatry clerkship students and faculty/staff/residents participated in a 2.5-hour workshop where they learned about mental health disparities, the global history of racism, and microaggressions focused on the experiences of Black/African Americans. The workshop included an interactive portion to better understand the experiences of vulnerable populations, reflections, and additional resources. Each school utilized a post-survey with a question about strengths/weaknesses of the activity, which was used to compare/contrast the two approaches.

Results: Data collection is underway; results will be available at the time of poster publication.

Discussion: We hypothesize that attendees will have more knowledge of the impact of discrimination on mental health, identifying and addressing microaggressions, and cultural humility. We hypothesize that attendees will also feel more confident implementing and utilizing skills from the workshop towards advocacy. References:

UTMB Workshop Lim, R. F. (2015). Clinical Manual of Cultural Psychiatry. American Psychiatric Publishing. UTSW Workshop Hays, Pamela A. Addressing Cultural Complexities in Practice, Second Edition: Assessment, Diagnosis, and Therapy. American Psychological Association Overview (2008) Sue DW, Capodilupo CM, Torino, GC, Bucceri JM, Holder AMB, Nadal, KL, Esquilin, M. Racial Microaggression in Everyday Life. American Psychologist (2007) Kendi, Ibram X. Stamped from The Beginning (2016) Metzl, Jonathan. The Protest Psychosis (2009) The New York Times Magazine. 1619 Project and Podcast (2019) (https://www.nytimes.com/2020/01/23/podcasts/1619-podcast. html) Shim RS, Compton MT. The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity. Journal of Lifelong Learning in Psychiatry (2020) (https://doi.org/10.1176/appi.focus.20190035) -More references on uploaded file

Research in Medical Education Posters — Presentations

1. Psychiatric Topics of Interest and Importance to Medical Students

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Background: Identifying psychiatric topics of interest to medical students may be helpful to educators in designing learner-centered psychiatry curricula and consider ways to enhance recruitment into the field. In addition, it has been shown that exposure to certain topics may impact medical student attitudes1, which is critical given the stigma associated with mental health and substance use. At Yale School of Medicine, all clerkship students are required to choose a psychiatric topic of their choice and prepare a presentation to their clinical team for formative feedback. Given that preparing a presentation requires significant time, the students likely choose a topic that they are either particularly interested in or that they think more knowledge of will benefit them in some way. The goal of this study is to better understand the specific topics of interest to medical students by examining student presentations at one clerkship site (a VA-based psychiatric emergency room [PER]). Objectives: The goal of this study is to better understand the specific topics of interest to medical students by examining student presentations at one clerkship site (a VA-based psychiatric emergency room [PER]). Methods: All medical students who spent a 3-week rotation in the PER from 2015-2020 as part of their required psychiatry clerkship were required to complete a presentation to the team on a psychiatric topic of their choice. Students were encouraged to select a topic that stimulated their interest and was clinically relevant. The student presented to the multidisciplinary PER team for approximately 10 minutes. Students were required to provide team members with a one-page summary of their presentation. These summaries were collected at the time of the presentation and stored. Six years-worth of these summary documents were later analyzed for primary content. A total of 101 presentation summaries were collected, however only 96 were valid as five were missing data. A thematic analysis divided the topics into those primarily related to substance use disorders (SUD) and those primarily related to mental health. Within these categories, these were sub-divided into core topics. Results: Of the presentations, 34 focused on substance use disorders (SUD), while 62 were about non-substance use mental health topics. The substance use disorder presentations included the following: alcohol use disorder (10), opioid use disorder (10), cannabis use disorder (5) and other SUD topics (9). Mental health topics included the following: depression (11), PTSD (10), borderline PD (5), deep brain stimulation (5), sleep disorders (5), conversion disorder (4), suicide (3), psychosis (3), social topics (2), ADHD (2) and other topics (12). Additional information on the specifics of the topics and presentations will be provided on the poster. Discussion: Approximately one-third of the students chose to focus on a topic related to substance use disorders. Of the mental health topics, several students chose topics not widely covered in the curriculum, including deep brain stimulation, sleep disorders and conversion disorders. This list of topics, including the detailed breakdown, may be of interest to medical school educators looking to enhance student engagement in the psychiatry clerkship or in psychiatry interest group activities, particularly in the context of learner-centered curriculum. The topics may also help to inform recruiting efforts of students into psychiatry by providing educators with topics that are seen as either the most interesting, important or beneficial by students. Finally, if topics being taught align

well with the student interests, it may impact medical student attitudes about mental health and substance use disorders.

References:

1.Koyi, M.B., et al. Change in Medical Student Attitudes Toward Patients with Substance Use Disorders After Course Exposure. Academic Psychiatry, 42:283-278, 2018.

2. Does engaging faculty in student assessment process improve timeliness, quality and completion rates of the evaluations?

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Background: The psychiatry clerkship at our school is structured so that each student rotates weekly through 4 clinical sites. We hypothesized that completing student evaluations within 2 weeks of contact with them should help students focus their efforts on areas of improvement during their clerkship experience. We also intended to use evaluations from weeks 1 and 2 during mid-clerkship feedback and incorporate these into learning goals for weeks 3 and 4. This should also serve to fulfill the institutional goal for our department. Our baseline completion average was 22% within 14 days and our goal was to achieve 80% completed evaluations within 14 days. Objectives: To improve timeliness of feedback to students and improve completion rates of student evaluations

by faculty.

Methods: In order to engage faculty in the assessment process for students, a 30 minute orientation session was developed for faculty. This included an outline of clerkship objectives, structure, didactics, formative, summative assessment and grading. Faculty were informed of student appreciation and positive experience during clerkship using metrics from the student evaluation of the clerkship. The institutional goals for the department presented were also presented. A survey was designed with previously reported challenges in mind. In addition to demographic information, faculty were asked the following questions: 1. What is your primary challenge with teaching medical students? 2. What is your most important concern with completing student evaluations? And 3. What is the main reason for delay in completing evaluations? The outcome measures were based on quarterly data provided by the institution. Year-end data was compared with baseline.

Results: The 14 days completion at the end of the academic year improved to 85% with the psychiatry clerkship being the only clerkship to have achieved the institutional goal. 98% of Students agreed or strongly agreed with having received feedback on what they did well or might improve.

Discussion: Providing timely feedback to medical students during clerkship helps with their learning and allows faculty to accurately assess student skills (1). Our students have requested timely feedback to identify gaps and work on improving deficiencies (2) during their 4 week psychiatry clerkship. Our institution set forth a goal of improving our student evaluation completion to 80%, within 14 days of last contact with student. Based on the survey response, the main themes with areas of concern were identified as brief rotation, busy service and access to evaluations forms. Since the structure of the clerkship is maintained for an academic year, we decided to first address concerns with a. Timely access to the evaluations and b. Lack of reminders to complete the forms. The office of Learner Assessment and Program Evaluation was involved to address these issues and updates on resolution of these concerns were provided to the faculty in an effort to keep them involved in the process. References:

1. Lamba S, Nagurka R. Tool for documenting clinical point-of-care direct observation and formative feedback. MedEdPORTAL. 2015;11:10093. https://doi.org/10.15766/mep_2374-8265.10093 2. Rudolph, J. W., Simon, R., Raemer, D. B., & Eppich, W. J. (2008). Debriefing as formative assessment: closing performance gaps in medical education. Academic Emergency Medicine, 15(11), 1010-1016.

3. Predictors of Depression Stigma Among Medical Students

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Background: The prevalence of depression among medical students continues to rise, mirroring established global trends. Despite having high rates of depression, medical students often do not seek mental healthcare. A major barrier to treatment-seeking behavior in medical school is the influence of personal stigma and stigmatized views of others' perceptions. Quantification of the stigmatization of beliefs about depression and identification of predictors of stigma may aid in developing initiatives to treat depression in medical students.

Objectives: The purpose of this study was to identify predictors of depression stigma among medical students at a large, metropolitan university.

Methods: An electronic survey was submitted to all enrolled medical students at a large, public university in the United States. The survey consisted of a concise socio-demographic questionnaire, Patient Health Questionnaire (PHQ-9), and Depression Stigma Scale (DSS). The PHQ-9 summed-item scoring method was used to determine the percentage of respondents that met criteria for provisional diagnosis of major depression disorder (MDD) and other depressive disorder. Predictors of depression severity, personal stigma, and perceived stigma, were identified by performing t-test, two-tailed, and assuming unequal variances. P<0.05 was used to indicate statistical significance. Data analysis was performed using IBM SPSS Version 26.

Results: To date, a total of 178 completed responses were obtained, constituting approximate 15% response rate. Approximately 11% of respondents met criteria for MDD and 13% met criteria for other depressive disorder. Nonheterosexual orientation (p=0.017), discomfort towards seeking treatment (p=0.003), and receiving treatment for depression in the past (p=0.001) or currently (p=0.006) were independently associated with increased severity of depressive symptoms. Male sex (p<0.001), heterosexual orientation (p=0.017), and discomfort towards seeking treatment (p<0.001) were significant predictors of personal stigma. By comparison, male sex (p<0.001) and non-Caucasian (p=0.037) race were predictors of perceived stigma. Perceived stigma was significantly greater than personal stigma among medical students (p<0.001). Data collection is expected to be complete by December 2020.

Discussion: The findings of this study suggest that nearly one in four medical students meet clinical screening criteria for a depressive disorder. Non-heterosexual orientation was predictive of both increased depression ang

personal stigma, underscoring the potential value of targeting screening efforts and mental health literacy efforts in medical students. Certain demographic groups such as male sex were predictive of high levels of both personal and perceived stigma, suggesting that focused efforts to reduce stigma in this subgroup may be warranted. Non-Caucasian students also exhibited significantly more perceived stigma, suggesting that mental health promotion by faculty and administration may be necessary to decrease stigma in this group. Given that medical students exhibited far more perceived stigma than personal stigma, strategies to promote mental health and supportive policies by administrators and faculty may be most effective to combat stigma in medical school. Format: In this study, discomfort toward seeking treatment as well as receiving treatment for depression were both independently linked to depression symptoms. Notably, certain demographics, such as male sex or non-Caucasian race were predictive of more stigmatized views regarding depression, suggesting that these groups may benefit from targeting interventions to reduce stigma among medical students. Moreover, perceived stigma was significantly greater among medical students compared to personal stigma, underscoring the importance of creating a positive campus culture regarding mental health. The discrepancy between personal and perceived stigma in this population may suggest increased mental health literacy in the current generation of medical students, concurrent with a robust perception that others (e.g. fellow students, faculty, administrators) hold negative views about students with depression.

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Rotenstein LS, Ramos MA, Torre M, Segal JB, Peluso MJ, Guille C, Sen S, Mata DA. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students. JAMA 2016;316(21):2214-36. doi: 10.1001/ jama.2016.17324. MacLean L, Booza J, Balon R. The impact of medical school on student mental health. Acad Psychiatry 2016;40:89-91. doi: 10.1007/s40596-015-0301-5. Brown C, Conner KO, Copeland VC, Grote N, Beach S, Battista D, Reynolds CF. Depression stigma, race, and treatment seeking behavior and attitudes. J Community Psychol 2010;38(3):350-68. doi: 10.1002/jcop.20368. Pendi A, Ashraf J, Wolitzky-Taylor KB, Lee D, Sugar J, Pendi K, Lee J, Baron DA. The association between depression severity and stigmatized beliefs in undergraduate students at a large metropolitan university: a cross-sectional study. J Psychiatry Ment Health 2016;1(2). doi: 10.16966/jpmh.108.

4. Positive psychological factors and the development of depressive symptoms in medical students Shannon Pan, Medical Student, Texas Tech University Health Sciences Center School of Medicine Kiran Ali, Medical Student, Texas Tech University Health Sciences Center School of Medicine Kerala Saugh, MD, Texas Tech University Health Sciences Center School of Medicine Marina Chavez, MD, Texas Tech University Health Sciences Center School of Medicine Regina Baronia, MD, Texas Tech University Health Sciences Center School of Medicine Yasin Ibrahim, MD, Texas Tech University Health Sciences Center School of Medicine

Background: Medical students have been shown to have higher rates of depression due to isolation, and the stress of maintaining a balanced life in the context of academic pressure, financial constraints, relationships and self-care. This study aims to examine the association between psychological factors such as resilience, spirituality, loneliness, engaged living and depression in medical students.

Objectives: Our long-term goal is to develop a model to predict the academic success of first- and secondyear medical students as measured by USMLE Step 1 scores, using academic predictors (e.g. MCAT scores, undergraduate science GPA), cognitive predictors (e.g. fluid IQ, verbal IQ, working memory capacity) and more importantly psychological predictors (e.g. symptoms of depression and anxiety disorders, positive psychological factors). The overall objective of the proposed study is to develop an empirically supported model to account for the effects of positive psychological factors in moderating the association between symptoms of depression among first- and second-year medical students.

Methods: First-year medical students were recruited within the first two months of the academic year via electronic and physical bulletins. Participants completed a demographic questionnaire, medical and psychiatric screening questionnaire, Connor-Davidson Resilience Scale (CD-RISC 10), DeJong Gierveld Loneliness short scale (DJG), Duke University Religious (DUREL) index, Engaged Living Scale (ELS), Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder scale (GAD-7), and Psychological Wellbeing Scale (PWB).

Results: Of the 137 students who responded, 80 met inclusion criteria and were enrolled in the study. There were 27 males, 45 were Caucasian, and the mean age was 23.6 \pm 2.38 years. Mean sample scores for the scales and exams were as follows: PHQ-9 score = 3.28 ± 2.81 , DJG score = 2.20 ± 1.57 , DUREL = 18.00 ± 7.44 , ELS = 50.26 ± 7.25 , CD-RISC10= 31.15 ± 4.42 , PWB= 151.70 ± 14.56 , GAD= 4.34 ± 3.81 , MCAT = 508.40 ± 4.49 , SAT= 1705.50 ± 333.08 . PHQ-9 scores positively correlated with DJG (r = 0.45 [0.26, 0.61], p < 0.001), GAD (r= 0.57 [0.40, 0.70], p<0.001) and age (r = 0.25 [0.03, 0.45], p = 0.026). PHQ-9 scores negatively correlated with ELS (r = -0.34 [-0.52, -0.13], p = 0.002) and PWB (r = -0.35 [-0.53, -0.14], p = 0.001). PHQ-9 scores negatively correlated with SAT (r= -0.18 [-0.42, 0.09], p= 0.19), MCAT (r= -0.11 [-0.33, 0.13], p = 0.39), DUREL (r= -0.10 [-0.32, 0.12],

p= 0.38) and CD-RISC10 (r= -0.18 [-0.39, 0.04], p= 0.11). However, these four findings were not statistically significant.

Discussion: Our data suggests that while loneliness seems to be associated with increased depressive symptoms, engaged living and psychological well-being seem to be protective against depressive symptoms. These results provide the first point of reference for this longitudinal study in determining the associations between positive psychological factors and development of depression in medical students. References:

1.Brody DJ, Pratt LA, Hughes JP. Prevalence of Depression Among Adults Aged 20 and Over: United States, 2013-2016. NCHS Data Brief. 2018: 1-8. 2.Ngasa SN, Sama CB, Dzekem BS, Nforchu KN, Tindong M, Aroke D, et al. Prevalence and factors associated with depression among medical students in Cameroon: a cross-sectional study. BMC Psychiatry. 2017; 17: 216. 3.Pham T, Bui L, Nguyen A, Nguyen B, Tran P, Vu P, et al. The prevalence of depression and associated risk factors among medical students: An untold story in Vietnam. PLoS One. 2019; 14: e0221432. 4.Jafari M, Sharifi Ebad T, Rezaei M, Ashtarian H. Association between spiritual health and depression in students. Health, Spirituality and Medical Ethics. 2017; 4: 12-16. 5.Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine. 2001; 16: 606-13.

Innovations in Medical Education Posters (Not Presented)

1. Breadth by PowerPoint": Psychiatry Clerkship Case Modules to Improve Student Confidence, Promote Resident-Student Interaction, and Increase Exposure to Mental Health Diagnoses

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Background: Medical students do not have equal exposure to various mental health illnesses and presentations during their psychiatry clerkship in their third year of medical school. Regardless of their clinical experience, they are tested on a variety of DSM-5 diagnoses, presentations, and management. They are ultimately responsible for learning outside of the scope of the clinical experience they are exposed to. They also have varied learning styles and there is a general movement toward more case-based learning. Additionally, their time is important, for they are balancing clinical duties with studying and managing their personal lives outside of medicine. For this reason, short, self-directed, case-based modules that students can access may serve as a way for students to review their knowledge, add to their existing knowledge or understanding, and think about mental health presentations from a biopsychosocial perspective.

Objectives: Our primary objective is to improve students' understanding of psychiatric conditions and treatment utilizing brief, focused case modules. Specifically, we hope to improve students' ability to identify common presenting symptoms, build a differential diagnosis, and discuss both pharmacologic and psychotherapeutic treatment. By covering a variety of topics, we aim to expose students to diagnoses not always encountered on rotation, and in turn improve performance in clerkship and on standardized exams. We hope to familiarize students with language and concepts used in a mental status exam and biopsychosocial formulation. Additionally, we aim to increase psychiatry resident involvement in student education by providing materials for discussion. We hypothesize there will be improvement in students' confidence ratings in identifying basic psychiatric symptoms and recognizing treatments and their side effects. This will be measured by surveys done before and after reviewing the case modules.

Methods: •Reviewed available educational resources for students in the clerkship. Identified a gap in the integration of patient presentation, differential diagnosis, and first-line treatment. •Established psychiatric conditions to develop cases about, which included schizophrenia, major depression, bipolar disorder, borderline personality disorder, generalized anxiety disorder, obsessive compulsive disorder, and mild and major neurocognitive disorder. •Developed case modules using Kaplan & Sadock's Synopsis of Psychiatry, the DSM-5, and the APA practice guidelines. •Disseminated case modules to medical students via email and their online learning management system. •Before and after each case module, collected survey data about students' comfort in identifying symptoms, recognizing first-line treatment, and discussing side effects of treatment for the selected topics. •Analyzed data to evaluate for improvements in students' scores before and after using the case modules.

Results:

117 medical students completed the psychiatry clerkship between dates of 4/1/2019 and 10/18/2019. With each student having the opportunity to complete seven case modules, there were a total of 819 possible surveys for each case, both pre and post module. 97 pre-module surveys (11.8% of possible responses) and 86 post-module surveys (10.5% of possible responses) were collected. Each survey consisted of the same three questions (Q1, Q2, Q3). Responses were measured on a range of 1-5, with higher scores indicating more confidence in identifying symptoms (Q1), recognizing first-line treatment (Q2), and discussing side effects of treatment (Q3) for each case. Averages were calculated for each question across the seven cases presented. For Q1, the average response increased from 3.77 to 4.63. For Q2, the average response increased from 3.35 to 4.58. For Q3, the average response increased from 2.88 to 4.16. 10.5% of post-survey responses indicated case was discussed with a resident.

Discussion: Survey results indicate improvement in confidence recognizing symptoms of diagnoses, first line treatments, and side effects of treatment, demonstrating that these cases were effective in achieving the primary objective. However, there was minimal to no improvement in increasing the facilitation of resident-student discussion. Project limitations include: •Anonymous, untracked surveys allow for potential multiple responses •Unequal number of pre and post responses •Low percentage of students completing the surveys •Lack of control for time spent in clerkship relative to survey date •Lack of knowledge if students had interest in or prior exposure to psychiatry Given the positive results from the surveys, it may be beneficial to create additional case modules on more topics in psychiatry. It may also be beneficial to disseminate this material to other programs. However, more work needs to be done to encourage discussion and teaching between residents and medical students.

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2. "The Sponge": A Trauma-informed model to describe and discuss Borderline Personality Organization (and Disorder) with our trainees, other colleagues, our patients and their loved ones Himanshu Agrawal, MBBS, DF-APA, Medical College of Wisconsin

Background: It is estimated that 1.4% of the adult U.S. population experiences Borderline Personality Disorder (BPD)(1). Nearly 75% of people diagnosed with BPD are women(1). Borderline Personality Disorder (BPD) is a condition characterized by difficulties regulating emotion(1). Often, it is associated with hypersensitivity to real or perceived criticism(2). Of equal importance, even though an accurate diagnosis may have significant benefits, studies show that being diagnosed with this condition also may be associated with risks [related to stigma(3), judgment(4,5), attitudes(4, 5,6) and bias(4,6,7)] that may have prognostic implications. Studies also show there is lingering discomfort amongst professionals to make this diagnosis and discuss the diagnosis with their patients(7). Objectives: The objective of this poster is to introduce to the audience, an idea that the author has developed. This idea utilizes an analogy, which if properly delivered and discussed, may help describe salient symptoms and signs of BPD in a manner which validates the afflicted individual's suffering, fosters empathy from professionals and alliance from patients, and reduces stigma (defined by Oxford Dictionary as "a mark of disgrace associated with a particular circumstance, quality, or person")

Methods: 1.At the center of this Poster Presentation (literally), will be an illustration (see attached PPT) which the author will utilize in live interactions with ADMSEP audience members, to facilitate the discussion of describing the etiology, risk factors, central psychological pathology and consequences & manifestations of BPD. If the poster is accepted, I will work with a graphic designer to improve the illustration. 2. (a)A video presentation will be created describing this model, and will be made available to trainees at MCW (including but not limited to M3 students, M4 students, psychiatry residents and fellows, faculty and staff). (b) Short Surveys will be administered Pre and post video presentation, assessing medical knowledge regarding BPD, attitudes towards individuals with this diagnosis, and comfort level discussing this diagnosis with trainees, other colleagues as well as patients.

References: 1.https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Borderline-Personality-Disorder 2.Psychoanalytic Investigation of & therapy in the border line group of neuroses, Stern A, Psychoanal Q 1938; 3.Self-stigma in women with borderline personality disorder & women with social phobia, Rüsch et al, J Nerv Ment Dis. 2006 Oct 4.Responses of Mental Health Clinicians to Patients with Borderline Personality Disorder, Sansone, Innov Clin Neurosci. 2013 May 5.The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours, Markham &Trower, Br J Clin Psychol. 2003 Sep; 6.The effects of diagnosis and noncompliance attributions on therapeutic alliance processes in adult acute psychiatric settings, Forsyth A, Jrnl of psych & mental health nursing , 18 Jan 2007 7.Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians, Black et al,CNS Spectrums, Mar 03.

3. Introduction to Telemedicine Course

Naomi Ambalu, DO, Hackensack Meridian School of Medicine Miriam Hoffman, MD, Hackensack Meridian School of Medicine Ofelia Martinez, MD, Hackensack Meridian School of Medicine Elizabeth Koltz, EdM, Hackensack Meridian School of Medicine

Background: It is estimated that 1.4% of the adult U.S. population experiences Borderline Personality Disorder (BPD)(1). Nearly 75% of people diagnosed with BPD are women(1). Borderline Personality Disorder (BPD) is a condition characterized by difficulties regulating emotion(1). Often, it is associated with hypersensitivity to real or perceived criticism(2). Of equal importance, even though an accurate diagnosis may have significant benefits, studies show that being diagnosed with this condition also may be associated with risks [related to stigma(3), judgment(4,5), attitudes(4, 5,6) and bias(4,6,7)] that may have prognostic implications. Studies also show there is lingering discomfort amongst professionals to make this diagnosis and discuss the diagnosis with their patients(7). Objectives: The objective of this poster is to introduce to the audience, an idea that the author has developed. This idea utilizes an analogy, which if properly delivered and discussed, may help describe salient symptoms and signs of BPD in a manner which validates the afflicted individual's suffering, fosters empathy from professionals and alliance from patients, and reduces stigma (defined by Oxford Dictionary as "a mark of disgrace associated with a particular circumstance, quality, or person")

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References: 1.https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Borderline-Personality-Disorder 2.Psychoanalytic investigation of & therapy in the border line group of neuroses, Stern A, Psychoanal Q 1938; 3.Self-stigma in women with borderline personality disorder & women with social phobia, Rüsch et al, J Nerv Ment Dis. 2006 Oct 4.Responses of Mental Health Clinicians to Patients with Borderline Personality Disorder, Sansone, Innov Clin Neurosci. 2013 May 5.The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours, Markham &Trower, Br J Clin Psychol. 2003 Sep; 6.The effects of diagnosis and noncompliance attributions on therapeutic alliance processes in adult acute psychiatric settings, Forsyth A, Jrnl of psych & mental health nursing , 18 Jan 2007 7.Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians, Black et al,CNS Spectrums, Mar 03.

4. Innovative Psychiatry Clerkship Curriculum: Incorporating Community and Social Determinants of Health

Naomi Ambalu, D.O., Hackensack Meridian School of Medicine Stacy Doumas, MD, Hackensack Meridian School of Medicine Bryan Pilkington, PhD, Hackensack Meridian School of Medicine Ramon Solhkhah, MD, Hackensack Meridian School of Medicine

Background: Most medical school psychiatry clerkships are hospital based, exposing students to severely mental ill patients in inpatient settings for much of their rotation. Our medical school incorporates the Determinants of Health into all courses and clerkships, as a focus of a longitudinal course named Human Dimension. Objectives: To develop a psychiatric clinical curriculum that is consistent with the vision of our medical school

where there is a strong focus on community engagement and social determinants of health. Methods: A literature search was completed looking at various psychiatry clinical curriculum. An innovative curriculum was then developed that integrated community psychiatry and social determinants of mental health in addition to the components of more traditional rotations.

Results: The psychiatry clinical curriculum developed was a 6 week rotation comprised of inpatient psychiatry, consultation/liaison psychiatry, emergency psychiatry, and outpatient psychiatry (including subspecialties). During the outpatient rotation students actively engage with patients, accomplishing ambulatory goals. These include writing a SOAP note, performing a mental status exam, completing AIMs and checking for medication interactions to name a few. Students experience ECT, dTMS and ketamine treatment. They rotate in community psychiatry programs, including an integrative mental health program embedded in a family practice clinic, a children's day program and a collaborative mental health program. Students attend a 12-step program meeting and a clinical training day at a rehab center. In addition to grand rounds and journal club, the core curriculum

features small group discussions on traditional topics and ethical debates incorporating social determinants of mental health.

Discussion: Our innovative psychiatry clerkship that is integrated into the community while still providing students with hospital-based experiences and a comprehensive core curriculum will better prepare medical students for their future as physicians than more traditional rotations. We also expect this curriculum to increase interest in psychiatry as a career. We expect improved faculty satisfaction in the training of our medical students as compared to students with traditional curricula. All students will graduate with the ability to prescribe buprenorphine. We plan to compare student outcomes in our innovative curriculum to traditional curriculums (NBME scores, grades, feedback, USMLE scores). We will compare number of students applying to psychiatry residency programs between curriculum types as well to assess interest in psychiatry as a career. References:

1.Ithman, Muaid. Pre- and Post- Clerkship Knowledge, Perceptions, and Acceptability of Electroconvulsive Therapy (ECT) in 3rd Year Medical Students. Psychiatr Q (2018) 89:869–880. 2.Marsh, MC. Introducing the Concepts of Advocacy and Social Determinants of Health Within the Pediatric Clerkship. MedEdPortal. 2019 Jan 25; 15:10798. 3. Moffett, SE. Social Determinants of Health Curriculum Integrated Into a Core Emergency Medicine Clerkship. MedEdPortal. 2019 Jan 4; 15:10789.

5. A Multimedia Approach to Medical Student Remote Electives

Marissa Flaherty, MD, University of Maryland School of Medicine

Background: The Cognitive Theory of Multimedia Learning cites the importance of a multisensory approach to teaching. This concept has been implicated and utilized in Adult Learning Theory to improve adult classroom settings and teaching modalities. In the era of the COVID-19 pandemic, all of graduate medical student education transitioned from an in classroom approach to a remote learning environment. While student engagement used to be observed through hands on learning and small groups, the remote learning atmosphere erased all interpersonal connection that allowed that student engagement and higher level of learning. Objectives: When the transition to online learning happened, the University of Maryland School of Medicine Department of Psychiatry Medical Student Education Division created two electives from scratch to supplement student learning. These online electives allowed students to continue to learn valuable information for their future careers. These electives were created with the multimedia approach in mind. From listening to podcasts, to watching films, to discussion of articles, to presentation of PowerPoint, to interactive lectures, to small group virtual work to completing online modules, the courses sought to present the information in creative ways, different than the traditional online classroom lecture setting.

Methods: It was hypothesized that through the presentation of the material in multiple media modalities, the students would form a deeper appreciation, understanding and knowledge of the topics. It was also hypothesized that the students would enjoy the course more than traditional courses. Post-elective surveys will be distributed to gather information about their subjective experience as well as objective ratings of the two courses. Results: Once these surveys are collected, the data will be aggregated to demonstrate the effect of the multimedia approach.

Discussion: In the era of a pandemic and the changing culture of medical student education, it is important to review the outcomes of new modalities of learning so that institutions can continue to improve their learning environments and implement change in real time.

References:

Riddell, J., Swaminathan, A., Lee, M., Mohamed, A., Rogers, R., & Rezaie, S. R. (2017). A Survey of Emergency Medicine Residents' Use of Educational Podcasts. The western journal of emergency medicine, 18(2), 229–234. https://doi.org/10.5811/westjem.2016.12.32850 Chin, A., Helman, A., & Chan, T. M. (2017). Podcast Use in Undergraduate Medical Education. Cureus, 9(12), e1930. https://doi.org/10.7759/cureus.1930 Cho, D., Cosimini, M., & Espinoza, J. (2017). Podcasting in medical education: a review of the literature. Korean journal of medical education, 29(4), 229–239. https://doi.org/10.3946/kjme.2017.69 Alonso Ortiz M, 2018, 'Commercial Cinema as a learning tool in medical education, from potential medical students to seniors ', MedEdPublish, 7, [4], 17, https:// doi.org/10.15694/mep.2018.0000238.1

6. The Great Debate: Teaching Medical Students Ethical Decision Making

(Jeremy) Kai-Hong Mao, Keck School of Medicine of USC

Background: The Liaison Committee on Medical Education requires each medical school "ensure that the medical curriculum includes instruction for medical students in medical ethics and human values." (LCME Functions and Structure of a Medical School, 2018) Previously, the psychiatry clerkship included a twenty minute individual session to discuss an ethically-complicated case; however, this session also included discussion about the medical student's upcoming Objective Structured Clinical Examination (OSCE). Evaluations from students highlighted the usefulness of the information given for the OSCE, but did not mention the ethical discussion. Upon review of the objectives that had been approved by the Humanities, Ethics/Economics, Arts and the Law (HEAL) Program, it was clear that they were not being met and revision of the ethics seminar was needed.

Objectives: Drs. Kai-Hong Mao and Susie Morris created a debate-style ethics seminar for third year medical students wherein ethically-complicated psychiatric cases were presented, and students were asked to design argument strategies supporting opposing clinical decisions for each case.

Methods: The 90-minute debate-style session was crafted based on objectives that had been approved by the Humanities, Ethics/Economics, Arts and the Law Program at USC and held once during each psychiatry clerkship. Beginning with a review of 2 ethically fraught real-life cases, students are randomly assigned a "side" regardless of their own personal beliefs. Students are given time to prepare their arguments and then asked to engage in a debate that includes an introduction, cross-examination, and closing statement. Drs. Mao and Morris close the seminar by discussing how these cases were resolved, allowing students to process the experience and ask questions.

Results: Since implementation on July 16, 2019, students have rated the Ethics Seminar highly, with an average rating of 4.46 (4.32-4.57) out of 5. Students endorsed that being exposed to "multiple perspectives" is beneficial, especially with "real cases." Students also commented that the session is "entertaining" and "case-based instead of lecture."

Discussion: The feedback we received demonstrates that students respond well to more active learning modalities. This seminar represents an innovative method to teach students ethical reasoning that other clerkships may also wish to adopt. It will contribute to the participating medical students' ability to critically assess all ethical and legal considerations of future ethical dilemmas.

References:

Liaison Committee of Medical Education. (2019). Functions and structure of a medical school: standards for accreditation of medical education programs leading to the MD degree.

7. Teaching the Biopsychosocial Model of Patient Formulation to Medical Students

Brent Schnipke, MD, Wright State University Boonshoft School of Medicine Morgan Alexander, MD, Wright State University Boonshoft School of Medicine Laura Virgo, MD, Wright State University Boonshoft School of Medicine Bethany Harper, MD, Wright State University Boonshoft School of Medicine

Background: The biopsychosocial model of patient formulation has been adopted widely in psychiatry and has been used in some primary care settings as well, but its utilization in other specialties remains limited. Students are underprepared to discuss and utilize this model of formulating a patient, partly due to shortened psychiatry clerkships that have decreased the amount of time available to teach patient formulation, and students are unlikely to learn this material elsewhere. Although our students have reported that they are not familiar with the biopsychosocial model of formulation in classroom settings, there is no data to determine our students' familiarity and confidence with the model. In addition, we expect that a novel method of teaching formulation – by simulating a patient interview while students utilize a provided handout (the biopsychosocial grid) – will increase practical understanding of the concept.

Objectives: 1. Discuss the background, role, and value of the biopsychosocial model of patient formulation and the use of a biopsychosocial grid 2. Introduce a brief intervention for teaching the model and patient formulation in general 3. Examine the results and value added with utilization of the method, and more broadly the impact of teaching patient formulation to third-year medical students

Methods: We administered a brief voluntary, anonymous survey in person before the teaching intervention, with pre- and post- assessments paired ahead of time. The assessment questions focused on students' familiarity with and confidence using the BPS model, as well as asking them to rate the relative importance of considering and explaining biological, psychological, and social factors. Demographics data, including clerkships completed and anticipated specialty interest, were included. A brief explanation of the model and instructions for using a biopsychosocial grid were provided prior to a prepared two-part patient interview. The first focused primarily on criteria and data collection and was followed by a second interview focused on a holistic exploration of a patient. Students observed the interview while building the patient formulation, and finally filled out post-assessment questions.

Results: 92 students completed the exercise including the pre- and post-assessment questions. On average, students reported low pre-existing knowledge of the BPS model of formulation (4.22/10, mode=1). Students rated the exercise effectiveness on average as 8.2/10. Subjective measures of confidence with using the model increased, as well as the perceived importance of psychological and social factors, and the importance of the physician's role in understanding these factors (all statistically significant findings). Students with prior exposure to the clerkship did report more familiarity and confidence with the model, but confidence was still increased by the session. Regardless of expected specialty, students believed that this model holds promise among various specialties; because of this, we believe it was a useful intervention to hold in an integrated setting to reinforce important concepts when shortened clerkships require reorganization of content.

Discussion: The results indicate that our intervention was valuable for several reasons. First, the low pre-existing knowledge confirmed this as a gap in our curriculum. Second, the intervention itself was rated as valuable. Third, the statistically significant increase in confidence and perceived importance suggest effectiveness. Students with prior exposure to the clerkship reported more familiarity and confidence with the model, but it was still increased by the session. The only factor which decreased post-intervention was the perceived role of the physician in considering psychosocial factors; this difference was pronounced when separating by specialty which indicates limitations outside psychiatry. We believe that considering the scope of biopsychosocial formulation may have led some students to consider that these issues are outside the physician's role, due to the same limitations mentioned. Overall we believe this was a useful intervention to teach widely applicable content.

References:

Chu SY, Lin CW, Lin MJ, Wen CC. Psychosocial issues discovered through reflective group dialogue between medical students [published correction appears in BMC Med Educ. 2018 Apr 30;18(1):83]. BMC Med Educ. 2018;18(1):12. Published 2018 Jan 10. doi:10.1186/s12909-017-1114-x Gilbert P. Understanding the biopsychosocial approach. Clin Psychol 2002, 14: 13-17 Wade, Derick T., and Peter W. Halligan. "The Biopsychosocial Model of Illness: A Model Whose Time Has Come." Clinical Rehabilitation, vol. 31, no. 8, Aug. 2017, pp. 995–1004, doi:10.1177/0269215517709890.

Let's Meet at the Art Museum: Art as a Teaching Tool

Research in Medical Education Posters — Not being presented

Psychiatry Clerkship Students' Perspectives on Virtual Learning and Telemedicine during the COVID-19 Pandemic

Alcides Amador, M.D., University of Texas - Rio Grande Valley Sason Dean Tavakoli-Sabour, D.O., University of Texas Rio Grande Valley

Background: The COVID-19 Pandemic has caused many changes in the ways medical students learn and participate in patient care while on their rotations. Although virtual learning and telemedicine are not new, the pandemic has led to an increase in use of virtual learning and telemedicine in medical students' education. Is virtual learning and telemedicine as effective as in person learning and in person patient care for medical students' education? This is an important question for the medical education community to investigate. 93% of 3rd year medical students at Wayne State University rotating in Internal Medicine via telemedicine felt that telemedicine was a valuable component of their clinical education1. In response to the pandemic, Soroka University Medical Center, designed a virtual course in Pathology for 3rd year and 4th year medical students. At the end of the course, 68% of the students reported that they would recommend a student to take the course and found the course interesting.

Objectives: From the available literature it seems that students do have favorable opinions on virtual learning and telemedicine. Psychiatry via telemedicine was gaining ground even before the COVID-19 Pandemic. However, Psychiatry via telemedicine is not an experience most medical students had the opportunity to experience before the Pandemic. At UTRGV students rotating through the Psychiatry Clerkship are now using telemedicine and virtual learning as integral components of their learning. Lectures are both live and pre-recorded, the pre-recorded lectures are provided via Lecturio and the live lectures are provided via Microsoft Teams. Their telemedicine experience is provided via Zoom. The question we aim to investigate is how students in the Psychiatry Clerkship, during the COVID-19 Pandemic, perceive virtual learning and telemedicine before and after the clerkship.

Methods: From August 2020 - June 2021, students will be sent a Pre-Clerkship Survey and Post-Clerkship Survey gauging their experience and attitudes towards virtual learning and telemedicine before the clerkship and at the conclusion of the clerkship

Results: The results of the Pre and Post Clerkship survey will be compared in order to see if attitudes towards virtual learning and telemedicine changed.

Discussion: As far as we know this is the first look into medical students' perspectives on virtual learning and telemedicine before and after their Psychiatry Clerkship. Our discussion will interpret the results of the surveys and propose ways to improve students' perceptions of virtual learning and telemedicine.

References:

1. Abraham H N, Opara I N, Dwaihy R L, et al. (June 24, 2020) Engaging Third-Year Medical Students on Their Internal Medicine Clerkship in Telehealth During COVID-19. Cureus 12(6): e8791. DOI 10.7759/cureus.8791. 2. Samueli, B, Sror, N, Jotkowitz, A, et al. Remote pathology education during the COVID-19 era: Crisis converted to opportunity. Annals of Diagnostic Pathology. 49 (2020) 151612

LGBTQIA+ Related Medical Education: A Look Across Four Institutions

Jacob Givens, Medical Student, University of Nebraska Medical Center Dana Raml, M.D., University of Nebraska Medical Center Shinny-yi Chou, MD, PhD, UPMC Western Psychiatric Hospital Samuel Fels, Sidney Kimmel Medical College at Thomas Jefferson University Christine Harb, A.T. Still University

Background: Healthcare providers have a duty to take care of a wide variety of populations. However, sometimes clinicians do not get the education they need nor deserve to appropriately care for diverse populations. One such population is the LGBTQIA+ community. Approximately 5 percent of the United States population is LGBTQIA+ and disproportionately face barriers to care1.Data suggest that bias and discrimination towards LGBTQIA+ patients has been observed by a majority of healthcare providers2. Such bias results in LGBTQIA+ individuals facing higher rates of substance use disorders, mental health disorders, HIV and HPV infection, and avoidance of healthcare3. Despite these disparities, education surrounding LGBTQIA+ issues is varied among institutions. The mean time spent on LGBTQIA+ related issues in curriculums in the US is 5 hours throughout the entire four-year curriculum educating about LGBTQIA+ related content.4 This shows a gap in much needed medical education.

Objectives: Through evaluating LGBTQIA+ related education at four US medical schools, we sought to judge what strengths and weaknesses are present in current medical curriculums surrounding LGBTQIA+ related issues. Ultimately, we hope this work could help identify ways LGBTQIA+ medical education can grow and improve.

Methods: LGBTQIA+ related curriculum was identified through online resources and individuals at participating institutions. Qualitative characteristics were then categorized based on distinguishing features and common themes. Common themes were used to summarize the findings based on reported curriculum data.

Results: Common features of LGBTQIA+ related education include HIV education and basic LGBTQIA+ terminology lectures. Three of the four schools included LGBTQIA+ standardized patients. Two of the four schools offered a preclinical elective. Two of the four institutions offered a gender-diverse patient panel opportunity. Further differences can be seen above in the Summary of Resources table.

Discussion: Overall, there is a need for robust LGBTQIA+ related education to better prepare providers to provide quality care to the LGBTQIA+ community. While some institutions offer robust offerings surrounding LGBTQIA+ related topics, the education can vary greatly between institutions. Collaboration and education about gaps surrounding LGBTQIA+ education would not only help rectify the shortcomings but would also better equip future providers to care for their patients. Through work like this, the medical education community can continue to improve LGBTQIA+ related education for students to come. References:

1. FRANK NEWPORT. In U.S., Estimate of LGBT population rises to 4.5%. Gallup. Published 2018. Accessed October 24, 2020. https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx 2. Bonvicini KA. LGBT healthcare disparities: What progress have we made? Patient Educ Couns. 2017;100(12):2357-2361. doi:10.1016/j.pec.2017.06.003 3. Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS. National Health Statistics Report (Number 77 - July 15, 2014)—Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey.; 2014. Accessed October 24, 2020. http://www.cdc.gov/ 4. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. JAMA - J Am Med Assoc. 2011;306(9):971-977. doi:10.1001/jama.2011.1255

Burned out students report similar utilization rates, lower perceived efficacy of wellness resources

Jackson Mitzner, Medical Student, University of Pittsburgh School of Medicine Michelle Nanni, Medical Student, University of Pittsburgh School of Medicine Shinny-yi Chou, MD, PhD, UPMC Western Psychiatric Hospital Jody Glance, MD, University of Pittsburgh School of Medicine

Background: Burnout is endemic in medical education, with estimated prevalence ranging from 45-55%(1, 2). The consequences of burnout are many-fold, including higher rates of self-reported unprofessional conduct, and suicidal ideation (3-7). Recognizing these problems, the LCME requires medical schools to have established student wellness programs(8). It remains unclear how effectively these resources can reach the student body or how attitudes regarding perceived effectiveness of school-provided wellness resources differ between burned out and non-burned out students(9, 10).

Objectives:

- Characterize the utilization and perceived effectiveness of school-provided wellness resources
- Assess differences in utilization and perceived effectiveness of resources related to level of burnout, psychological distress, and identification as having a mental illness
- Gauge student attitudes regarding mental health and burnout
- Qualitatively analyze student thoughts regarding burnout prevention

Methods: Campus wide emails addressed to 1,730 medical students were sent to three institutions, which provided background regarding the study and a link to an anonymous online survey. Interested students completed the 12-item questionnaire and responses were compiled in a central cloud-based system. The questionnaire included demographic information, self-identified psychiatric history, and Likert-scale questions on 14 wellness resources. It included the K6 psychological distress scale(11), a single-item burnout survey(12), and write-in space for students to comment about burnout prevention. Data were analyzed via SPSS. Descriptive statistics were generated for demographic information. One-way ANOVA and t-tests were used to compare responses between student groups. P<0.05 was considered significant. Free-form responses were analyzed using qualitative content analysis.

Results: 495 students responded. Of those, 328 completed the survey sufficiently for analysis. The overall rate of burnout in the population was 32%. There was no difference in burnout rates by institution, year, or sex. Burnout was more prevalent amongst students with current mental health diagnoses (p<0.001) and students with history of seeking mental health services (p<0.001). There was no difference in the rate of resource utilization between burned out and non-burned out students (p=0.975). Non-burned out students were significantly more likely to rate the resources they had used as effective compared to burned out students (p=0.002) and their mean ranking of resource effectiveness was also significantly higher (p=0.001). Qualitative analysis is ongoing.

Discussion: Students suffering from burnout have similar rates of resource utilization, but they perceive those resources as less effective compared to their non-burned out peers. Further study is needed to determine if this more negative perception predates the onset of burnout or if students them after trying resources without alleviation of their burnout. Efforts should be taken to engage with burned out students to better determine methods to improve their burnout.

References:

1.Dyrbye LN et al; Academic medicine : journal of the Association of American Medical Colleges. 2014;89(3):443-51. 2.Ishak W et al; The clinical teacher. 2013;10(4):242-5. 3.Maher BM et al; BMC medical education. 2013;13:13. 4.Dyrbye LN et al; Jama. 2010;304(11):1173-80. 5.Dyrbye LN et al; Academic medicine : journal of the Association of American Medical Colleges. 2010;85(1):94-102. 6.Dyrbye LN et al; Annals of internal medicine. 2008;149(5):334-41. 7.Rotenstein LS et al; Jama. 2016;316(21):2214-36. 8.Standards for Accredidation of Medical Education Programs Leading to the MD Degree. Washington, DC: AAMC; 2019. 9.Wasson LT et al; Jama. 2016;316(21):2237-52. 10.Williams D et al; Academic psychiatry. 2015;39(1):47-54. 11.Kessler RC et al; International journal of methods in psychiatric research. 2010;19 Suppl 1:4-22. 12.Dolan ED et al; Journal of general internal medicine. 2015;30(5):582-7.

Final Workshop:

Let's Meet at the Art Museum: Art as a Teaching Tool

Stuart Munro, M.D., University of Missouri–Kansas City Susan Lehmann, M.D., Johns Hopkins School of Medicine Michael Ziffra, M.D., Northwestern University Feinberg School of Medicine Eric McDonald, M.D., Stanford University

Background:

Visual Thinking Strategies (VTS) directs learners to engage more deeply with visual cues to foster empathy through: developing listening skills, improving facial emotion recognition, and increasing tolerance for ambiguity. Thus, VTS provides a novel method by which to improve communication between physicians and their colleagues and patients [1]. VTS proves to be not only an effective training tool but also low-cost and easy to incorporate into established curricula [2,3].

Objectives: Upon completion of this session, participants will be able to: Objective

- 1. Describe a tool, Visual Thinking Strategies (VTS), to utilize in teaching medical students and residents.
- 2. Develop lesson plans that utilize art as a teaching tool through VTS.
- 3. Improve their own observational skills in clinical situations, using VTS techniques

Methods: The presenters will demonstrate use of the visual arts in teaching medical students and residents through exercises in VTS, which involves group examination of works of art using a standardized process. This drives learners to make meaning out of their visual experience and appreciate multiple interpretations of the pieces of art. Through group discussion, participants will reflect on how their experience with VTS enriched their ability to consider multiple perspectives. The presenters will then guide the audience through the process for developing VTS teaching exercises to later integrate into their own regular teaching practices.

Format: In this workshop we will use our time as follows:

Introductions + icebreaker (exercise in which participants name their favorite work of art)

Lecture on the concept of Visual Thinking Strategies (VTS)

Group exercise, demonstrating and practicing the VTS approach with several works of art.

Group discussion: Participants will reflect on how their experiences with VTS enriched their ability to consider multiple perspectives.

Participants will break into small groups and will be assisted by the presenters as they develop their own VTS teaching exercises, based on their favorite work of art that they identified in the icebreaker.

References:

[1] Reilly JM, Ring J, Duke L. Visual thinking strategies: a new role for art in medical education. Fam Med, 2005, 37:250-252. [2] Jacques A, Trinkley R, Stone L, Tang R, Hudson WA, Kandelwal S. Art of Analysis: A Cooperative Program Between a Museum and Medicine. Journal for Learning through the Arts, 2012, vol 8, num 1 [3] Klugman CM, Peel J. Art Rounds: Teaching interprofessional students visual thinking strategies at one school. Acad Med, 2011, 86(10): 1266-1271



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KEYNOTE SPEAKER for 2022 Quinn Capers, M.D.

Associate Dean for Faculty Diversity, and Inaugural Vice Chair for Diversity and Inclusion in the Department of Internal Medicine UT Southwestern Medical Center, Dallas, TX

> Association of Directors of Medical Student Education in Psychiatry