Purpose: The AAMC emphasizes a holistic admission process that weighs the experiences, attributes and academic metrics of applicants to meet the specific mission of each medical school (1). While MCAT and undergraduate GPA scores predict scholastic achievement later in medical school (e.g. USMLE scores), consideration of the non-cognitive attributes necessary to become a physician are increasingly emphasized in the overall selection process (1, 2). However, the best methods to evaluate and weigh these non-cognitive attributes remain unclear (3). The Multiple Mini-Interview (MMI) has gained popularity in the selection process to the health professions, appears to be more reliable in assessing non-cognitive attributes than the traditional unstructured interview, and has reasonable acceptability to applicants (3-5). However, the potential for bias in the MMI process in regards to gender, age, and other socioeconomic factors has been recently raised (4).

Approach/Methods: The University of California Riverside (UCR) School of Medicine (SOM) adopted the MMI format as part of its holistic admission process in 2009. Between the years 2011-2015 a total of 693 students were interviewed for an allotted 50 seats per year. A score between 1 and 7 is assigned to each applicant after each interview and all of the interviewers' scores for that applicant are normalized to report a z-score that is used with all other components of the application to determine admission status. The z-score is simply the standard deviation of the applicant’s score to the mean. This large sample enabled us to look for differences in MMI scores based on gender and self-reported racial groups.

Results/Outcomes: Of the 693 total students interviewed using the MMI, 389 were female and 304 were male. Two separate one way ANOVA were conducted for race/ethnicity and gender. Differences were detected in the average z-scores based on self-reported race/ethnicity and gender. White applicants scored highest with an average z-score of +.2224. Asian applicants scored the lowest of all applicants with a mean score of -.0682. Latinos also had a negative average at -.0502. The difference between Asian and white applicants was significant at p=.030. No additional statistical differences were realized with comparisons to other racial or ethnic groups. Female applicants received higher z-scores (+.1363) than male applicants (-.0993) across all races and ethnicities. (p=.001). Among students offered acceptance to medical school (N=138), no differences were found by race/ethnicity or gender.

Discussion: MMIs are increasingly utilized to assess non-cognitive attributes in the selection process of medical students and other health professionals (3-5). For many medical schools using MMIs, they have become central to the holistic review process advocated by the AAMC to increase the diversity of the student body while meeting the mission of the medical school (1). Our findings add to the mixed results reported in the medical literature on MMIs and a gender preference for women and raise for the first time potential differences among applicants based on self-reported racial/ethnic groups (4).

Significance: Admission committees using the MMI should examine their own institutional results for potential hidden biases in regards to gender and racial/ethnic groups.

References: (1) Association of American Medical Colleges (AAMC): Roadmap to excellence: key concepts for evaluating the impact of medical school holistic admissions. AAMC. 2013.


Level of Audience: Expert
Focus of Presentation: UME

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The Challenges of Implementing an LGBT Curriculum at a New Medical School: Utilizing Community-Based Resources and Cross-Campus Collaborations to Meet Student Needs

Nirmala Prakash

Highlights in Medical Education

Innovation

Purpose: The Charles E. Schmidt College of Medicine (CoM) at Florida Atlantic University is a new medical school established in 2011. The development of a cultural competency curriculum with a focus on LGBT health was planned for implementation during the M2 year. The primary challenge encountered was finding faculty and staff from the LGBT community with the expertise to create and deliver the curriculum in an authentic manner.

Approach/Methods: The CoM engaged in strategic partnerships with community and university organizations for the development and implementation of the LGBT component of the cultural competency curriculum. The main partners included the Boca Raton Museum of Art (BRMA), the university’s Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and Ally Resource Center (LGBTQARC), and undergraduate student leaders active in the campus LGBT community.

The M2 LGBT curriculum unfolds in the following order: (1) a visual arts presentation at BRMA focused on human sexuality. This 90 minute session, facilitated by museum staff, creates a safe space outside of the medical school for students to express and learn from each other’s viewpoints on sexuality; (2) a training session hosted by the staff of the LGBTQARC where students learn about minority stress and the spectrum of gender identity and sexuality; (3) medical school and LGBTQARC faculty co-deliver a session focused on the epidemiology of LGBT health inequities and skills required to care and advocate for LGBT patients; (4) para-curricular events, e.g., lunch-and-learns and webinars allowing for specialized in depth learning. These 60-minute events include an LGBT peer and physician panel. The peer panel is moderated by an undergraduate pre-medical student active in the LGBT community. Peer panelists include LGBT community members who train and educate members of various LGBT health organizations in South Florida. The physician panelists specialize in hormone therapy management, mental health and gender affirming surgeries.

Results/Outcomes: As a new medical school with a small faculty, we initially struggled to gather the expertise required to deliver a curriculum focused on LGBT health. In collaboration with community and university partners, we have developed, implemented and iteratively modified, over ten hours of LGBT health content for our students. Due to student response and identified curricular gaps, additional LGBT components are being added such as an M4 year LGBT Health Elective.

Discussion: New medical schools must leverage community partnerships to create a critical mass of educators trained and equipped to deliver relevant curricula. These broad and diverse partnerships not only leverage expertise from LGBT advocates and experts in the design and delivery of curriculum but they also integrate the medical school into the university and broader community. Additionally, it is often challenging to increase curricular hours for a given topic, especially in medical schools like ours where self-directed learning and independent study time are prioritized. The use of para-curricula such as lunch-and-learns and webinars to enhance key areas, such as within LGBT health, allows students to deepen their learning.

Significance: The implications for our work include opportunities for new schools to leverage university and community-based partnerships in the education of their medical students and residents; utility of using extracurricular time to augment classroom experiences; acknowledgment and appreciation for non-physician faculty, including university staff, undergraduate and medical students, who offer significant and valuable expertise especially with regard to marginalized and/or minority populations and exposure of non-traditional community partners to medical students.

References: Hollenbach, A., Ekstrand, K., Dreger, A., (2014). Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD A Resource for Medical Educators. Washington, D.C. AAMC.

Level of Audience: Early-career
Purpose:
The world refugee crisis is at unprecedented levels exceeding post World war II. Michigan is home to the world’s largest Iraqi Christian community and second largest Arab Community outside of the Middle East. In FY 17, Michigan anticipates resettling 5,000 Syrian refugees in Metro Detroit. Current medical school curricula do not prepare students to address the unique physical and mental health needs of this highly traumatized population that has experienced prolonged migration. Faculty at Oakland University William Beaumont School of Medicine developed and implemented a one-month summer internship to provide for students seeking a culturally challenging, complex “glocal” learning experience with a population challenged by multi-faceted health issues.

Approach/Methods:
The internship was a collaboration between OUWB School of Medicine and three NGOs that provide refugee resettlement and post resettlement services. The curriculum design incorporated didactic and clinical exposure to selected issues unique to the refugee experience. Directed readings and faculty guided seminars discussed conflict and migration as determinants of health including their impact on family constellation, poverty, health status and access to care. Through the NGOs, students participated in individual and family centered experiences, went on home-visits, observed medical intakes and counseling sessions with victims of torture. Site experiences focused on the refugee experience and local services including reception and resettlement, integration into the health care system and mental health issues and interventions.

Results/Outcomes:
Culminating the internship each student presented a case and a group poster reflecting the experiences of a family they followed. Students gained an understanding of the linguistic and cultural challenges confronting refugees entering the US. Through interactions with refugee families and NGOs, students saw the difficulties encountered by refugees trying to navigate our health care system; acquired understanding of trauma’s impact on mental health and the importance of linguistic and culturally appropriate communication.

Discussion:
Most medical school curricula teach broad global health issues, social determinants of health and disease incidence/prevalence. In this age of conflict and migration with massive population shifts, the global health dynamic is shifting from “over there” to “here”. A structured educational module addressing the refugee situation and refugees in our country is relevant, real and prepares future physicians to address the needs of the patient cohort whom they will certainly be serving. This internship is an opportunity for OUWB and other medical schools to prepare future practitioners for a major health challenge facing our world today.

Significance:
This internship facilitated teaching core competencies: conflict and migration as unique determinants of health; cultural humility; human rights and ethics; health systems for migrants, health promotion and disease prevention and combined multiple educational methodologies into a novel approach for preparing future physicians as they deal with real and emerging challenges to the health care system in our “Glocal” and global communities.


Gold, Steven J.(editor), Nawyn, Stephanie (editor) Routledge Handbook of Migration Studies (Routledge International


Ziegahn, L, Ibrahim, S., Al-Ansari, B. Et al. The Mental and Physical Health of Recent Iraqi Refugees in Sacramento, California. UC Davis Clinical and Translational Center, Sacramento, CA: UC Davis.

**Level of Audience:** Mid-career

**Focus of Presentation:** UME, GME

**PRESENTER:** Nelia Afonso

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Purpose: Exposure to underserved patient populations has been shown to positively influence cultural competency skills. Given the limited dedicated health disparities or cultural competency curriculum in residency training, we sought to explore whether resident experiences in contrasting social and economic clinical settings enhances development of communication and professional values competencies.

Approach/Methods: We conducted a qualitative study of 3 emergency medicine residency training programs (University of Michigan, Emory, and University of Chicago). Interviews were from May to December 2016. Residents across all post-graduate training years were eligible. We elicited resident experiences related to working at the different clinical sites (which include direct patient care/observed interactions). We used semi-structured interview guide to explore topics related to: cultural identity, frustrating patient care experiences, strategies for identifying and caring for vulnerable populations, and the residents’ understanding of and application of health disparities/social determinants of health knowledge in daily practice. Residents were also asked about cultural competency knowledge development, as well as suggestions for improvement in their current curriculum and ways to assess their interpersonal communication competencies.

Residents interviews were via phone, audio taped, transcribed, de-identified and analyzed using systematic and iterative coding methods. Interviews continued until thematic saturation.

Results/Outcomes: Our study included 21 residents (10-UM, 6-UofC, 5-Emory). Residents discussed difficult patient care experiences and attributed the interpersonal communication conflicts to underlying differences in perceived personal values (i.e., religion, appropriate use of ED, etc.), lack of trust in provider due to cultural differences, poor health literacy, lack of ability to address non-medical barriers (i.e., financial, social), and lack of adequate time to devote to patient’s social/educational needs in the ED setting.

Residents shared how their interpersonal communication skills were shaped primarily though informal observation of senior residents or faculty behaviors and recalled minimal substantive cultural competency curriculum during residency training. Suggested areas of improvement included greater emphasis on accommodating gender identity preferences, religious beliefs relevant to the local population, and greater awareness of non-medical resources.

Discussion: Our findings contextualize the complex challenges EM trainees face as they attempt to adapt to the diverse needs of their patients, highlight gaps in current curricular content, and provide suggestions for reaching communication and professional values milestones.

Significance: Our study challenges the predominant clinical residency training practices, which expect trainees to develop interpersonal communication and professional values indirectly without deliberate guidance or integrated curricula. Enhancing residents’ ability to navigate interactions with patients from varied socio-cultural backgrounds coupled with knowledge of health disparities has tremendous potential to improve their ability to address barriers to health care, and improve delivery of care to diverse populations.


Level of Audience: Mid-career

Focus of Presentation: GME