Change processes to transform health professions education
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Data driven support of change management
Outils de soutien aux processus de gestion du changement fondés sur les données
AJ Kleinheksel

Background: Within the steady stream of innovations and reforms to medical education curriculum lies the commonality of change management. Change management is a complex, multifactorial construct that can either ensure the success or prevent the adoption of an innovation. Furthermore, change management is a process rather than an event. As such, it is critical to integrate longitudinal, systematic evaluation and organizational support into the implementation strategy for any innovation.

Purpose: The purpose of this innovation was to support the implementation of a curriculum redesign at the Medical College of Georgia (MCG). This rigorous study used a validated framework, the Concerns-Based Adoption Model (CBAM), to measure the change management process. The purpose of this study was to both document and disseminate benchmarks and developments for other medical colleges embarking on curriculum reform, but, more importantly, to use the data collected during the study to support and refine the change management process at MCG.

Results: Two years of data have been collected in each of the diagnostic dimensions, and the results have been reported to stakeholders at MCG. As a result, changes have been made to the implementation process.

References
11:30 am EDT

Time to move from “push” to “pull”: a collaborative process for implementing movement behaviour curricula in undergraduate medical education

Lorsque « pousser » ne marche pas, on « tirer »: Un processus de collaboration pour la mise en œuvre d’un cursus sur le comportement lié à l’exercice dans la formation médicale de premier cycle

Tami Morgan

Years of research and several “calls to action” have pushed for medical schools to include physical activity in their already overextended curricula. These efforts have recommended physical activity content and objectives, yet have often neither considered medical education stakeholders’ views nor the full complexity of the medical school context, such as competency-based learning.

With this external “push” for curriculum change, few medical schools have sustainably or sufficiently implemented physical activity in their curriculum. Furthermore, with Canada’s new 24-Hour Movement Guidelines, which have replaced Canada’s Physical Activity Guidelines, the focus is now on integrated movement behaviours across a continuum, from physical activity to sedentary behaviour to sleep. Thus, curriculum change efforts centering on physical activity alone are no longer adequate. This presents an opportunity to think differently about curriculum renewal. For instance, new content on physical activity, sedentary behaviour, and sleep may be incorporated into the medical curriculum in an integrated manner.

Our research argues for a “pull” model of curriculum change by using an integrated knowledge translation (iKT) approach. Medical education stakeholders become equal collaborators who help guide more successful curriculum implementation, leading to more relevant, feasible, and sustainable changes. To illustrate our approach, we will present our findings from a two-phased environmental scan of 24-Hour Movement Guideline content in the Queen’s University School of Medicine’s undergraduate curriculum and an iKT curriculum map highlighting where new, competency-based content may be embedded that acknowledges the complexity of the medical education context. Emphasis will be placed on the iKT process used.

12:00 pm EDT

Change processes to transform health professions education

Processus de changement orientés vers la transformation de l’enseignement des professions de la santé

Emily Scanlan, Angela Bergene

Faculty at academic medical centers have long been accustomed to competing demands on their time, leading to high work stress, burnout, and limited capacity to meaningfully engage in education-related competencies. In 2019, COVID-19 emerged and demanded an emergency response from educators to rapidly transition their classroom teaching to an online format. In support of faculty who were affected by the pandemic, we created just-in-time faculty development resources for best practices on teaching and implementing active learning strategies virtually.

For this session, we will share strategies to support faculty who transitioned their curriculum to an online format during the pandemic. It is designed to be engaging and relevant for conference attendees by incorporating the following elements:

1. Describe common challenges to faculty who have competing demands
2. List a variety of educational technologies that stimulate active learner engagement for faculty to incorporate while teaching online.
3. Describe next steps for transitioning out of an emergency teaching response to more proactive teaching in an online environment
4. Large group sharing of how attendees’ academic medical centers are approaching virtual teaching and addressing challenges associated with it.

We referenced our needs assessment data to help with the creation of quick reference guides, and short videos for faculty to reference. Our needs assessment told us faculty would like to learn more about:

- Instructional design components (61%)
- Development of online education materials (61%)
- Clinical teaching and assessment strategies (45%)
- Self-service tools and periodic consultation to help with creation of instructional modules (31%)
How do medical educators rate content when selecting for courses: a scoping review

Comment les éducateurs médicaux évaluent-ils le contenu à intégrer dans leurs cours : un examen de la portée

Marcel F. D’Eon,1 June Harris,2 Claire Wright,2,4 Greg Malin,2 Paulette D’Eon,1 Harold Bull,1 Kyle Anderson,1 Damon Sakai,4 Kalyani Premkumar,3 Trustin Domes,2 Erin Watson1

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5University of Saskatchewan, Saskatoon, SK.

Background: Medical educators have published hundreds of articles reporting multiple different ways to rate content for courses. We sought to capture and analyze those varied approaches.

Methods: We searched databases for articles about rating content in medical education. From over 9000 articles, we included 134 to extract data. Two authors screened each title and abstract and then two different authors screened the full text. Two authors also extracted data from each article. MD and PD resolved conflicts. Small groups of authors analyzed groupings of related data.

Results: The articles we reviewed undertook the process of rating content to provide clear direction (116 articles), rectify deficits in training (48 articles), address poor learning outcomes (38), and to meet societal needs (32) among other reasons. Researchers collected data using a Delta or similar method (80 articles), a one-time survey (39), and others. They used many different criteria such as importance (32 articles), relevant (11), and essential (6). In only 36 studies researchers provided a rationale for the selection of criteria. Most studies used a range or scale (95 articles), a dichotomous scale (14), and interviews of various kinds (16). For judges, most researchers chose physicians (87 articles), then trainees (46), and other health care professions (24).

Conclusions: This area of activity is underdeveloped. Researchers provided few if any rationales for any of the study components or processes they chose. Furthermore, we found little evidence to support any design decision. Future studies need to focus on the strengthening the process such as comparing physicians to trainees, important to relevant, and Delphi to one-time surveys.

1:30 pm EDT
You don’t need to be an English teacher: transforming writing instruction in health professions programs
On n’a pas besoin d’être professeur d’anglais : Changer la façon d’enseigner la rédaction dans les programmes de formation des professions de la santé

Michael Madson

Background: Writing is an important skill in health professions education. Students need to write to complete academic requirements, develop professional competencies and attitudes, and do the work of health care and health promotion. Accordingly, numerous resources on writing, including textbooks, have been developed to support health professions students. But there are far fewer resources available for health professions faculty who, in many programs, find themselves teaching or at least assessing writing.

Some faculty members teach writing with considerable skill and effectiveness. Yet, many have had little experience or training in writing instruction, and they consider it an afterthought or an unwelcome challenge. A common concern is the time needed to teach writing. It is no surprise, then, that faculty development needs assessments in the health professions have repeatedly stressed training in writing and teaching.

Methods: This twitter thread will suggest change processes, aligned with the McKinsey 7-S model that can help health professions faculty “level up” their skills in writing instruction, even in an overcrowded curriculum. The thread will include links to relevant scholarship in “writing across the curriculum,” “writing in the disciplines,” as well as medicine, nursing, pharmacy, and public health, which have their own bodies of scholarship on teaching writing. Share models of institutional collaboration with English departments and writing centers, and list practical resources on teaching writing. It will also briefly highlight a forthcoming edited collection, Teaching writing in the health professions (Routledge, 2022), which will provide additional resources for driving curricular change in writing instruction.

References

2:00 pm EDT
Universal design for learning in health professions education and patient care
Conception universelle pour l’apprentissage dans l’enseignement des professions de la santé et les soins aux patients

Larry Hubertise

Universal Design for Learning (UDL) is a set of principles, for designing instruction that seeks to provide all learners equal opportunities, regardless of (dis)ability, gender, age, or cultural background. While many schools have instituted inclusive practices in admissions, there is a dearth of experience among clinician educators about UDL.
The session will follow the #hmichat tweet chat design process (used by @erhall1, @KreuterMD, and @teresasoro). Participants will be guided to 1) develop a common understanding of UDL, 2) tie the principles to previous learning, 3) analyze UDL practices, 4) apply them to their context, and 5) develop next steps for applying UDL. To facilitate the discussion, the 2021 article, Twelve tips for designing an inclusive curriculum in medical education using Universal Design for Learning (UDL) principles 1 will be shared with the participants and the author @karl_luke will be invited to join the discussion. The session will begin by inviting participants to share their experiences with UDL as a concept and the specific 12 tips. Next the participants will explore how the UDL strategies benefit learners and patients and wrap up sharing plans for implementing UDL in their context. The facilitator will share additional resources about effective teaching strategies that align with UDL principles. In addition to the content, participants will be encouraged to employ effective tweet chat strategies like using hashtags, including the number of the question to which they are responding, and using a “yes and” approach to encourage interaction through reminder tweets and facilitator modeling.

References

2:30 pm EDT
How to rate content: which criteria are the best?
Comment les enseignants en médecine évaluent-ils le contenu à intégrer dans leurs cours: un examen de la portée
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This study falls within the conceptualization of curriculum derived from outcomes1,2 which implies the importance of content. Few authors provide any direction for this complex activity. Blight3 described several methods but did not include one of the most widely used: a panel of expert judges.

We wanted to find evidence to support the use of certain criteria when asking judges. We developed then pilot tested our instrument that asked participants to select the most appropriate criterion (and to explain why). We then revised our survey. Participants selected one of four criteria applied to four likely medical school objectives. The four criteria contained either the verb “improves” or “contributes to” and the object “patient care” or “general medical practice.” One criterion was “contributes to general medical practice”. Each of us authors analyzed the text responses. We tallied then analyzed the 2x2 matrix of responses for any significant differences using a Chi square calculation.

Our 30 participants selected the criterion “improves patient care” 52 times, almost twice as often as each of the other three criteria. They selected “contributes to medical practice” only 19 times, the least often. There was no statistically significant difference among any of the choices. In the text responses, we found participants had different interpretations of the criteria.

Further research should involve larger sample sizes, different criteria, participants from different groups of potential judges, and an explanation of each criterion. There is much work remaining to develop an evidence informed approach to rating course content for medical schools.

References