



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
School of Medicine

Office of Curriculum

Forás I Educational Summit

March 26-27, 2009

Executive Summary

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Executive Summary

The Forás I Educational Summit was held in Lubbock on March 26-27, 2009, hard on the heels of a site visit from the Liaison Committee for Medical Education in early March. Although the final report from the LCME visit has not yet been received by the School of Medicine, the indications from the exit interviews with the site visitors were that the educational program would not be cited with any major findings. Thus, the focus of the Forás I summit was on the future evolution or development of the educational programs of the SoM. One hundred and twenty faculty, students and administrators registered for the summit with over 100 attendees on the first day. Attendance was slightly lower on day two due an impending winter storm and the afternoon session on day 2 was cancelled due to weather concerns. Nevertheless, the attendees made significant progress on issues ranging from student assessment to faculty mentoring and from curricular content to educational technology.

Most of the work of the summit was performed in two sets of breakout groups and reports from most of these groups are presented in this document. Some of the major issues that were addressed are listed below along with recommendations from the groups. Progress that has been made in the interim is included, where appropriate.

Student Grading and Assessment

- A Grading Task Force should be established to examine the statistical basis for determining grades in blocks in Years 1 and 2. This Task Force began meeting in July 2009
- The Integration Seminar for MSIII students should be a graded activity using a Pass/Fail grading system
- Clinical encounter cards could be used to improve formative feedback for students in MSIII clerkships. These cards would provide regular and immediate feedback for students and increase the volume of written comments to use in determining final grades in the clerkships. A Pilot study employing these cards in Lubbock clerkships and Obstetrics & Gynecology clerkships across campuses will be performed between July and December 2009.
- Despite vigorous discussion of alternative scoring methods for assigning grades in Clerkship NBME exams, no consensus was reached either in the morning or afternoon sessions about the best way to do this. A detailed analysis of scoring trends over the past 5-6 years is underway at the time of writing and these data will be evaluated to ensure that future decisions about the incorporation of NBME grades into final clerkship grades are based on accurate data analysis.
- An extensive review of clerkship OSCE programs revealed that there may be differences between campuses in areas such as standardized patient training, total number of cases and methods for design of cases. An OSCE Task Force has been established by the Clinical Education Operations Committee to evaluate all OSCE programs and to make recommendations to ensure comparability across all campuses.

- The Continuity Clinic group strongly recommended continuation of this experience but noted the need for financial support for faculty and administrators, and for continued support from clerkship directors, department chairs and faculty
- The Year 4 group recommended restoring the Ambulatory Selective to 4 weeks, protecting elective time, ensuring that all departments offering Year 4 experiences employ a common core manual format and improving methods for tracking students in Year 4. A Year 4 Task Force should be established to further evaluate the need for and possible design of a capstone experience and the group also recommended the introduction of a system for preparing students for residency interviews. The Year 4 evaluation system was reviewed and possible changes noted and the geriatrics subgroup carefully evaluated comparability in the Geriatrics Rotation on all campuses.
- Each clerkship group evaluated current levels of cross-campus comparability and considered recommendations from the earlier sessions. Some common topics that need addressing include the current professionalism form (this will not be used for 2009-2010 as the SoM pilot tests new forms designed in collaboration with the NBME), improved implementation of technology (e.g. OPLOG, online case presentations) and the use of additional “active learning” teaching methods.
- This last topic was also addressed by a separate afternoon group which reviewed available technologies that enhance learning. This group highlighted the extensive available technologies, many of which are underutilized and the need to balance active learning experiences with traditional lectures. The need to take advantage of expertise in the library was also highlighted.
- The Vision and Dream group recommended the establishment of a Task Force to investigate further development of the Year 3 curriculum, which would address issues such as the need for additional exposure to specialty areas, particularly in Surgery and Internal Medicine. The group made several additional recommendations, including innovative experiences for student preparation immediately prior to Year 3 and for research experiences.

The ideas and issues raised here and in the succeeding documents will be addressed at a variety of venues within the SoM, including standing committees and ad hoc task forces, over the next year and will be revisited at subsequent summits, where successes and remaining challenges will be evaluated. I would welcome any feedback from interested faculty students and staff, either directly to the email address on the front of this report or via any of the committees charged with managing the curriculum of the SoM. Thank you for your interest and commitment and I look forward to working together to promote excellence in the educational program of the School of Medicine.

Breakout Groups Session I

- Group 1: Year 1 and 2
Group Leaders: Vaughan Lee and Art Freeman
- Group 1A: Integration Seminar
Group Leaders: Kendra Rumbaugh and Patricia Aristimuno
- Group 2: Clinical Evaluation Procedures
Group Leaders: Robert Casanova and Angelica Chavez
- Group 3: Standardized Examinations: NBME and beyond
Group Leaders: JoAnn Larsen and Charmaine Martin
- Group 4: Observed Structured Clinical Examinations
Group Leaders: Fiona Prabhu and Dinorah Nutis
- Group 5: Continuity Clinic
Group Leaders: Betsy Jones and Steve Urban
- Group 6: Year 4 Curriculum
Group Leaders: Pete Davis and John Marchbanks

Group 1: Years 1 and 2

Group Leaders: Vaughan Lee and Art Freeman

Group Members: Ballew, Barbara; Brown, Candace; Callaway, Michael; Casey, Lindsey; Colmer-Hamood, Jane; Dickerson, Richard; Fowler, John; Hutson, Jim; Lombardini, Barry; Lutherer, Lorenz; Orr, Judith; Patterson, Patti; Peck, Kim; Straus, David; Webster, Dan; Wood, Richard.

Overview of task: This group considered three issues regarding the Year 1 and 2 curriculum.

- A. Grading Comparability among Blocks: What methods are currently used, are they statistically sound, and are they relatively comparable between Blocks with no unintended bias.
- B. Narrative Evaluations: How are narrative evaluations currently used in the curriculum, in which components are they appropriate, and should we expand their use further?
- C. Development of Electives: What electives currently exist in the first two years, how are they managed and is there a need for more.

Summary of discussion

A. Grading Comparability among Blocks:

Michael Callaway presented an evaluation of a sampling of grades from Year 1 Block 1 2008 (appendix 1). In his comparison, the Grade 1 column is the grades as calculated by the Block, and RO1 is a simple rank order based on Grade 1. The Grade 2 column is a recalculation with all tests standardized to a mean of 83 and a standard deviation of 8 before application of percentage weights. RO2 is a simple rank order based on Grade 2. Comparing RO1 and RO2 showed the impact on classification of students. Descriptive statistics were presented along with reliability data and 95% CI for Grade 2. Ten percent of the students might be classified differently using the Grade 2 instead of Grade 1 calculation methods. All tests are acceptably or nearly acceptably reliable ($\geq .70$). Intercorrelations between tests are moderate, which is desirable. Size of 95% CI is ± 5 and range is 33, suggesting you may define at least three distinct levels of performance (3 grade categories are obvious and not hard to imagine you could defend 5 grade categories). In summary, the current method is good, but the Grade 2 method (adjusting SD and avg.) may be more appropriate statistically.

Discussion focused on the subtle differences among Blocks relative to calculation of the final grade. Although most Blocks end with an average around 83 (appendix 2), the methods differ because each Block has unique components including number of written exams, practical exams, quizzes, assignments, small groups, type of final exams, etc. The two ECE Blocks are most different with more subjective components of evaluation as compared to the other Blocks, which have a majority of the grade coming from multiple-choice exams. The students are not necessarily interested in the minor statistical variations of calculating final grades, but more concerned with the overall makeup of what determines their final grade. In conclusion, it is not realistic to develop one magic formula that will fit all Blocks. It may be more appropriate to seek a common philosophy and some guidelines to document comparability among the Blocks.

The group was in agreement that Block Directors should maintain some freedom in determining final grades in order to accommodate unexpected factors that may occur from year to year such as different lecturers, variation in difficulty of exams, technical experiences during exam administration, etc.

Adjustment of individual exam grades with respect to “bad questions” is the area that had the most variation. Here we define a “bad question” as one that for some reason (poorly written, poorly taught, etc.) has an undesirable discrimination value and is discarded from the exam grade calculation. Some recalculate grades based on fewer questions; some give everyone extra points, while others give only those who missed it credit. This area needs further research and discussion to appropriately address.

B. Narrative Evaluations:

The group discussed the current use of narrative evaluations for student assessment in MS1 and MS2 Blocks and the feasibility of including such evaluations in other Blocks. Narrative evaluations are currently used only in ECE I and ECE II. These Blocks have appropriate settings for this as the ECE Block structure includes regularly scheduled required small group sessions, one-on-one faculty-student interactions as well as OSCEs where patient interaction skills may be assessed. Thus, by design, each student will have repeated interactions with individual faculty from which narrative evaluations can be generated. Narratives were considered to be valuable components of student assessment and should continue to be used in ECE. Other Blocks are not amenable to this form of student assessment. The group did not see this as a deficit but as a reflection of the modes of instruction (involving large volumes of material) in basic science Blocks and a team-taught nature with revolving exposure to different instructors.

Meaningful narratives that include assessment of academic performance and professional behavior must derive from repeated interactions of a faculty member with the same student. This does not occur unless a Block is structured to ensure that it does as in ECE I and II. Due to inherent Block design or faculty resources within a Block, many Blocks do not have small group sessions that require attendance, participation, or other mechanisms through which it can be assured that every student can be fairly, if at all, evaluated by faculty in a narrative fashion. The group agreed that it is not realistic to propose that all Blocks be required to perform narrative evaluations.

Medical students may participate in formal research experiences or clinical preceptorships. By their nature, these activities involve frequent contact with a mentor. From these interactions, the mentor could clearly acquire sufficient information to write a meaningful narrative evaluation. The group suggested that students be encouraged to obtain a narrative evaluation for such research activities and clinical preceptorships.

C. Development of Electives:

Perhaps not widely known to all faculty, there are opportunities for MS1 and MS2 students to take electives in addition to the various specialty medical clubs. Currently, there are two Pass/Fail elective courses, *Surgical Anatomy* and *Medicine in Film*. There was general discussion of the idea of developing additional electives although no direct recommendation was made. In addition, several MS1/MS2 students are enrolled annually in the M.D./MBA program. Although not electives *per se*, the MBA courses present added responsibility that demands allocation of a certain amount of time by these medical students in the joint degree program.

The group discussed whether all students should continue to be eligible for taking elective courses and whether academic standing should affect participation. The group was concerned that there be qualifying criteria based on academic standing for 1) acceptance into an elective and for 2) continuing participation in an elective. Many of us have concluded that extracurricular activities can negatively impact student performance even when the student is late to consider this. The same consideration may apply with respect to electives. The group did not formally take up the question of whether

continuing enrollment in the MBA program should be dependent on a certain level of performance in the medical curriculum as this seemed outside the charge of the group.

There does not appear to be a pressing need for introduction of additional electives. Proposals for new electives can be evaluated on a case by case basis with the caution that students already have high demands on their time from the curriculum.

Recommendations

- A. Grading Comparability among Blocks: EOC should form a taskforce consisting of Year 1&2 Block Directors to further evaluate the options of different methods of final grade determination, the practice of addressing “bad questions” on exams, and maintaining Block Directors’ discretion in final grading decisions.
- B. Narrative Evaluations: The group suggested that students be encouraged to obtain narrative evaluations from their mentors for such things as their research activities and clinical preceptorships.
- C. Development of Electives: The group recommended that acceptance into and continued participation in electives have qualifying criteria based on academic standing.

Next steps

- A. Grading Comparability among Blocks: Grading Task Force proposal approved in EOC on April 1, 2009 (appendix 3). This Task Force will begin monthly meetings on June 17, 2009 to address these grading concerns.
- B. Narrative Evaluations: Recommendation should be forwarded to the Office of Student Affairs.
- C. Development of Electives: Recommendation should be forwarded to the Educational Policy Committee.

Group 1A: Integration Seminar

Group Members: Aristimuno, Patricia; Baldwin, David; Eichbaum, Quentin; Rumbaugh, Kendra

Overview of task

We were tasked with deciding on ways to standardize the Integration Seminar Series (ISS) at each campus.

Summary of discussion

The directors from the ISS who were present compared notes and noticed there were considerable differences in how the Integration seminars (IS) are being conducted. Lubbock emphasizes basic science, while El Paso emphasizes clinical reasoning and integrates basic science into the clinical picture. This design fits their new medical school curriculum. Permian Basin was only in the planning stages for their first IS. We discussed the need to standardize the format and evaluation of the seminar.

Recommendations

We agreed that the structure of the ISS should follow the 'El Paso Model'. Therefore the directors should meet at least twice with the students in each group- once to decide how the case will be presented, and one to 'practice' the complete seminar with the students. The students will also be directed to practice on their own, prior to the practice with the director. We agreed that this design should create a more worthwhile presentation for the faculty. We also agreed on the following:

1. The ISS will be evaluated as Pass/Fail. This grade will be assigned to the entire group presenting. If the group fails, they must repeat the ISS on another case. An evaluation sheet will be distributed to the students and faculty in attendance, which will provide the students with feedback and aid the directors in assigning a grade.
2. The selection of cases from the NEJM will rotate between campuses on an annual basis. Lubbock chose 2008/2009 cases, El Paso will choose 2009/2010, Amarillo 2010/2011, and Permian Basin 2011/2012.
3. There will be compulsory attendance for all MSIIIs and MSIVs (on campus). A sign in sheet will be available at each IS.
4. Based on the success of the El Paso campus, we recommend all campuses try to schedule their ISS for noon and provide lunch to attendees.

Next steps

We will finalize an evaluation sheet and prepare a proposal for the CEOC outlining the format and evaluation of ISS so that these changes can be implemented in Fall 2009.

Group 2: Clinical Evaluation Procedures

Group Leaders: Robert Casanova and Angelica Chavez

Group Members: Aranda, Rebecca; Bowles, Timothy; Dalley, Bernell; Dela Rosa, Manuel; Haynes, Allan; Henderson, Ashley; Kruse, Dawn; Lummus, Janet; McGovern, Thomas; Moreno, Daniel; Peiris, Vasum; Sheehan, Marita; Simpson, Jordan; Sims, Colleen; Sponcel, Charles; Warren, Thomas; Young, Rodney.

Overview of tasks

1. Student Assessment – Procedures for use of Clinical Assessment Form
2. Formative versus Summative experience
3. Regularity of assessment
4. Evaluate criteria for honors

Summary of Discussion

Assessing Medical Students – Assessment Drives Learning

Our main discussion centered on the theme of formative versus summative assessments. Several articles were discussed in detail. Summaries of the articles are included at the end of this report.

1. In essence we felt that the clinical assessment form was time-consuming and provided very little formative feedback. Furthermore its structure was such that evaluators were hesitant to assign the highest rating because of the terms such as “far exceeds expectations” and the rather wordy descriptors such as “consistently mentions seven components of symptoms and pertinent review of systems without prompting.” Most group members felt that this was not applicable to most of the observed activities. It was strongly felt that a more general descriptor and different subject headings would provide more versatility in the form. Ultimately, based on one of the articles reviewed we strongly felt that a clinical encounter card could be substituted for the first six dimensions on the form.

2. Formative versus summative assessment was further discussed and it was decided that most of our feedback consisted of summative assessments. It was overwhelmingly felt that formative feedback would be more beneficial to the students’ growth and maturation and again it was felt that this could be accomplished with the use of the clinical encounter card. Additionally, a self-reflectance component would be added to the clinical encounter card. For example, after observation of a procedure or history and physical, the student would be asked to rate his/her performance. Then the observer would complete his/her assessment and discuss any discrepancies. The assessment would always end with a plan of action for improvement of the student’s performance.

3. Regularity of assessment was subsequently addressed. It was strongly felt that a four-week mid-rotation sit-down evaluation with the clerkship director was imperative. But we also felt that ongoing real time assessments should be implemented. Again, it was felt that this could be accomplished with the clinical encounter card used on a regular (weekly?) basis.

4. Finally, our discussion turned to the criteria for honors. There was a consensus that sub honors four-week mid rotation grades followed by marked improvement and achievement of honors on the final evaluation should stand as criterion for honoring the course.

Recommendations

Our suggestion was to have each department investigate the use of formative assessment and to consider the use of the clinical encounter card. This recommendation appeared to be well received. We further suggested that the subject headings and descriptors of the present evaluation cards be reviewed and possibly revised to fit the needs of each department with consideration given to incorporating frequent assessments using the encounter cards.

References

1. **Epstein, R. M.** 2007. Assessment in medical education. N Engl J Med **356**:387-96.
2. **Farmer, E. A., and G. Page.** 2005. A practical guide to assessing clinical decision-making skills using the key features approach. Med Educ **39**:1188-94.
3. **Greenberg, L. W.** 2004. Medical students' perceptions of feedback in a busy ambulatory setting: a descriptive study using a clinical encounter card. South Med J **97**:1174-8.
4. **Norcini, J., and V. Burch.** 2007. Workplace-based assessment as an educational tool: AMEE Guide No. 31. Med Teach **29**:855-71.

A synopsis of the articles follows.

	Formative vs.	Summative Assessments
Purpose	Feedback for Learning	Certification or Grading
Breadth of Scope	Narrow Focus/Specific Objective	Broad Focus /General Objectives
Scoring	Explicit Feedback	Overall Performance
Learner Affective Response	Little Anxiety	Mod to High Anxiety
Target Audience	Learner	Society

The purpose of formative assessment feedback:

designed to be an ongoing part of the instructional process and to support and enhance learning
 feedback promotes student learning in three ways

1. it informs trainees of their progress or lack thereof
2. it advises trainees regarding observed learning needs and resources available to facilitate learning
3. it motivates trainees to engage in appropriate learning activities

Formative assessment methods

1. mini clinical evaluation exercise (mini-CEX)
2. clinical encounter cards (article attached)
3. clinical work sampling
4. blended patient encounters
5. direct observation of procedural skills
6. case-based discussions
7. multisource feedback 360

Quality of feedback:

61% of feedback sessions included a response from the trainee to the feedback
 only 34% elicited any form of self-evaluation by the training
 only 8% of mini-CEX encounters translated into a plan of action

Nature of the feedback:

conceptualized as information provided by an agent regarding aspects of one’s performance or understanding

information can be used by the learner to confirm, add to, overwrite, tune or restructure information in memory, whether that information is domain knowledge, meta-cognitive knowledge, belief about self and tasks or cognitive tactics and strategies (Winnie & Butler 1994)

Perspective of the learner

Three fundamental questions for the learner

1. Where am I going?
Clearly defined goals
2. How am I going?
Provision of concrete information derived from an assessment of the performance of the task or goal.
Clear indications of whether the task has been completed properly
3. Where to next?
What actions need to be taken in order to close the gap between actual performance and desired performance i.e. the action plan

Focus on feedback

1. Feedback about the task
The easiest and most frequently provided. Quality of the task performed. Concentrates in the performance rather than the knowledge required for the task
2. Feedback about the process of the task
Enhances an understanding of the relationships, cognitive processes and transfer to different or novel situations. More likely to promote deep learning. Strategies for error detection and correction. A cueing mechanism leading to more effective information search strategies. Cueing is most useful when it assists trainees in attacking faulty hypocrisies and provides direction for further searching and strategizing
3. Feedback about self-regulation
Interplay between commitment, control and confidence. Concentrates on the way trainees monitor, direct, and regulate their actions relative to the learning goal. Effective learners are able to generate internal feedback and cognitive routines while engaged in the task
4. Feedback about the self as a person
Students who are able to self appraise and self manage are able to seek and receive feedback from others.

Adverse Feedback:

Feedback that is typically concentrated on personal attributes of the trainee and seldom contains task related information, strategies to improve commitment to the test, or better understanding of the self or the task itself. This focus for feedback is generally not effective, its impact is predictable and it can have an adverse affect on learning. Particularly true of negative feedback directed at a personal level

Effective feedback in the context of formative assessment:

1. integral to the learning process
2. criteria are clearly articulated
3. feedback is provided immediately after the assessment event
4. trainees engage in multiple assessment opportunities
5. trainee ownership of feedback

Strategies:

1. encouraging trainees to engage in a process of self assessment prior to receiving external feedback
2. permitting trainees to respond to feedback
3. ensuring that feedback translates into a plan of action for the training

Group 3: Standardized Examinations: NBME and Beyond

Group Leaders: JoAnn Larsen and Charmaine Martin

Group Members: Blunk, Dan; Dove, Dennis; FitzSimon, Denise; Halldorsson, Ari; Johnson, Adam; Kakarala, Bharat; Kirkland, Jerry; Lyn, Heidi; McCurdy, Fred; Nuwayhid, Bahij; Robinson, Valerie; Schneider, Brandt; Tenner, Tom; Van Husen, Russell; Varma, Surendra; Wagner, Elizabeth.

Overview of tasks

- a. Review National Data for each clerkship
 - i. We reviewed how to interpret the scoring for the NBME
- b. Evaluate TTUHSC year to year summary data 2008 – 2009
 - i. Each represented clerkship reviewed their data
- c. Evaluate $\geq 75\%$ Honors and $\leq 4\%$ Fail policy
 - i. See discussion
 - ii. Consideration of the quartile scores rather than whole year score to determine honors/fail

Summary of Discussion

- a. There were many views regarding the grading. The group agreed that performing well on these tests is at of the top the student agenda. The group wanted to be sure the clerkships encompassed balance between teaching the art of medicine and medical knowledge. Part of the group wanted to reward those students who came very close to achieving honors (those off by 1 or 2 percentile points) and have those scoring in the barely passing percentile to have more motivation to increase their scores. Other group members felt that we should keep the grading as it is, as everyone is not meant to make honors.
- b. The group discussed possible ways to help with improving NBME scores.
 - i. All clerkship directors have access to look at NBME tests in their area
 - ii. Faculty and residents should regularly review the questions and incorporate them into their lectures.
 - iii. Use of more interactive learning, using an audience response system in the lectures.
 - iv. Assignment and review of NBME type questions

Recommendations:

- a. The group had many differing opinions (from students and faculty). Here is a summary of those opinions.
 - i. 5 category grading system for Year 3
 - ii. Narrow percentile range for passing NBME
 - iii. Lower percentile for Honors
 - iv. Give Clerkship Director the discretion in awarding Honors to students who honored all other components but missed NBME honors by 1 or 2 percentile points.
 - v. Using yearly quarter percentiles for NBME scores

Next steps

- a. Unfortunately, we could not arrive to a consensus as this is a very controversial topic.
- b. If we are to change the grading system to one of the options listed above, this needs to be agreed upon and voted on by the entire group.
- c. Development of a task force of students and faculty to agree upon future implementation of these recommendations
- d. Implementation of an NBME Improvement plan as discussed under item b in the summary above.

Group 4: Observed Clinical Structured Examinations

Group Leaders: Fiona Prabhu and Dinorah Nutis

Group Members: Baker, Teresa; Beale, Peter; Bristo, Sherrie; Caples, Stephanie; Carty, Rhonda; Hermosillo, Crystal; Kelly, Randall; Lampe, Rick; Logvinoff, Martine; McLean, Susan; Naqvi, Mubariz; Neilson, Robert; Pick, Jennifer; Schaef, Julie; Subia, Aurora.

Overview of Task

- Discuss goals and objectives of current clerkship OSCEs and the campus-wide OSCE
- Review the various types of OSCEs performed at TTUHSC SoM
- Review skill sets tested by the OSCE
- Assess comparability of evaluation
- Describe the use of data generated by the OSCE
- Assess technical support needs to administer OSCEs

Summary of Discussion

Goals and objectives of clerkship OSCEs

- Current goals and objectives are centered on testing skills learned in the clerkship itself; the group consensus was that it should continue this way
 - Skills:
 - focused history and physical exam
 - development of differential diagnosis
 - interpretation of common diagnostic tests (x-ray, ECG)
 - evidence-based medicine search/application to problem

Goals and objectives of campus-wide OSCE

- Current goals and objectives are not clear; group consensus was that we should use the campus-wide OSCE to assess global skills acquisition across the third year; need to work on better defining the skills that we expect an MSIII to have by the end of the third year.
 - Skills
 - Advanced communication
 - Breaking bad news
 - Dealing with the challenging patient – angry, non-talker, too much talker, multiple people in room
 - Screening for difficult social issues (child abuse, intimate partner violence)
 - Focused history, physical exam, and differential diagnosis related to common complaints that all clerkship directors need to agree that students should be able to do by end of MSIII year
 - Chest pain
 - Shortness of breath
 - Abdominal pain

Types and Number of OSCEs

- Much discussion centered on the types of OSCEs performed in the varying clerkships
 - Standardized patient
 - Paper-based case
 - Telephone-based case

- Cases have been written by the clerkship directors/faculty within a clerkship and disseminated across campuses; no testing of validity/reliability has been done on any case
- Standardized patients are obtained mostly from office staff and trained by the clerkship director; there is no common way in which standardized patients are trained; there is no manual; group discussion found that there are a lot of things they found in common when training standardized patients that they learned by trial and error – creation of a training manual could help reduce these problems in the future
- Most clerkships have a faculty observer of the student during OSCE vs. evaluation by standardized patient alone; some of these faculty observers are senior residents; orientation of faculty observers is done by the clerkship director
- Number of OSCE stations vary across clerkships but are consistent within a clerkship
 - Family Medicine – two stations
 - Internal Medicine – five stations – including an EBM search and EKG, X-ray interpretation station
 - Obstetrics/Gynecology
 - Pediatrics
 - Psychiatry – 1 station
 - Surgery – 5 stations – mostly standardized patients drawn from office staff

Comparability of Evaluation

Need better standardization across clerkships

- What students need to expect when they walk into an OSCE – format varies among clerkships and among campuses;
 - e.g. actual length of time in the room; actual length of time to write a note; actual length of time for feedback,
 - e.g. where we select our standardized patients – many are from existing office staff and students are unsure of how much of the physical exam they can perform
 - e.g. in pediatrics, the standardized patient is a child but is often “played” by an adult –
- Common tools to assess communication skills, history-taking, physical exam
 - current tool being used in the 2008-2009 campus-wide OSCE where standardized patients evaluate students communication skills was circulated to group with consensus that they need to start using this or something similar
 - faculty observers do not have common checklists or well-defined items to assess
 - Need agreement on which elements of the history to assess consistently across clerkships (e.g. chief complaint, history of present illness, medical history elements, family history, social history, review of systems)
 - Need agreement on which elements within a regional physical exam to consistently emphasize across clerkships and to disseminate this across clerkships and campuses

Grading of OSCEs

- Pass/fail
 - Determination of how to derive this consistently
 - 70% of all items = pass
 - 1 Standard deviation above the mean = pass
 - Total number of stations passed vs. total number of items on each station combined at the end
 - Some clerkships only have 1 OSCE station and others have up to 5 OSCE stations

- Better information needs to be reported back to the student so that they know which areas to work on
 - Discussed coding checklists with specific skills
 - Discussed need for more detailed, behavior specific feedback = training of standardized patients and faculty observers on how to do this better

Technical Support

- Lap-top computers for standardized patients, faculty observers, and students
 - Computer-based evaluation so that data can be more easily collected and analyzed
 - Computer-based note writing so that students can be prepared for Step 2 CS and faculty can better assess the note
- Video recording
 - Use of video tapes for student self-review, for inclusion in a student portfolio
 - Use of video tapes to re-evaluate a student if there is no faculty observer in the event of a dispute between the student and standardized patient
- Faculty
 - Need protected time to work on issues of comparability and evaluation

Recommendations

- Evaluate the currently written cases and develop a method to assess their validity and reliability
- Develop a pool of standardized patients
 - Create a standardized patient training manual to improve consistency of training
 - Better define which roles these standardized patients can play
- Determine items that should be assessed across all clerkships regardless of clerkship content
- Review assessment tools and decide which ones to use across clerkships for both standardized patients and faculty observers
- Decide on basic rules of OSCE station operation to improve consistency
- Decide on how to code items so that more specific feedback can be provided to students about their performance; have this data housed in the Curriculum Office so that clerkship directors can access this information when they have a problem student
- Faculty that participate in creating and maintaining the OSCEs need better training and need to attend the USMLE Step 2 CS workshop to see what is being evaluated at a national level

Next Steps

- Create a task force that includes members from all campuses to review the clerkship and campus-wide OSCEs and to work on implementing these recommendations

Group 5: Continuity Clinic Experience

Group Leaders: Betsy Jones and Steve Urban

Group Members: Anderson, Christy; Camarillo, Pam; Cisneros, Nayra; Dreimani, Daina; Espinoza, Lydia; Evans, Lance; Gonzaga, Yolanda; Horn, Kathryn; Jordan, Richard; Jumper, Cindy; Milton, John; Mittal, Neha; Morales, Jessica; Murphy, Kip; Ragain, Mike; Richie, Harvey.

Overview of Task

Group #5 used the following agenda for its group discussion:

1. Where we have been

- a. Brief history of continuity clinic and each campus' experience.
- b. Review of course description and orientation materials
- c. Review of recent evaluation data from MS3 & MS4 students
- d. Tools for evaluation of the students

2. LCME site visit: what exactly IS a transition issue?

3. Continuity Clinic in 2009/2010 and 2010/2011

- a. How should continuity clinic be continued?
- b. How will CCE be implemented in Odessa?
- c. How will we incorporate new students?

4. Areas for improvement/discussion

- a. Ideas to improve and achieve real continuity
- b. Community vs university preceptors
- c. What to do with "down time?"
- d. Should there be a more formal curriculum (textbook, required reading, formal presentations)?
- e. Role of the home visit/humanities project
- f. OpLog use
- g. Can EBM (evidence-based medicine) be formally incorporated into the CCE?
- h. Role of podcasts

5. Future directions of the CCE

- a. What do we want the CCE to look like in 5 years?
- b. How will we staff it?
- c. How will we maintain enthusiasm?

Supporting documents provided to the group included:

CCE Clerkship Form_LCME 2009

CCE Orientation materials used in Lubbock for 2008/09

CCE Clinical & Professionalism evaluation forms

CCE evaluation report for 2007-08 mid-year & end-of year

CCE evaluation report for 2008-09 mid-year

CCE evaluation report from the recent MS4 survey

Summary of Discussion

Where we have been

Taking advantage of each campus' strengths and special circumstances, the CCE has followed consistent course goals and objectives but somewhat different strategies for implementation on each campus. Thus, Group 5 began with campus reports, outlining how the CCE has been implemented on each campus. Key details for each campus include:

Amarillo: All students assigned to FM (1 preceptor) or IM (2 preceptors), with CCE conducted 3 afternoons per week, generally with 3 students each. Didactic teaching occurs throughout the afternoon, as issues arise. Students complete a home visit/ humanities project. Scheduling patients for continuity is a continuing challenge.

El Paso: Students are assigned to HSC clinics in IM and FM, but most have community assignments, with 4 afternoons per week scheduled for CCE. Students see a lot of patients, but opportunities for didactic teaching are not structured and students often have too much downtime during their CCE days.

Lubbock: All CCE activities take place on Wednesday afternoons, in FM, IM and OB/Gyn clinics. Activities vary by clinic, with FM using the first hour for didactic teaching, and IM making article assignments to students, who are responsible for leading discussions. FM has developed some techniques to encourage repeat visits; IM is rebuilding their continuity practice following the loss of Dr. Bickley.

Student Perspective, Donovan (Kip) Murphy, MS# Lubbock: Students worry about missing experiences during their clerkship rotations on CCE days, especially if it's a unique surgery or other case. Kip recently began having some continuity in his IM clinic, which helped him to appreciate the value of CCE.

Consensus List of CCE Strengths:

- We were able to implement the CCE on all campuses beginning in the fall of 2007 on very short timeframe
- Although the LCME noted that the CCE was a "transitional issue," we avoided a citation based on lack of comparability across campuses
- All campuses have recruited outstanding faculty to be involved in the CCE
- We have implemented a very comprehensive evaluation of CCE across campuses, which include assessing student outcomes via the MS3 OSCE and Step 2 CS.
- Evaluations have shown steady improvement, especially regarding student satisfaction with the CCE
- The Class of 2009, which experienced the CCE's initial year, also reported improved assessment of the CCE in a retrospective evaluation of the Continuity Clinic Experience.
- Giving students access to close faculty mentoring—continuity with same mentor and developing a relationship—continues to be an important strength of the CCE
- Overall, the CCE enhances the mission of the medical school, and improves students' experience with primary care.

Consensus List of CCE Challenges:

- Achieving patient continuity with student doctors remains a challenge on all campuses
- Continuity is primarily a function of patient scheduling, which requires constant monitoring and attention to clinic systems and responsibilities

- Improvement in the TTUHSC overall “reputation” requires positive support from departments (faculty and residents), including those departments that do not participate in CCE and may “lose” students from clerkship rotations on CCE afternoons
- It is crucial that those involved in the CCE communicate often and effectively with the students about all aspects of the CCE; for example, we have learned not to expect patient continuity before about 6 months into the year, information that should be shared students

LCME site visit: what exactly IS a transition issue?

As reported by the Dean, the LCME site visitors listed the CCE as a “transitional issue, “ suggesting that this new curricular initiative has not yet been extensively evaluated at the level of the school curriculum committee. Their concerns—as our own—seem to relate to comparability of experiences and equivalency of evaluation.

Recommendations & Next Steps

Continuity Clinic in 2009/2010 and 2010/2011

Report on CCE Implementation in the Permian Basin: Current plans call for students to be in CCE for one half-day on Thursdays, with 9 students in CCE every-other week, and the other 9 in a lecture or given time available for study or catch up. Three mentors have been assigned and 6 more are being recruited (for a 1-to-1 ratio), all of whom are community-based. **Note:** Group 5 members reported some concerns about using primarily community physicians.

Group 5 strongly endorses the further development and continuation of the Continuity Clinic should be continued, based on the successes that have already been achieved. Moreover, the group encourages that on all campuses we place greater curricular focus on continuity itself, including the following, which are not linked to specific clinic settings:

- Helping students to see the results of their own doctoring
- Building rapport with patients
- Improving doctor-patient relationship
- Addressing cultural competency

Areas for improvement/discussion

- The best possible faculty mentors for the CCE are those who believe in the Continuity Clinic Experience; each participating department should recruit its best teachers and committed clinicians for the CCE and take advantage of their faculty practices to build and ensure patient continuity
- The CCE will continue to need support from clerkship directors (including from those departments that do not participate in CCE) and residents where student complete clerkship rotations
- The current Professionalism Evaluation form could be improved for CCE use; any changes made to the Clerkship Evaluation forms will also need to include changes to meet CCE needs

Future directions of the CCE

- Further improvements in the CCE, especially to ensure that mentors are committed HSC faculty members, **will likely require financial support from the Dean’s Office** to cover faculty salaries and administrative support.
- Each participating CCE department/ clinic **should have its own administrative coordinator** to help facilitate student and patient scheduling
- All campuses and participating clinics **should improve their use of the patient OpLog**. Matthew in the Curriculum Office will be asked to set up a reminder for the students, with copies to the

clerkship coordinator. All participating CCE clinics will be given more training in how to use data downloaded from the CCE OpLog

- The cross-campus CCE Task Force, which currently meets monthly via TechLink **should continue its efforts to improve comparability in student experience as well as evaluation**; a more standardized didactic curriculum should be considered, along with use of podcasts and other means for asynchronous learning
- The use of a **portfolio and humanities project as part of the CCE curriculum offers an excellent opportunity to augment the CCE's emphasis on doctor-patient communications and relationship-building and should be further considered on all campuses**

Group 6: Year 4 and Geriatrics

Group Leaders: Pete Davis and John Marchbanks

Group Members: Aragon, Lorenzo; Bell, Todd; Benton, Timothy; Bourgeois, Michael; Casner, Paul; Condray, Nora; Dentino, Andrew; Escudier, Suzanne; Freedman, Kenn; Gonzales, Elizabeth; Gonzalez-Ayala, Rafael; Haynes, Jamie; McClaran, Tracie; McClure, Stephanie; McMahan, Terry; Oommen, KJ; Shippey, Stephanie; Vugrin, Margaret.

Overview of Task

Review year curriculum 4 as relates to length of rotations, core manuals, student attendance, capstone experience, residency interview skills, evaluation process, and patient logs.

1. **Review the current structure of year 4 and make recommendations for changes in length or organization.**
 - a. Geriatrics rotation. The group considered the geriatrics rotation to be essential and beneficial to students preparing to care for our aging population and the anticipated increasing number of people with geriatric problems. It was noted that the students did obtain some geriatrics experience during internal medicine and family medicine rotations; however, a more focused approach is indicated, appropriate, and needed.
 - b. Neurology. Students consider the neurology rotation to be very beneficial. It is anticipated that this rotation will soon improve on the Lubbock campus as a new chair of neurology has recently been appointed.
 - c. Critical care selective. The critical care component is a worthwhile rotation that is well received by the students. Many students take their critical care elective in the emergency room which appears to be relatively unstructured at this time. Goals and objectives for the emergency room rotations are needed especially on the Lubbock campus.
 - d. Sub-Internship. The sub internship rotations were functioning well and are well received by the 4th year students.
 - e. Ambulatory care selective. Most members of the committee considered a 2 week ambulatory selective too short to truly evaluate student performance in this area. Typically during the first week the students became adjusted to the rotation. Meaningful learning follows during the second week. This does not leave adequate time for a worthwhile learning experience or enough time to evaluate the students. By the time students are in the 4th year, they should be able to demonstrate more initiative and diagnosis and treatment. However, it is difficult to assess this in a limited 2 week observation period. The consensus of the group was that the ambulatory selective should be extended to be 4 weeks in length. The needed 2 weeks could either come from one of the 2 week elective periods or from one of the unassigned periods. It was suggested by some that as the continuity clinic further develops the students will have more ambulatory experience and this could

possibly take the place of the ambulatory selective as it becomes more refined. The group felt we should reevaluate this next year.

f. Recommendations:

- i. Our specific recommendations related to the structure of the 4th year. The ambulatory selective should be extended to a 4 week rotation by taking the extra 2 weeks either from elective time or from unassigned time that the students have during their 4th year.
- ii. Re-evaluation of the ambulatory evaluation should be done at the end of the year to see if we are accomplishing our goals.
- iii. Students felt that elective time should be protected as this gave them an opportunity to do off-site electives to hopefully increase their probability of obtaining a residency program in a difficult to obtain sub-specialty or to give them more exposure in a specialty they hope to pursue as their career.

2. Review student registration for selective and electives in year 4 and comment on choices and selections.

- a. Regarding ambulatory care selectives, there were no surprises. The family medicine selective was the number one choice of ambulatory selective. Second was pediatrics and third was psychiatry.
- b. Among critical care selectives, emergency medicine was the number 1 choice in Lubbock followed by surgical intensive care unit and medical intensive care unit. For sub internships, internal medicine was the number one choice, general surgery and pediatrics numbers 2 and 3.
- c. Regarding electives, the students considered these rotations among the most interesting in the 4th year curriculum. The biomedical management information elective was the number 1 choice for an elective on some campuses followed by anesthesiology, radiology and plastic surgery. It was noted that there is a newly created radiology rotation on the Lubbock campus which will take 2 students per rotation with a private radiology group in Lubbock. Also it was interesting that the students chose plastic surgery as an elective as it is available only in the private practice setting on most of the campuses. Departments should be aware of this data so as to consider which electives these students are choosing.

3. Review examples of the common core manual for year 4 experiences and recommend best system for organization of this information.

- a. The group considered the template for the common core manual to be appropriate and likely to ensure comparability among courses that are available across the campuses. The templates were reviewed by the group. It was understood that the sections for individual course descriptions could be individualized to represent the specific rotations that were

available on each campus with the understanding that not all courses are available on each campus.

- b. Once these core manuals are developed, they should be placed on the web so students would have easy access. It was also stressed that the templates should be a joint effort by the various campuses to prevent reinventing the wheel or developing a different set of goals and objectives for the same courses. This will obviously require communication between the year 4 directors on each campus to avoid a duplication of effort.

4. Evaluation of current absence policies for year 4 experiences.

- a. It appears there is very little consistency in the way that students are tracked during their year 4 rotations. It is especially difficult to keep track of students when they are doing off campus rotations. It was stressed that the students should be aware of the student handbook policy that for a 4 week rotation they have 2 days excused absence and for an 8 week rotation they have 4 days excused absence. The consequences for the student who exceeds the number of days allowed absence was discussed. Consideration of possible actions included repeating the clerkship, repeating the year, or dismissal from medical school for failure to complete a rotation. It appears that several different approaches have been taken for absences: students have been given a research paper to write in lieu of making up actual time; others had taken extra call or had come in after the rotation on weekends or some other time on their elective or free time to make up absences. It was stressed that despite the fact that the student made have already gone through match and may have a PGY position secure, if they fail to complete the course they could have their diploma withheld until the course had been satisfactorily completed.
- b. Our recommendation at this point was to be certain that the students were aware of these policies.

5. Discuss options for a capstone experience in year 4.

- a. Several members of the group felt that a capstone experience would be a worthwhile endeavor for the 4th year but there was no real consensus as to what this capstone experience should be. The topic of a possible research paper to tie in the experiences of the 4 years of medical school was discussed. Also the topic of an internship boot camp as is presently being developed on the Amarillo campus was brought up. It was felt by some of the committee members that a poll of the PG1 level people on the campus would be beneficial to find out from them what information they would have liked to have before starting their first year of internship and then possibly gearing the capstone experience to some type of endeavor that would fill in the holes that they felt they were lacking before starting their first day on the wards as an intern.
- b. Recommendation: a task force should be formed to consider the types of learning experiences to be addressed in a capstone experience. The task force should include first year residents who can contribute with a fresh memory of the initiation of the internship as well as 4th year students. The task force should develop specific recommendations for a

capstone experience to be presented to the Education Policy Committee or the year 4 subcommittee for review to include in the curriculum.

6. Discuss residency preparation for MSIV students and possibility of introducing mock interviews.

- a. With the support of faculty advisors at the MSI level, initial considerations and preparation for residency program decisions should begin in the first year of medical school. Advisors can counsel students as to the availability of various residency programs and what it would take to be competitive for specific types of residency.
- b. Mock interviews should be made available to students on an elective basis as it is unlikely that all students would want to participate. However, some students would likely benefit from the added experience of undergoing a mock interview to help develop their communication skills.

7. Discuss evaluation system in year 4, are they sufficient? What about NBME exams in year 4?

- a. The year 4 evaluation form was considered too long and too complex.
 - i. Under HISTORY & INTERVIEWING SKILLS, question number 1 (gathers complete and accurate history) should be left in place. Item 2 should be deleted. Item 3 (makes appropriate documentations of findings) should be retained. The examination skills and history and interview skills should be combined with item 4 (exam is appropriate in scope and technique) under a single heading, deleting questions 5 and 6.
 - ii. Under FUND OF KNOWLEDGE/CLINICAL REASONING, number 7 (accurately integrates symptoms, signs and test results related to clinical conditions) should be retained but numbers 8 and 9 should be deleted.
 - iii. Under INTERACTIONS, this could be combined into one question which would be number 10 (communications effectively with patients, staff and residents) and delete number 11 and 12. Also a heading that includes work ethics and reliability should be added as another dimension.
- b. In questioning the group, no one was administering any type of examination to the year 4 students with the exception of the Department of Internal Medicine in Lubbock which is currently evaluating the use of the NBME Subject Examination for the Sub-Internship. This exam is designed specifically for internal medicine on a year 4 level. It was the consensus of study group to defer considerations for expanding the use of NBME exams in year 4 pending a review of the outcome of this study.

8. Evaluate comparability of geriatrics rotations across campuses and development of patient logs.

- a. Geriatrics was well represented in our group and each member stated that they communicate on a monthly basis on developing their course material and ensuring that it is comparable across campuses.

- b. The geriatrics program is developing a patient log for the geriatric experience. The committee felt that it would be a good idea to use this as a pilot study and consider expansion to other rotations if it is successful. It was noted that the neurology rotation in Amarillo is using a paper log that the students have to fill out and this has to be signed by the attending.

Geriatrics (Year 4 'working subgroup')

Participants: Dr. Stephanie McClure (AMA)
Dr. Paul Casner (ELP)
Dr. Andrew Dentino (LBB)

Theme: Comparability Issues (always vastly important):

The group participants (the three clerkship directors at those TTUHSC SOM campuses presently offering the MS4 year) agreed that, considering that 2008-2009 is the pilot first year for this new, required, 2 week MS4 rotation, the following items were considered as warranting standardization for the group to prepare for the 2009-2010 academic year:

- make number of GeriaSims (on-line simulated geriatrics learning modules produced by the University of Iowa Geriatric Center) same across all three sites
- work toward a computerized patient log for the rotation, so that each student may verify their seeing six patients from at least five of the following clinical domains during the 2 week clerkship (note: these five domains are those stipulated by the AAMC as the 'Geriatrics Core Competencies'):
 - Medication Management
 - Cognitive and Behavioral Disorders/Self-Care Capacity
 - Falls, Balance and Gait Disorders
 - Atypical Presentations of Disease
 - Health Care Planning and Promotion/Palliative Care
 - Hospital Care for Elders (we decided to have this domain be an option, as not all campuses are presently utilizing in-patient hospital settings as learning venues for this rotation)
- there would be one "full patient write up" required for each student during the 2 week clerkship
- the grading format will remain as: 60% clinical; 20% special project; 20% final exam. However, the grading system will be amended such that a student will need obtain scores of =>90% in all three of the above areas in order to obtain an overall grade of "Honors" (presently is just =>90% in two of these three areas, with an overall combined final score of =>90%).
- we will also look very much forward to the development of the new intercampus videoconferencing system, with a possible goal of having certain learning activities occur simultaneously and interactively across all campuses at once
- work together towards creating one final exam for all three campuses (as is no NBME 'shelf' exam in geriatrics that we know of)

Breakout Groups Session II

- Groups A-F: Clerkship Groups:
A. Family Medicine
B. Internal Medicine
C. Obstetrics/Gynecology
D. Pediatrics
E. Psychiatry
F. Surgery
Group Leaders: Lead Clerkship Chairs
- Group G: Faculty Mentoring
Group Leader: Tom Tenner
- Group H: Active Learning and Educational Technology (ED-5A)
Group Leaders: Jane Colmer-Hamood and Richard Dickerson
- Group I: Vision and Dream Group
Group Leaders: Kathy Horn and Marita Sheehan

Group A: Family Medicine Clerkship

Overview of Task and Discussion

1. Review of recommendations from Session I
 - a. Clinical evaluation
 - i. Anchors for each item revisited and updated and checked for internal consistency
 - b. NBME
 - i. Agreed to continue to use <5th percentile for failure and to use quartile adjustments of raw scores to adjust for the 75th percentile throughout the year
 - ii. Continue to give students 2 days off in the last week of the rotation
 - c. OSCE
 - i. Reviewed current case topics for comparability; adjusted to ensure comparability across campuses
 - ii. Look into “hard-wiring” one or more exam rooms so that we can video tape OSCEs on each campus
 - iii. Use tapes for student self-evaluation
 - iv. Use tapes in event of disputes
 - v. Grading of OSCE
 - vi. Eliminate “honors” since the OSCE is now a pass/fail component of the clerkship and “honors” isn’t valued in this system
 - vii. Timing of OSCE
 - viii. Change to week 6 of rotation to ensure time to grade OSCEs and plan for remediation if needed
 - d. Continuity clinic
 - i. There are no major changes with the continuity clinic. It was reported by Dr. Aragon that the students are enjoying the mentorship they have with the faculty.
 - ii. We need to be more cognizant of scheduling activities that may conflict with the continuity clinic.
 - e. Maintenance of cross-campus comparability
 - i. We are going to meet a minimum of four times per academic year by tech link. This will be led by the Lead Chair.
2. Patient log data
 - a. Cross-campus comparability
 - i. We realize that there are going to be some variations. If students are lacking in seeing certain types of patients, we are utilizing the design a case to make up for it.
 - ii. These meeting allowed us to make adjustments to further ensure cross-campus comparability.
 - b. Student patient encounters
 - i. Amarillo has a higher number of average patients seen/student. El Paso and Lubbock are the same.
 - ii. Students have comparable performance of H & P’s and limited encounters with patients’ cross-campus.
 - iii. Student encounters by diagnostic categories, El Paso has heavy cardiovascular and endocrine- given our population. Otherwise there is decent comparability across the campuses.
3. Patient log summary data

- a. Inpatient/outpatient distribution
 - i. Approximately 10 to 14 days of inpatient
 - ii. There is variation cross-campus
- b. Improvements in the log system
 - i. Student dependent
 - ii. Need to re-visit this topic; we were unable to access the log to see the student input side
 - iii. Once we get access, we agreed to each enter one of our clinic-day's worth of patients to test out the log to see what changes need to be made
 - iv. Agreed to continue to use the same minimum numbers
 - v. Agreed to continue to use data at the mid-clerkship evaluation point and to plan for remediation based on lack of a particular encounter
 - vi. Develop a system to improve continued data entry of patient encounters by students
 - vii. Discussed revisiting patient log data at week 6 to ensure that remediation has been completed and that the log continues to be updated
 - viii. Students are informed at orientation and mid-clerkship feedback about the importance of keeping olog up to date.

Recommendations

1. Student Professionalism evaluation form
 - a. Needs a major overhaul
2. Clinical Encounter Cards
 - a. Agreed to make some modifications and use it on all family medicine campuses in the MSIII clerkship; four encounter cards per student per clerkship
3. Consider more comprehensive sources of evaluation
 - a. Clerkship coordinator
 - b. Nursing staff
 - c. Front-desk staff
 - d. Patients
4. Consider using similar patient evaluation card as CCE and pilot it on FM Clerkship to obtain patient evaluation data
5. Have student pick two half-days in clinic and have the ask each patient they encounter to complete an evaluation; have the patient place completed card at check-out from clinic; have clerkship coordinator gather/compile data
6. Teaching of students
 - a. Need to develop a more comprehensive program during residency to teach resident physicians how to be better teachers
 - b. E.g. delivering meaningful feedback
 - c. E.g. how to teach students and still provide good patient care
7. Final report of clerkship performance
 - a. Reviewed and agreed to update line items
 - b. Add the additional components that need to be passed to pass the clerkship on the report
 - c. Add "Patient interview and physical exam" and "Mid-rotation evaluation" as line items to the report

Next steps

1. Complete the Clinical Evaluation form
2. Overhaul the Professionalism form
3. Implement the clinical encounter form
4. Establish meeting times for the next academic year

Group B: Internal Medicine Clerkship

Individuals present: Cindy Jumper, M.D., Harvey Richey, D.O., Rob Neilson, M.D., Steve Urban, M.D., Dinorah Nutis, M.D., Pete Davis, M.D., Neha Mittal, M.D., Andrew Dentino, M.D., Rafael Gonzalez-Ayala, M.D., Colleen Sims, Julie Schaefer, Aurora Subia, Lydia Espinoza, Nora Condray, Jessica Morales.

Minutes of the last Clerkship Directors in Internal Medicine (CDIM) meeting were reviewed. This meeting took place in conjunction with the national CDIM meeting in Orlando, Florida.

Overview of task

1. To review current 3rd year core clerkship in IM, in particular to insure comparability among the four campuses in curriculum, expectations, evaluation tools (in particular, OSCE exams) and clerkship manual. Also to start the process of integrating the Permian Basin campus into our curriculum and to figure out how to deal with the influx of students starting in 2011.
2. To review the current 4th year selectives/electives, also with an eye toward changes that will need to be made by 2011.

Overview of discussion

1. The curriculum and course expectations are substantially the same across the campuses. There are minor variations in how the (admittedly brief) ambulatory part of the clerkship is actually done and in the amount of faculty teaching time devoted to ambulatory teaching.
2. The evaluation tools are the same across campuses. General dissatisfaction with the professionalism form was expressed.
3. A form for documenting that each student has had experience in patients from all 10 diagnostic groups has been developed but has not been received by the ElPaso campus. Paper remediation in the deficient groups was felt to be the best method of remediation. Dr. Neilson provided 2 sources for the remediation cases
4. Is the NBME score overemphasized in student grading? There was general consensus that the clinical performance is the most important aspect of the MS3s performance but no consensus as to how the NBME score should be used. One proposal was to give the clerkship director the option of giving an overall Honors grade to students with outstanding clinical evaluations but with NBME scores in the 60-74th percentile. Should the threshold for passing be raised from the 4th percentile (as currently exists)? There was general feeling the 4% is too low, but no consensus as to what the cutoff should be.
5. The department OSCE was reviewed. The cases and evaluation tools are exactly the same. The clinical case, the 2 chest XRays and the 2 EKGs, the EBM case, and the geriatrics podcast questions are shared among campuses and are exactly the same. We hope to be able to use a simulation station, as all campuses are gearing up for a more robust simulation component in the future.
6. The clerkship directors meet by TechLink (hopefully a less antediluvian system is on the way) every 2 months. We will integrate the clerkship director and coordinator from Permian Basin into this meeting in the future. The immediate task facing the clerkship directors is revision of the student orientation packet before the class of 2011 starts (i.e. before July 2009).

7. Continuity Clinic and its impact on the IM clerkship were discussed. Overall we perceive a positive effect on our clerkship. The one-on-one mentoring helps our students, especially with outpatient and ambulatory problems, since our clerkship is inpatient-heavy.
8. We will share all information with our colleagues on the Permian Basin campus and encourage them to come to our campuses to observe teaching rounds, OSCE exams, etc.
9. Various ways of enhancing the ambulatory aspects of the IM clerkship were reviewed, but no consensus achieved. The amount of faculty time and interest in ambulatory teaching varies greatly from campus to campus. Students are dissatisfied with the fact that we deemphasized the teaching of procedures when the clerkship went from 12 to 8 weeks. Some of the campuses still teach rudimentary procedures to the students; others have dropped formal procedure testing completely. Perhaps Sim man will step in to fill the breach (if we use the term “step in” in a somewhat figurative way).
10. Regarding the 4th year rotations: Drs Mittal and Bell have done a great job in coming up with a uniform curriculum for the subinternship, ICU rotations, and subspecialty electives.

Recommendations:

1. The 6 week OpLog evaluation form will be sent to the El Paso and Permian Basin campuses
2. The EPC should consider revising the professionalism form
3. We will work toward integrating simulation into the curriculum and the OSCE exam.
4. We use a different final grade report form for OSCEs on various campuses (although the grade is calculated the same way). We’ll come up with a uniform final report form.
5. The EPC should consider whether the current grading system overemphasizes the NBME score at the expense of clinical performance.
6. In the fourth year, the EPC should consider making neurology a fourth year elective rather than a required rotation (unless a good way can be found to equalize the staff and teaching methods on each campus).
7. The NBME is developing a subinternship shelf exam, but we’re not sure if we need it or if it will be worth the eventual cost. The exam is based on the Sub-internship curriculum from the CDIM.
8. We will strive toward making almost all of our “lectures” (a term not recognized by Dr Davis but still occasionally used by the hoi polloi) into interactive case-based “learning sessions.”
9. The transition in 2011 will be significant for all 4 campuses. Faculty will need to be in place and up to speed before the 11th hour.

Group C: Obstetrics/Gynecology Clerkship

Attendees: Bahij Nuwayhid, M.D. – Lead Clerkship Chair
Robert Casanova, M.D. – Clerkship Director, Lubbock
Randall Kelly, M.D. – Clerkship Director, Permian Basin
Teresa Baker, M.D. – Clerkship Director, Amarillo
Elizabeth Wagner – Clerkship Coordinator, Lubbock
Janet Lummis – Clerkship Coordinator, Permian Basin
Michelle Carty – Clerkship Coordinator, Amarillo
Becky Aranda – Clerkship Coordinator, El Paso

Overview of Task and Discussion

1. Evaluations: Clinical & Professionalism forms:
 - a. A Clinical Encounter Card (CEC) was discussed as an option for improving the students' evaluation process. The new form will contain the first 6 dimensions listed on the Clinical Evaluation Form, and will have a professionalism question and a self assessment question for the procedure just completed. The group recommended that each student submit a Card /week or have 6 Cards completed for the rotation.
 - b. The goal is to provide immediate feedback to students as they complete a procedure.
 - c. The CEC form is to be completed by a faculty member or resident.
2. Mid-rotation evaluations:
 - a. Campuses should continue to provide mid-rotation feedback to students.
 - b. Feedback should include a form of self assessment.
3. Final Grade Report:

Presently, the 4 campuses are using the Final Grade Report (FGR) form, however only the El Paso FGR form has the needed explanation(s) and criteria for granting a final grade on the rotation. The representatives from the 4 campuses recommended that the El Paso FGR form be used for end of rotation grading purposes.
4. Annual Percentile:

The issue of using annual versus quarterly percentiles for comparison of students' performance from one year to the next was discussed at length. The Group found that there was no benefit from a shift to a quarterly percentile and thus decided to keep using the annual percentile for comparison with the previous year.
5. Cultural Sensitivity Competency
The Group discussed the issue of Cultural sensitivity at length and agreed that it should be incorporated into the curriculum in such a way as to allow appropriate evaluation by the faculty mentors. The Group recommended that each student will be required to prepare a 1 page written report on an issue of cultural sensitivity as it affected them during the rotation. The group decided that each student will present & discuss this report with the Clerkship Director at the mid-rotation meeting (Effective AY 09-10). This will not become a component of the final grade, but only to be graded as Pass or Fail.
6. Study Time
The Group discussed the issue of Study time for the students. After much discussion, the Group decided that all campuses should follow the same guidelines and maintain comparability as much as possible. As such, no change in the study time was recommended.
7. Other items:
 - a. Discussion of the use of u-Wise & Web-CT: All agreed that both systems remain very helpful and students should be encouraged to utilize them more frequently.

Group D: Pediatrics Clerkship

Group E: Psychiatry Clerkship

Overview of Task and Discussion

1. El Paso provided study notes that I had prepared for the students to the other 3 campuses. The study notes included topics covered during their orientation week and the first two weeks of the rotation. I also provided how I assigned students to prepare study notes from the remaining chapters from their textbook. This hopefully will provide comparability between campuses.
2. We compared notes on how the OSCE's are done on all 3 campuses.
 - a. We all use the same forms to evaluate students.
 - b. Our grades across all three campuses are remarkably consistent.
 - c. We all use the same file of cases but the cases can vary between campuses because we may not do the OSCE on the same day.
 - d. The only difference is that Amarillo does only one case while Lubbock and El Paso do two cases. However, starting in July, all four campuses will do only one case to be consistent across all campuses.
3. We looked at the final grade page and this is consistent across all campuses.
 - a. We will add that op-log has been checked and that the student has met the minimum requirement.
 - b. We felt that the grading should be amended to allow the Clerkship Director to give honors if the student honors in their clinical evaluations and their OSCE. This would be permissible if the student scores between 70-74. We also felt a high pass should be added from 65-74.
4. We looked at the diagnostic categories for the diagnoses that represent the minimum cases that a student should see. We felt the category for Adjustment Disorders should be dropped.
5. We also talked about what should a student do should they not get the minimum number of cases. The course of action at the seventh week is to assign cases from Case files. This way the student can have exposure to the necessary cases.
6. We also look at the Clinical Evaluation Forms and we suggested changes in these forms. The particulars were left with the people that were from Lubbock, so this could be discussed with our Lead Chair.
7. We also thought that the professionalism form is not very productive and should be incorporated into the Clinical Evaluation Form. This was left for future discussion when we meet again by TechLink in May.

Group F: Surgery Clerkship

Group G: Faculty Mentoring

1. Overview of task:

The task-force was charged to consider “**How do we mentor our faculty to become better teachers?**” The task force decided to consider this charge in four parts. First, who are the ‘customers’? Second, what are the historical barriers and current issues for our Faculty achieving ‘excellence’ in teaching? Third, how do we determine excellence in teaching, i.e., what are the metrics involved? Fourth, what resources are at our disposable?

2. Overview of discussion:

A. The task force members identified three (3) customers:

Clinical Faculty
Basic Science Faculty
Community (Volunteer) Faculty

B. It was determined that there were barriers /issues unique to the teaching mission of each group:

i. Clinical Faculty:

Historically, there has been no such thing as “protected time” to do academic activities for clinical faculty. Several anecdotes of faculty taking vacation time to prepare lectures, poster presentations, evaluate data, etc. were reported. Many reported that ‘administrative time’ was usually consumed by the need from Departments for help with clinic or hospital coverage. In other words the “Tyranny of the Urgent” was always present such that clinical demands take precedence. In addition, it was felt that historically, teaching didn’t have value, rather RVU’s are valued. There is no ‘cost center’ for teaching activity within departments and when one is required to generate their own salary, an hour lecture or clinical training of students is truly – uncompensated time.

There appears to be some positive movement in these areas. The faculty T&P survey conducted in 2008, revealed that the faculty considered ‘teaching’ as the most important role/function of SOM. This sentiment was incorporated into the revised Guidelines for T&P where teaching is now considered equal to scholarship and clinical practice as a potential area of excellence for supporting tenure and promotion. In addition, there has been some effort by the administration to provide salary support for Faculty with significant educational administrative responsibilities, i.e., block and clerkship directors.

ii. Basic Science Faculty

Historically, there has been no such thing as “protected time” for teaching. Basic Science faculty reported that in today’s climate for research funding (NIH funding less that 10% for RO1s) research faculty need 150% time for generating preliminary results, preparing grants, and writing manuscripts. As was the case for clinical faculty, basic science faculty felt that historically, teaching didn’t have value. Grant dollars, especially NIH, have value.

Basic science members of the task force also acknowledged that teaching was being better recognized both in terms of tenure and promotion and in salary support but this shift in school attitudes could not help the primary responsibility of basic science faculty, i.e., to generate research grant support for their respective labs.

iii. Community (Volunteer) Faculty

There was agreement among the task force members, none of whom was a community (volunteer) faculty member, that historically, TTUHSC-SOM had been a bad steward of our Volunteer Faculty. Many of these faculty are our alumni and there was concern that they felt used and of little regard to the School of Medicine. By in large these faculty take our students into their practices in the ‘Early Clinical Experience’ courses (MS1 &2), and for 4th year electives. It was generally agreed that these voluntary faculty receive little recognition and little benefit for their services. Of a more important concern however, was what are our students learning from volunteer faculty? Are our students being exposed to

and modeled the core competencies? Do these volunteers understand our key educational objectives relative to the knowledge, skills, behaviors, and attitudes for students?

The task force members reviewed several current initiatives relative to better aligning our volunteer faculty with the visions and goals of the School of Medicine. With the assignment of Yolanda Gonzaga, a clear attempt at outreach has been initiated by the School of Medicine to communicate with the volunteer faculty. Likewise, annual events to acknowledge the many contributions of our volunteer faculty and expose them to our vision and goals have been taking place. It was reported that the event in November 2008 was very successful. Yet it was realized that these initial steps must be expanded upon.

C. What metrics define a good teacher?

If we are to mentor our faculty in ways to become better teachers what are the metrics that define the outcome. The old 'tried and true' approach of "You'll know it when you see it" seems to remain the standard. Learner evaluations have come under fire of late as not being reliable especially in an environment where many students don't seem to want to provide evaluations on their instructors or the courses. (The cause for this lack of participation in the evaluation process was examined and several reasons for this behavior discussed. Consensus formed around the opinion that students have forsaken evaluations because they feel that over the years, they have not been able to identify 'change for the better' as a result of the evaluations and therefore they are a waste of the students time.) Regardless it was agreed that learner evaluations should still be considered the gold standard and pursued with the goal of increasing student participation. Parenthetically, there was consensus that those individuals considered 'great teachers' have weathered the test of time in terms of student and peer recognition, even though no truly formal evaluation system has been developed.

Several other approaches to evaluating teaching excellence were discussed. On the one hand, 'peer-evaluation' seems to be a nationally accepted and recognized mechanism for evaluating teaching excellence and mentoring appropriate teaching skills. Peer-evaluation would be relatively easy for classical didactic instruction (with the acknowledgement that, once again, faculty time would be required pulling them away from their clinical or research responsibilities and requiring appropriate compensation.) In contrast, an appropriate mechanism for instituting 'peer-evaluation' of clinical and community volunteer 'bed-side teaching' would be a more sensitive and difficult problem.

3. Specific recommendations for Basic Science and Clinical Faculty:

A) Administration at all levels should continue to emphasize the importance of teaching in the mission of the Departments, School, and University.

B) Administration at all levels should strive to promote positive attitudes and enthusiasm for teaching among the faculty. Likewise it should promote the role of 'ownership' by the faculty of the teaching mission and its place of prominence in the School of Medicine. (Perhaps if Faculty felt more valued in their roles as 'Teacher', attendance at various student-centered functions such as the White Coat Ceremony and Graduation would improve.)

C) The SOM should utilize the **Teaching, Learning, and Technology Center (TLTC)** found on the TTU campus. Professional Evaluators are associated with the TLTC who might be enticed to assist TTUHSC-SOM Faculty with becoming more accomplished teachers.

D) The TTUHSC-SOM Mentoring Program should be continued and expanded, (on a voluntary basis, driven by mentees) whereby excellent teachers willing to mentor faculty be identified.

E) Peer evaluation and mentoring can be accomplished by Block/Clerkship Directors evaluating specific lectures of Faculty on a regular basis supplying them feedback on how to improve their didactic teaching skills.

D) Peer evaluation and mentoring can be accomplished by continuing Faculty Development Courses on Medical Education where identified expert teachers from within the SOM share their enthusiasm and

techniques for teaching with junior faculty. This provides an excellent opportunity for networking in the educational arena for all participants.

E) Establish a “Pair& Share” Clinical (Bedside) Teaching evaluation program where clinical faculty pair off and make rounds with students and residents. One Faculty member leads the rounds while the other observes. After the rounds, the pair discusses the pros and cons of the session. Through this interaction both presenter and evaluator hone their bedside teaching skills.

F) Teaching Academy should be re-energized to identify ‘Master Teachers’ on all campuses and recruit them as peer evaluators and to teach teachers how to teach.

G) All of the above will require TRULY protected time as well as salary replacement for time away from clinical/research duties.

H) Chairs and Assoc. Dean for Faculty Affairs and Development should have yearly contact with Junior Faculty to evaluate mentoring needs, i.e., initially Big Brother/Big Sister, possibly shifting to lecture preparation, bedside teaching skills, grant writing, etc. as Junior Faculty grow into careers.

4. Specific recommendations for Community (Volunteer) Faculty:

A) The SOM should establish Faculty Development Programs where Community Faculty can achieve CME credits (Enduring Materials) based upon topics such as “Competencies” , “SOM Curricular Goals and Objectives”, and “How to be an Effective Preceptor” .

B) Provide Community Faculty with administrative navigation support (Paper work: evaluation of students)

C) Academic interactions with Community (Volunteer) faculty must be taken out to the Community faculty

5. Next steps (e.g. formation of task force, submission of detailed proposal to CEOC, EPC, etc.)

We need to provide our Junior Faculty with the opportunity to succeed as Academicians and to equip them with the skills to avoid burnout.

- A) This report should be shared with the Dean of the School of Medicine and the Associate Deans for the Curriculum and for Faculty Affairs and Development with the following goals in mind:
 - a. Devise a mechanism to protect “protected time”, i.e., time to be ‘Academicians’
 - b. Increased recognition for effort in teaching
 - c. Realization of the role of teaching in Promotion and Tenure
 - d. \$\$ for Academic efforts

- B) Members of the Teaching Academy should be charged with re-energizing that organization to establish peer evaluation and mentoring in the area of Medical Education.

Group H: Active Learning and Educational Technology

Overview of tasks

A. Review requirements of LCME standard ED-5-A related to contemporary methods of pedagogy

“The educational program must include instructional opportunities for active learning and independent study to foster the skills necessary for lifelong learning.”

Students must learn to evaluate their own learning needs

Identify, analyze synthesize information relevant to their learning need

Assess the credibility of information sources

The group reviewed and discussed ED-5-A in context with our LCME Medical Education Database 2008-09. This document relates the standard to the Institutional Educational Vision, Goals and Objectives; and, includes a listing of the major alternative pedagogies already in use at TTUHSC SOM. A number of these alternative methods are outlined below. [attached to report]

B. Review distribution of pedagogical methodologies in years 1 and 2 and define expectations for lecture/non-lecture formats (in context of previously designated 50/50 split)

The group discussed the existing alternative pedagogies and e-learning modalities currently in place for years 1 and 2. The following list, while long, may not be exhaustive. It represents modalities gleaned from discussion as well as the document mentioned above.

Alternative pedagogies:

Case Studies with active discussion

Participatory Q & A sessions

Team-based learning in large groups

Review sessions to dissect USMLE questions

Audience response system

Cross-sectional anatomy and medical imaging primarily taught through WebCT with tutorial quizzes

Assessing source credibility

Voice-over lecture/ cases powerpoints

e.g. read EKGs

Students requested “lectures” over sessions!

PPTs online/no lecture

Crossfire –similar to scientific meetings

Simulation center

Embryology online

Ability to pause and repeat

Issues from students regarding availability of faculty for questions immediately

Student teaching students

Neurojeopardy

Clinical correlations

eLearning modalities:

eOffice hours

eTests

eCases

eFormative quizzes

Study Mate: games, flash cards, etc.

Podcasts available from iTunes on iPage University; “pushed” to students

Streaming video

Blogs

Chat room

Discussion board

The underlined items above are in use in different blocks. The others have been used by faculty elsewhere, or are used by faculty in other schools within TTUHSC. Study Mate is part of the Respondus software package, which has not been explored thoroughly by many faculty (at least within our group's knowledge). A question was raised regarding the students expectations of instant responses; that is, just how available are we supposed to be to the students. We were all in agreement that reasonable office hours and relatively quick turnaround times for exam grades are important. We also agreed that "instant access" was not necessary.

C. Review potential uses of advanced educational technology approaches to provide alternative pedagogical methods

On review of the lists we had generated above, the group agreed that many resources are available to us as faculty, more that we are probably aware. Some of these include:

Netter's presenter, others from library

WebCt/Blackboard (none of us felt truly aware of the all of its capabilities)

Respondus

Audience Response System

Exam Master

Help from librarians

Teaching podiums

Other software, hardware that are/may be available through the library, other departments, freeware, other universities, etc., etc., etc.

Overview of discussion

A. Faculty set goal to achieve 50:50 ratio of didactic lecture : active learning modalities: This was viewed by the group as arbitrary, but motivational. Those longest in the Block Director position remember the original goal set by the faculty was 60:40 rather than 50:50. Once we had neared the former goal, the goal was revised (although we were not sure this was by the "faculty") to 50:50. For 2007-2008, the distribution was Year 1 – 53:47 and Year 2 – 65:35. The group agreed that, while maximal use of alternative pedagogy should be maintained, setting an arbitrary standard was just that, arbitrary. As a group, we agreed that we are meeting the spirit of ED-5-A.

B and C. The faculty at TTUHSC SOM are innovative and have found a number of alternatives to didactic lectures when possible. We did find it interesting that, in at least two instances, students requested lectures to accompany the alternative methodology. While many modalities are in use, it appears that more are available. We expect the Block Directors to encourage faculty to use innovative technologies and techniques.

Recommendations

Strategies for providing faculty with access to alternative pedagogical methods

Regarding the proportion of lecture to alternative pedagogy: each block director should determine what split is equitable for each Block

Maximize alternative pedagogy

Encourage/train faculty to use innovative technologies and techniques

Keep a log of what has been tried and the student response to these methods

Compilation of modalities that are available

Who is using what?

Can that person teach it to another?

What can we do to enhance the availability of these to all teachers who want to use them

Training for Block Directors and faculty

To utilize WebCT to its fullest capacity; especially for Block Directors to be able to use WebCT to fullest and to train faculty

Training courses on new technology, but focused on specific topic

AAMC meeting attendance for Block Directors to learn about new technologies

Find innovative ways to use small groups

Tape all sessions? Cost/technical

Teachers who want to teach and who have TIME to teach

Insure Block Directors have updated hardware

Office computer

Laptop

Sufficient software for their work (e.g., an updated version of ADOBE for printing PDFs; educational software if relevant)

Next steps

EOC meeting agenda item to bring forward proposal to rescind the 50:50 split and replace it with a directive to “maximize alternative pedagogy and Encourage/train faculty to use innovative technologies and techniques” and to “keep a log of what has been tried and the student response to these methods.”

A subcommittee composed of an expert on WebCT/Blackboard, someone from the Library who is involved in SOM teaching, at least one Block Director, and interested faculty (e.g., someone who is already using one or more of the alternative methodologies) to compile a list of what we are using, what we have tried and how successful these approaches have been, and what is available as a first step toward training in these modalities.

For those items that involve money, we did not develop a plan

Group I: Vision and Dream

Overview of task

Tasked to consider where we as a group would like to see the school go next – dreams of future recommendations

Overview of discussion

I. Year 1 and 2

attendance in class in Year 1 & 2 discussed

more collaboration between basic scientists and clinicians to bring relevant clinical correlation

more interactive sessions to draw students

students should be able to audiotape and would like to see videotaping done as well

incorporate fourth year students in a teaching elective/requirement to teach first and second years –

improve student interest and help soon to be intern on how to be a good teacher

Use “clickers” to be more interactive and keep track of attendance

Incorporate USMLE type questions in lectures/small groups

Utilize WebCT more – not being used to its full capacity

II. Year Three Concerns

A. More surgery and internal medicine exposure

felt like they have lost some important time with the decrease from 12 to 8 weeks but more importantly they don't get time to explore subspecialties

B. Exposure to subspecialties in the third year - allow away rotations within TTUHSC in the third year if a subspecialty isn't on that campus

C. More assistance in getting involved in research when get to regional campus

D. Have an orientation to third year to prepare for being on floor of hospital - survival, writing orders, not really H&P which they feel they have enough of in ECE

III. Fourth year concerns:

A. Combine neurology into the third year of psychiatry to allow more students exposure to this earlier in their careers

B. Don't know if ambulatory is needed in Year 4 with more in year 3 w/ CCE

C. More helpful to have a First Contact type of experience required – Emergency Medicine or Urgent Care – so they have to make their own assessment

D. Geriatrics – would like to see a building of knowledge appropriate to the level of the students – so that fourth year rotation is not really an introduction again – horizontal integration across 4 years

E. Capstone – if it is done needs to have real value to make it worth time lost in year 4 – prepare for residency maybe specialty specific

a. Include ACLS/ATLS/ALSO to prep for internship

b. Maybe Step 3 Preparation

Recommendations

- Audience response system to help with interactive learning
- Incorporate step 1 questions into 1st and 2nd year
- Form taskforce to continue to revise Third year – to include re-looking at neurology in the third year as part of psychiatry and giving students an elective month in the third year
- More extensive introduction 3rd yr. (EMR, scrubbing, writing orders, ect.)
- Library Rotation-early 3rd year to help include introduction to research
- Service learning-student led clinic (3rd and 4th year directed) started in Lubbock see if other regional campuses have interest as well

- Advisors for residency programs that TTUHSC doesn't have (online-career advisor)
- Expand access to global health-resources for students to take away rotations for international health
- Specialty specific capstone experience
- Add in 4th year 1st contact rotation in acute care/urgent care center, ER or ambulatory care
- Review geriatric education through the 4 yr period to gain more detailed exposure earlier

Next steps

- A. Establish Third Year Task Force to take it to the next level
- B. Recommend that the EPC evaluate the horizontal objectives of geriatrics across the whole curriculum
- C. Continue to make recommendations on the improvement of Fourth year to include suggestions above