



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
School of Medicine™

Office of Curriculum

Forás II Educational Summit

March 11-12, 2010

Executive Summary

Submitted By:

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Date

The Foras II Summit was held in Lubbock on March 11-12, 2010. Approximately 100 faculty and staff registered for the meeting and about 95 people actually attended. The summit was opened by Dr. Berk who highlighted the innovative curricular activities currently underway in the areas of primary care (the Family Medicine Accelerated Track) Geriatrics and Women and Gender Health. Dr. Williams then provided a summary of the curricular redesign process as it has developed over the last 6-7 years and presented data concerning improvements in student scores on standardized exams. Several breakout groups met and presented plans for future improvements to curriculum and other activities in the SoM. Final reports from these groups will be available soon but the important points are summarized below.

Breakout Groups – Day 1

Vision and Goals Group: This group reviewed the current version of the Institutional Vision, Goals and Objectives. They recommended altering the VGO to reflect competencies expected of physicians along the lines of the ACGME competencies. The group presented a draft modified version of the VGO which will be brought to the EPC for further discussion.

Clerkship Grading: Recommended developing appropriate grading methodologies that will ensure that clerkship grades are not simply determined by student scores on the NBME exam. This will require significant improvements in methods for evaluating OSCEs and clinical performance. The criteria for a High Pass grade in Year 3 will need to be determined. These recommendations will be further considered by the CEOC. There was a general clamor for Faculty Development activities to train clinicians in evaluation techniques.

Student Preparation: This group recommended developing pre-matriculation courses that will assist students with weak backgrounds in critical areas (Biochemistry, Anatomy) arrive at TTUHSC with better preparation. Assistance in assessing learning styles was also recommended. Furthermore, the group recommended addition of an exercise to Year 3 orientation that refreshes student skills in physical exams.

Women and Gender Based Health (WGH) Curriculum: This group explained the strategy underway to develop a curriculum with a focus on WGH. The recommendations from the group will be considered by an existing ad hoc curriculum committee.

Clerkship Directors: All CDs in attendance met to examine curricular comparability and evaluation equivalence. Some concerns about non-comparability were raised by students in attendance and these concerns will be evaluated by the CEOC and campus education committees.

Year 4 Directors: Year 4 Directors embraced the concept of changing evaluation in Year 4 to a competency based method. A revised grading form is being circulated for adoption in 2010-2011. The group also considered the impact of increased student numbers and recommended emphasis on the need for enhanced community physician training.

Day 2

Three breakout groups assessed curricular development and integration in several focus areas, such as Genetics, Nutrition, Cultural Competence, Professionalism. The analysis performed by these groups showed that focus on a particular area could result in improved student performance and satisfaction in these areas. There is clearly significant need for a comprehensive curriculum-mapping project and this is underway in the EOC and the Office of Curriculum

FMAT and CCE

The group recommended continuing the CCE in its current format for at least the next year while its future is further evaluated. There are clear divisions in opinions of the value of CCE, with mentoring being the major positive point. Community based activities (e.g. El Paso, PB) appear to be most popular.

FMAT: There was a lot of discussion about FMAT, most of which can be attributed to misunderstanding of a new program. Several comments addressed the intensive nature of the program and the implication for students who complete the program but then decide FM is not what they want to do. Clearly, the selection process will be crucial for avoiding such issues.

Forás II Educational Summit
Breakout Group Review of
Institutional Education Vision, Goals and Objectives
Conducted March 11, 2010

Focus: Is the present VGO still relevant? Will it take us into the future in light of the prospect of Competency Based Medicine?

Subcommittee Members: H E (Pete) Davis MD (Chair), Neha Mittal MD, Sharmila Dissanaiké MD, Rick Badillo MS III El Paso, Jordan Simpson MS IV Amarillo, Marita Sheehan MD Amarillo (Administrative Support)

Breakout Group Members: See Conference Assignments Sheet

The Breakout Group reviewed:

- The current the current TTUHSC School of Medicine Institutional Educational Vision, Goals, and Objectives (VGO) as approved by the Educational Policy Committee March 10, 2003 (attached as Enclosure #1)
- ACGME Approved General Competencies
- Report of the Summit Planning Subcommittee for Review of Vision, Goals, and Objectives
- TTUHSC School of Medicine Institutional Educational Vision, Goals, and Objectives, Revision as proposed by the Summit Planning Subcommittee for Review of Vision, Goals, and Objectives, March 8, 2010.

Findings

The key findings of the Breakout Group included:

- Concurrence with the concept of using the ACGME approved general competencies as a framework for a revision of our current VGO.
- Recommendations for revision to include reduction of redundancies.
- The edited revision was presented to the Plenary Session with a positive response.

Recommendation

The edited VGO revision should be presented to the Educational Policy Committee for review and action as appropriate to adopt a revised VGO based on the ACGME approved general competencies.

Enclosures

1. TTUHSC School of Medicine Institutional Educational Vision, Goals, and Objectives, Approved by the Educational Policy Committee March 10, 2003.
2. ACGME Approved General Competencies
3. TTUHSC School of Medicine Institutional Educational Vision, Goals, and Objectives, Revision as developed by the Summit Breakout Group, March 11, 2010.

Submitted by:

Harry E. (Pete) Davis II, MD, FACP

Vice Chair for Education

Department of Internal Medicine

TTUHSC El Paso

Breakout Group Facilitator

Chair, Sub Summit Planning Subcommittee for Review of Vision, Goals, and Objectives

April 8, 2010.

Foras II Educational Summit 3/11/2010
Breakout Group 3 – Report

Clerkship Performance:

What is the philosophy behind Year 3 grading? Pass a standardized test? Graduate SOM as a well rounded MD with a deep fund of knowledge?

Summary:

The group's discussion revolved around two themes, 1) the current grading system, appropriate cutoff points on the NBME shelf exams, inclusion of a "high pass" category, and concerns about the way the clinical performance aspects of the rotation were weighted, and 2) creation of a "competency based" grading system with the hope of creating a more "well rounded student".

There was consensus that the goal of the SOM should be to produce students that were global, well rounded physicians who provide compassionate care at the highest professional standard. There was also general agreement that the current evaluation system emphasizes the value of test performance on the NBME exam over the student's clinical performance during a clerkship. (To a certain degree, the evaluation system is fractionated between clerkships and campuses, leading to confusion amongst the students on what are required by each clerkship.) The value of a high test score vs. good clinical evaluations as they pertain to achieving an "honors" evaluation was discussed as were other perceived inequalities of the current system. This part of the discussion centered on the current grading system and the "status quo". It was noted that there has been a Task Force group appointed by the CEOC looking at the grading system and that their report to the CEOC was recently approved and would be moving forward to the EPC. Student concerns about what was really valued in the residency selection process were addressed. Different views were expressed as to the importance of NBME shelf exam scores, Dean's letters and personal letters of recommendation. Some discussion was held about the possibility of identifying students at risk for problems with USMLE Step 2 exams prior to the end of year 3. There are tests aside from performance on third year NBME's which may be better screening tools for this purpose.

The development of a competency based evaluation system for medical students was discussed at length. Most participants were knowledgeable about the ACGME six core competencies currently used for resident evaluation, and most felt that the transition to a competency based evaluation system would be plausible. Discussion arose concerning the need to integrate "common ground" material and concepts between clerkships as well as incorporating standardized clinical exams and common procedural skills. There was concern about the level of "competency" that would be expected of a MSIII or IV student if such a system were adopted and that "competency" education was not "time based" and therefore not necessarily amenable to block rotation limitations. It was suggested that a "milestones" approach might be useful in this respect. It was acknowledged that there would need to be a concerted effort made to develop appropriate evaluation tools, and to train the students and faculty on a new evaluation system if we wanted to improve the reliability of the clinical evaluations. The need for better feedback mechanisms for students was also discussed. Ultimately the students and our graduate education programs would significantly benefit from such a transition to

competency based teaching and evaluation as it will better prepare them for their next step in residency training.

Recommendations:

1) Short Term

- A. Form a Task Force group to a) review the clinical evaluation process, b) identify ways to improve the reliability of current clinical evaluation (recommend consultation with experts in psychometrics and evaluation theory), and 3) decide how to better incorporate the clinical evaluations into the current grading system so that a student could achieve an "Honors" evaluation based on clinical performance with less singular emphasis on the NBME shelf exam.
- B. Standardize the grading system across all clerkships on all campuses.
- C. Provide more education to students about the residency selection process and how meaningful the grades and evaluations are considered by program directors. Perhaps a program directors roundtable discussion with students at each campus at the end of third year.
- D. Enhance efforts in Faculty Development in evaluating clinical performance.

2) Long Term

- A. Form a Task Force to study the feasibility of converting to a competency based evaluation system for MSIII and IV students as a way to achieving the goal of well rounded physicians. Key stakeholders to include clerkship directors.
- B. Continue to study the core curriculum of the SOM looking for ways to integrate pertinent material between the different clerkships as a way to reinforce important topics and themes common to all practitioners of medicine.

R. Moss Hampton, MD

J. Barry Lombardini

Report on the Breakout Group Session “Student Preparation for Matriculation/Clerkships” presented at the Forás II Educational Summit on March 11, 2010: The participants of the breakout group session discussed a number of problems that had been submitted by medical students and certain of the clerkship directors. In the course of the two hour discussion a solution was proposed for each of the problems.

A) Evaluate student preparedness for first year and identify any interventions -

Problem 1: Non-traditional students need a “*leveling course*” before matriculation?

Solution: A 2-4 week course beginning with an assessment of the incoming student’s learning styles and preparedness (a battery of tests) for year 1 as well as basics of biochemistry and anatomy and other areas that the students have insufficient preparation. The following question was posed but not answered - “*should this course be voluntary or mandatory?*”

Problem 2: Do we need an orientation for the Anatomy course (laboratory) to go over basics of anatomy such as anatomical planes/positions, movements, *etc.*?

Solution: There already is assigned introductory readings for the Anatomy course at the beginning of the course.

Problem 3: Do we need a comprehensive syllabus?

Solution: No, but we need a comprehensive list of learning objectives focused on the content to be taught in each course.

Problem 4: Is there a need for a pre-matriculation reading list?

Solution: There is no assurance that students would use such a list. However, if a list was compiled it should be individualized to very specific areas. Some participants suggested that a reading list should include material on how to study and what to expect in Medical School rather than specific books on anatomy, biochemistry *etc.* as these subjects will be taught in Medical School.

Problem 5: Should the students use the summer between year 1 and year 2 to prepare for neuroanatomy?

Solution: There was a suggestion to recommend a few books but in general the participants of the summit thought that the summer should remain free for the students to gain clinical or research experience. It was proposed that the students who just finished the first year should be polled to learn which were the most useful required/recommended books in their just finished blocks. This information should then be passed on to the next’s years incoming freshman.

Problem 6: Too much time spent with easy concepts and not enough time with difficult material?

Solution: Use competency exams to identify students with deficient background. Teach to the lowest level of required competency.

Problem 7: Lack of competency in basic biochemistry and anatomy?

Solution: Require biochemistry and laboratory-based anatomy courses prior to admission (pre-requisites).

B) Evaluate student preparedness for clerkships and identify any interventions -

Problem 1: Students perceive that resources between campuses are unequal? Example a “Redbook” was provided to Lubbock students which was written by the students and printed by the Office of Curriculum and not distributed to the other campuses which found out about this resource only serendipitously.

Solution: Policy should be to ensure that didactic resources are shared between campuses.

Problem 2: Third year students have no clear guidelines on division of time between clerkship/hospital duties and studying for NBME?

Solution: Unified learning objectives should be developed for each clerkship to cover all topics tested on the NBME exams and there should be clear expectations that students need to spend adequate time on clerkship/hospital duties as well as studying at home.

Problem 3: Student’s are not exposed to equal/similar learning experiences on each campus or clerkship?

Solution: Provide sufficient simulated patients and/or reading assignments to fill in the gaps.

Problem 4: Students are not prepared for year 3 in terms of writing SOAP notes, admittance notes, etc.?

Solution: Each campus needs a “boot camp” for students entering 3rd year to teach common fundamental tasks.

Problem 5: Clerkship directors are not familiar with what is taught in ECE?

Solution: ECE directors should distribute list of learning objectives to each clerkship director.

SUMMARY: Many potential changes can be discussed and perhaps implemented. However, it is well to note:

“We should be cautious about making huge changes when what we are doing now works”

Wise words to think about!

Foras, Summary document, March 2010

Foras Educational Summit Final Report

March 11, 2010

Women and Gender Based Health Curriculum Breakout Session

Facilitators: Marjorie Jenkins, MD; Betsy Jones, PhD; Leigh Johnson, PhD

Overview of Breakout Group's Task

The following agenda was used for the group discussion:

1. Overview of WGBH Curriculum
 - a. Definitions of WHGB curriculum
 - b. Review of core competencies
 - c. Overview of curriculum development process
2. Identified breakout group objectives
 - a. Establish a process to develop a curriculum in Women's & Gender-Based Medicine at Texas Tech School of Medicine
 - b. Review the current curriculum to assess where WGH is currently covered, as well as strengths & gap
3. Areas Identified for Improvement
 - a. Reviewed all blocks to identify gaps in gender based learning
 - i. MS1
 1. Logical Blocks/ Courses: Normal Anatomy, Physiology, Histology, ECE1, Student Clubs
 - ii. MS2
 1. Logical Blocks/ Courses: Systems Disorders, ECE2
 - iii. MS3: Logical Placement
 1. Clerkships– Problem-based learning cases
 2. Integration Seminar– Gender-differences emphasized in articles and case discussion
 3. Continuity Clinic
 - iv. MS4: Logical Placement
 1. Women's Health Elective (Amarillo as model)

2. Geriatrics rotation
 3. Neurology rotation
- b. Developed top ten list of health issues
- i. Cardiovascular/ Stroke
 - ii. HTN
 - iii. Cancer (Lung, Breast, Colorectal)
 - iv. Diabetes
 - v. Obesity/Nutrition
 - vi. Osteoporosis
 - vii. Arthritis
 - viii. Cognition/ Dementia
 - ix. Psychosocial Issues/ Violence/ Addiction
 - x. Sexual Dysfunction
4. Recommendations
- a. Assemble a repository of slides about gender-differences that can be added to existing lectures
 - b. Develop PBL/TL cases that can be integrated into the existing blocks, courses & clerkships
 - c. Establish easy access to resources for faculty
 - d. Add WGH to winter & summer teaching institutes
 - e. Develop CME & Grand Rounds experiences for faculty (& resident) development + forums, brown-bag sessions, etc.
 - f. Provide financial support & recognition for WGH teaching, travel to meetings, student research, etc.

Summary of areas identified for improvement

The break group reviewed each year of the medical school curriculum to identify areas that need improvement as well as logical placements for the WGB curriculum. For year one several logical placements for the curriculum we identified: normal anatomy, physiology, histology, ECE1, and student clubs. From the students perspectives one way to involve the medical students in this process was to offer gender based health lectures to the student club meetings. In MS2, system disorders and ECE2 were identified as logical placements for the curriculum. The general consensus was to focus on gender differences across the lifecycle and look at differences in manifestations and process of pathology and treatment. In MS3, it was suggested that problem based learning cases, which focus on gender differences in treatment of diagnoses, should be provided for the clerkships. Additionally, gender differences should be emphasized in articles and case discussion in the integration seminar. Lastly, continuity clinic was considered another logical place to insert gender based learning cases. In MS4, the group suggested the most logical places to focus on gender based health were the geriatrics and neurology rotations. Additionally, the group suggested the development of a gender based or women's health elective for this year.

The students recommended the LBWHI Integrate gender-difference discussions across teaching of the "Top 10 Health Issues." The students felt that learning would be enhanced by breaking down the gender differences in diagnosis, prognosis, and treatment of these major and most common health issues.

Summary of group recommendations

The group offered several recommendations for the curriculum development process. First, instructors felt the easiest way to integrate this information into their lectures would be for the Institute to develop a repository of slides regarding gender differences that could be easily added to the end of their lectures. This will allow faculty to easily access information regarding gender based health issues. In addition, it was recommended that the group develop PBL cases which can be integrated into existing blocks and clerkships. Lastly, providing resources and assistance for faculty development was also recommended. These resources include: adding WGH to the winter and summer teaching institutes, developing CME and grand rounds and brown bag session for faculty members, and providing financial support and recognition for WGH teaching, travel for conferences, and student research.

Speed Dating: Third Year Clerkship Directors

Robert Casanova, M.D.

A gathering of the TTUHSC Clerkship Directors took place on March 12, 2010. The format for the meeting was that of Speed Dating, that is, the attendees would first meet in a Campus Specific Meeting (CSM) then switch to a Specialty Specific Meeting (SSM). There were representatives from Family Medicine, Internal Medicine, Pediatrics, Ob.Gyn and Surgery. All campuses were represented but not necessarily across all specialties.

The **CSM** involved a questionnaire requiring self-reflectance revolving around the strengths and weaknesses of each campus and measures that could be taken from within to further the strengths and correct the weaknesses.

The main recommendations on ways to improve are as follows:

- More formal instruction on educational methods
- Teach teachers to teach.
- Education on feedback would be useful
- Medical Spanish - send teachers to Spain or Costa Rica for 6 week immersion
- Expand Residents as Teachers

The **SSM** involved the questionnaire below. Answers are included.

Clerkship Directors Speed Dating Questionnaire

1a. Are you doing Mid Evaluation at 4 weeks?

Yes

1b. Are you doing Final Evaluations within 30 days?

Yes

75%

2. As we go to Competency Based Evaluations, how will it affect you?

We are used to doing it for residents, so little difference.

Sounds like a lot of work. Who will pay for my time?

Learn how to grade [consistently across departments and campuses]

3. How can we help you evaluate students? How can we help you standardize evaluation?

Same evaluation scale throughout clerkships 3.2 vs 3.5

Training on student evaluation

Overhaul the evaluations. Train the evaluator.

Help me get faculty to do the evaluations (mostly residents do it now).

Help get evaluations to students in real time.

Seminars and educational faculty development

4. How can we help you standardize evaluation?

Have each core competency measured in discrete manner: example from Ob/Gyn

1. Patient care - OSCE and selected scenarios or schemes

2. Medical knowledge - NBME

3. Practice based learning and improvement - clinical encounter cards with self-evaluation, cultural awareness assignments

4. Interpersonal and communication skills - 360 eval

5. Professionalism – NBME professionalism project

6. Systems based practice – your guess is as good as mine or selected scenarios

5. Can you integrate with other Clerkships?

IM and psych

ObGyn: Breast and pelvic with FM

Surgery and OB/GYN: suturing and surgical principles,
preop and postop care, hypovolemia and shock, acute abdomen
with ObGyn

Meet with other CD in other specialties

Final Recommendations:

1. Regular meetings between campuses, more communication within campuses
2. Residents as Teachers
3. Faculty development on teaching

Feedback (Formative and Summative)

Teach the teacher to teach (Pedagogy)

4. Redo the clinical evaluation forms to make them more objective. Link to competencies.
5. Assist in getting faculty to actually do the evaluations.
6. Revisit Clinical Encounter Cards to provide real time feedback. There appears to be great support among students.

Foras II, 2010
Genetics, Nutrition, Rehabilitation Medicine Theme Team Report

Members:

Timothy Benton, MD; Brandt Schneider, PhD; Charla Allen, MS III

Methods of Assessment Used

- Sessions Listed in CurrMIT for Each Topic Area
- Sessions Listed in CurrMIT for UTMB and UT Houston
- Student Performance on USMLE and CBSE
- AAMC Graduate Survey
- LCME Standards
- Review of Previous Theme Team Reports

Results

Genetics:

Although the goals of the previous theme team were not fully implemented significant progress has been made in the curriculum regarding Genetics. Test scores (CBSE and USMLE 1) have improved over the last four years and the AAMC Graduate Survey reveals student satisfaction at or above the national mean in 2009 with progressive increase in the previous years. Analysis of the curriculum content using CurrMIT shows numerous educational sessions in years one and two devoted to the topic with comparability to other Texas medical schools. The third year, however, has only erratic representation of genetics application.

Nutrition:

Like Genetics the previous Nutrition Theme Team goals have lost momentum yet the curriculum has improved significantly in this area. Student performance on USMLE Steps 1 and 2 have improved over the last four years and CurrMIT content reveals numerous educational sessions in years one and two with comparability to other Texas medical schools. Also, like genetics sessions devoted to nutrition are sporadic in the third year.

Rehabilitative Medicine:

Little data is available to assess Rehabilitative Medicine in the curriculum other than the AAMC Graduate Survey, which showed student satisfaction at or above the national mean for the last 4 years. Listings of this topic in CurrMIT are sparse yet discussions during the small group breakouts at Foras II seemed to indicate there is adequate exposure during the clerkships but there is a need for more integration in the first two years.

Conclusions

Strengths

1. Appropriate and adequate progress has been made in the areas of Nutrition and Genetics within the first two years of the curriculum.

Weaknesses

1. More vertical integration with respect to Nutrition, Genetics and Rehabilitative Medicine needs to occur within the curriculum. Specifically the former during the clerkships and the latter during the basic science years.
2. Members expressed frustrations and concerns with use of CurrMIT and the accuracy of the data obtained.

Recommendations

1. Investigate and develop the possibility of a “note sharing” database whereby MS III’s can search and access educational resources provided during the first two years for use during the clerkships. The group recommended piloting a Genetics basic and clinical sciences integrative database.
2. Members expressed a desire to consider standardizing lecture and notes presentations.
3. Rehabilitative Medicine needs to be better defined and identified within the curriculum and perhaps a task force of the EPC assigned to further develop this portion of the curriculum.
4. EPC should continue to evaluate ways to maintain momentum in the areas of success.

Foras II

Group B March 12, 2010

Professionalism, Cultural Competence and Population Health

Chairs: Richard L. Dickerson and Patti Patterson

Reporter: Jane Colmer

Group Members:

Lorenzo Aragon
Rick Badillo
Barbara Ballew
Joseph Bishara
Michael Callaway
Sam Campbell
Robert Casanova
Lauren Cobbs
Lance Evans
Naghma Farooqi
Rafael Gonzalez-Ayala
Marjorie Jenkins
Jerry Kirkland
Kit Linton
Heidi Lyn
Mubariz Naqvi
Karen Nelson
Valerie Robinson
Bettina Schmitz
Kyle Schwetzer
Jordan Simpson
Tom Tenner
Maryam Turcel-Kara

I. Charge from the Education Policy Committee:

- Review Theme Team Reports for Cultural Competency, Population Health and Professionalism-Communication. Summarize goals of each of the original teams.
- Evaluate progress in achieving goals of each theme team. Use CurrMIT searches to evaluate current offering in both areas. Compare curricula at TTUHSC with those available through CurrMIT for other schools.
- Evaluate recommendations for curricula in these areas from national groups such as the National Institutes of Health, National Center for Cultural Competence and National Heart, Lung and Blood Institute.
- Evaluate recommendations for topics to cover to prepare students for USMLE Step 1 and USMLE Step 2CK/CS. Are these topics adequately covered in the curriculum?

- Evaluate performance of TTUHSC students in these areas from CBSE, USMLE Step 1 and USMLE Step 2 where applicable. These data may be obtained from the Office of Curriculum
- Identify LCME standards pertinent to these topics and entries from the TTUHSC LCME database from March 2009. Make specific recommendation for actions by relevant groups (theme teams, curriculum committees, etc.). These standards include ED-21, ED-22, and ED-23

II. Objectives:

It was immediately apparent that the scope of the charge was such that the group needed to narrow its focus. Previous discussions with the executive group (Joseph Bishira, Richard Dickerson, Patti Patterson, Bettina Schmitz) resulted in the following objectives:

1. Assess how well professionalism, cultural competency and population health has been integrated into the new curriculum
2. Determine how successful we are in increasing student competency in these areas by talking to students and examining the student report
3. Compare our efforts in these areas to other medical schools in Texas and across the nation by looking at CurrMIT reports

III. Synopsis of Discussion:

CurrMIT Search

TTUHSC – ECE I, BCT, Systems I, Systems II, PEDS, OBG, Psych
 State-wide – Baylor TTHSC TAMU
 Nationally most
 TTUHSC and the Ohio State University have the most entries

A. Professionalism:

Pilot project for professionalism using forms to evaluate students in years 1-4, mostly in 1 (ECE I), 2 (ECE 2), 3 (CCs) – almost a 360 approach – Mike Ragain, Dennis Dove, Kathy Horn; 4 (some)

Are we where we need to be?

Are we using the new forms, 4 is on target, 5 is excelling, 1-3 indicate warning, in danger, improvement needed. Global assessment and individual areas – list of students who receive 1's and 2's to be sure they are improving (moving out of the danger zone)

Very good tool, mid-block evaluation allows correction of behavior in timely.

However, in EP, one clerkship has NOT seen improvement in students entering second rotation – were there problems in first rotation, how could they not know how to dress, etc.

Certainly allowing real time identification of students who are having trouble

Idea of “blank slate”, each student is evaluated on what they do in THAT clerkship, but when a student has problems, knowing whether they had similar problems in other clerkships, may lead to intervention that will get student back on track. On the other hand, it may be a problem in a specific clerkship.

Process needed to address the “problem” student. Who to notify, who should access information about performance in other clerkships? 2’s clerkship director should talk to the student; 1’s Office of Curriculum needs to talk. How many poor evaluations are needed before student is referred to SPPCC? When to involve Assistant Deans? Process needs to be integrated into rotations before the student gets kicked to SPPCC. Give them professionalism guidelines – written; feel this is done.

Talk to them if they get a 2; make sure they improve; need to have consequences. Remember that students often see bad examples – professionalism considered a “soft” competency. Need teeth at student AND faculty level to make this a serious issue. That is, should we fail students who fail professionalism? Yes.

Do the students come in to clerkships with idea of professionalism? Are the ECE I and II aspects of professionalism continuing into 3rd year; do professionalism issues addressed in 3rd year flow into 4th?

Students felt that professionalism is more a self-taught process; student evaluations would be beneficial as students may say things that faculty might feel constrained to say; must be anonymous. Student receives a final “pooled” evaluation that includes all evaluations including those from students.

Professionalism regarding pharmaceutical industry (gifts, food, etc.). AMSA stressing pharm-free; LBB is pharm-free.

Professionalism must begin among faculty – there are those who are late, “bad mouth” other department or specific faculty members. What kind of role models are we for the students? Residents begin to behave like faculty and this translates to students. Who should handle issues of professionalism among faculty – Block directors, clerkship directors, chairs, Office of Curriculum.

Professionalism integration map. Integration of competency: professionalism and role recognition in the 4-year Indiana University School of Medicine curriculum, IUSM Indianapolis campus. Slide provided by Casanova

B. Cultural Competency

Nation-wide – 30 medical schools incorporate cultural competency

State-wide – UTMB and TAMU-SOM incorporate cultural competency

TTUHSC - Mainly in ECE I (Patterson): See homeless, write papers, need more case based and/or experience based for some of the lectures and possible the small groups.

Should also be a piece in clerkships; OB/GYN has some cases. What else should be done?

Should this be a continuum throughout the clinic?

Obesity, homelessness, elderly, adoption, uninsured, end of life care, many other experiences would fall into this. THIS IS SYSTEMS-BASED PRACTICE.

Teach cultural competence from the point of information about a different culture; needs to be experienced to really learn it; patient centered care means working with the patient as they

are. Cultural humility; ECE I start with this – see your patient in context of the family, community, otherwise there will be mistakes. This is covered in communication; but, still sees inability among 3rd year, 4th year, and residents to “shut up and listen”. They need to learn to ask the “right” questions – e.g., Why is this child in foster care?

Students: ECE I/ECE II get a lot; videos some more
Cultural competency should have continuity in each rotation (clerkship) along with professionalism. Counseling experience? They feel they learn more about cultural competency from experience – working with the people – rather than writing an essay. However, the writing experience allows the evaluation of the student.

Clerkship directors/faculty can find cases that teach cultural competency where students can discuss the issues. But HOW do we assess this? Discussion with participation, write Case Report on one patient who illustrates

C. Population Health

TTUHSC – ECE I, Integrated Neuroscience

State-wide – none

Nation-wide – less than 10 in US; most Canadian medical schools

Patterson: part of professionalism and cultural competency – evidence-based practice, clinical preventive services, health systems and health policy, community aspects of practice

Evidence based medicine: Warner’s piece in year 2 Epidemiology biostatistics etc

CPS: screening, counseling, chemoprophylaxis, one more

Health systems and health policy:

Organization of clinical care and public health systems

Health services financing

Health workforce

Public policy process

Community aspects of practice:

Occupational and environmental health

International health issues

Cultural dimensions of practice

Ancillary community services; crisis hot-lines poison control centers, family services, food banks, prosthetics, disaster preparedness, bioterrorism, weapons of mass destruction, the physicians role in emergency response systems, etc.

Global health certificate – new program available; supported foreign experience in disadvantaged country/area

RURAL HEALTH search – not one hit nationwide

Implementation strategies

Develop of the specific modules for the fourth year internet based course – 2007 – not done

Develop of the bank of test questions for the internet-based examination (2007) – not done

Identify and support of faculty at each regional campus who would coordinate the teaching of population health in 3rd year (2006). Warner has an elective (4th year) 8-10 students; Mennonite population, refugee clinics, etc. up and down I-29

Development of a teaching syllabus and other resources for faculty identified as population health receptors at the regional campuses

Identify and support one or two senior faculty members who would coordinate population health activities on each campus

MPH program?

Defining “population”; must it be overseas? What about a military population? What about other local “populations”. Most experiences occur between 1st and 2nd year or in 4th year.

Experiences are being developed in northern Spain, southern Spain, Himalayas, and India. But can we develop experiences here in our own “backyard” similar to what Warner’s elective does for “public health certificate”

Conclusions and Recommendations:

Professionalism: The NBME pilot program in assessing professional behavior is aiding our efforts in assessing professionalism in medical students. However, we need to close the loop by developing policy on how poor professionalism will be handled both in medical students and faculty. A written policy needs to be drafted to specify who will accumulate professionalism reports, how poor performers will be identified, who will be responsible for management of poor performers, and what steps will be taken to remediate poor performers, and if necessary, dismiss them. It was unaminos that poor professionalism is sufficient to fail a clerkship and that the new professionalism forms are a major improvement over the previous forms. A policy needs to be developed and immediately implemented to address poor professionalism in faculty. School of Medicine Faculty serve as role models for students and residents from Day 1 and must be held to the highest standards.

Cultural Competency: We have made progress but more effort is needed. Cultural competency must be emphasized, taught and assessed throughout the curriculum. A good foundation is presented in ECE I. Currently, OB/GYN uses cases studies to teach elements of cultural competency. Cultural competence is systems-based practice and needs to be considered in patient management. It needs to be part of each clerkship and rotation. Cultural competency is really cultural humility – students, residents and faculty need to talk less and listen more. Students should write case reports on patients that illustrate how cultural competency influenced patient care.

Population Health: This area fell behind the previous two and needs more emphasis.

Population health is included in all NBME exams. It is taught in ECE I and II, Systems I and II,

and some clerkships. Effort needs to be made in developing the Global Health Certificate program. Although rural health is stated as an emphasis item by this institution, there was not one entry in CurrMIT here or nation-wide. Overseas experience is great but there are major health disparity problems in our own backyard that need recognition. We listed several strategies in a previous Summit that have not yet been implemented. We need to deliver on these as well. These include developing a teaching syllabus for population health preceptors, establishing key faculty at each campus to work with 3rd and 4th year students, develop a bank of test questions related to global health, develop modules for a 4th year internet-based course.