



Renaissance VII Medical Education Summit

March 6–8 2008

**Executive Summary
and
Recommendations**

**TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
School of Medicine**

**Summary: Renaissance VII Education Summit
March 6 - 8 2008
(85 attendees)**

REPORT CONTENTS

- Summary: Final Recommendations – *p. 1*
- Breakout Groups: Key Points – *p. 2*
- Summary Plenary Sessions: Key Points – *p. 3*
- Appendices: A – Surgery and ObGyn Breakout Group – Full Report; B - Internal Medicine-Psychiatry Full Report; C – Reorganization of Year 4, Report of Dr. McCurdy – *p. 5*
- Summit Evaluation – *p. 12*

SUMMARY: FINAL RECOMMENDATIONS

Year 3

- Clarify governance for Years 3 with respect to Clerkship Directors, Chairs, and Education Deans and Directors. Clerkship Directors not favorable to lead clerkship director concept from workload standpoint and standpoint of “adding a layer”. Consider lead chairs instead.
- Establish clerkship director role at 0.5 FTE (voted item) and strengthen role.
- Continue to evaluate Continuity Clinic

Year 4

- Establish regular and separate campus and intercampus meetings for Year 4 Directors. Provide support for Year 4 Directors.
- Review length of Year 4
- Establish capstone/longitudinal portfolio with reference to ACGME competencies
- Modify Year 4 evaluation forms
- Continue Neurology requirement

Years 1 to 4

- Expand access to WebCT for all Year 1 and 2 Teachers; review access for Years 3 and 4 faculty
- Strengthen career advising system
- Create a Task Force for outreach to Community Teachers
- Increase use of medical informatics and simulation in Years 3 and 4
- Strengthen EPC Triennial Review process for Years 3 and 4

BREAKOUT GROUPS: KEY POINTS

ED 33: Years 1 and 2: Gwynne Little PhD and Patti Patterson MD, Co-Chairs

- All faculty need to write session objectives. Currently these are not necessarily linked to the School's Vision/Goals/Objectives
- More consensus needed on criterion vs norm-based grading. Combination is currently used, with normalizing at the end of the block, but this is not done the same way in all blocks.
- All Year 1 and 2 faculty need access to WebCT
- Exam question review needed prior to exams but difficult to implement
- Role of Chair in Block Director job description needs revision
- Cecil's Essentials can be required in Year 1
- Poll Block Leaders re content relevant to translational research

ED 8: Year 3 Clerkship Groups: Comparable and Equivalent *Family Medicine and Pediatrics: Kathy Horn MD and Rodney Young MD, Co-Chairs*

- Family Medicine: students must get at or above 75th percentile to get Honors (given to ~5% to 8% of students)
- Clerkship Director – Chair link needs to be stronger
- Weighting of evaluation components should remain flexible for different clerkships
- TechLink technology needs to be improved

Surgery and ObGyn: Ari Haldorsson MD and Leonidas Miranda MD, Co-Chairs. This group had representatives from Clerkships on all four campuses. See full report in Appendix A.

- Comparability of experiences, common goals and objectives, are achievable
- New evaluation forms need to be shorter and more user friendly
- Include documentation of observed H and P in procedure and patient logs. Review if appropriate in surgical rotations where vascular and trauma exams, for example, are also important
- Standardize criteria for Honors across all clerkships. Now this varies by clerkship
- Provide protected study time so students can improve subject exam scores. Lubbock has revised its didactic series with this in mind.
- Improve communication across clerkships. Ensure that clerkship director has 0.2 FTE protected time with good coordinator support.
- Continuity Clinic time interferes with clerkship learning and needs to be reviewed.
- Make sure volunteer faculty have SOM appointments and email addresses to improve communication.
- Length of clerkship is too short at 8 weeks.

Internal Medicine and Psychiatry: Steve Urban MD and Deborah Nutis MD, Co Chairs See full report in Appendix B

- Psychiatry: experiences are probably not comparable on the different campuses
- Ensure that observed H and P is being done. In Psychiatry there is no observed H and P - ?include in clerkship OSCE
- Grading: do not recommend that subject exam Fail cutoff be raised to 10th percentile
- Clerkship directors need to get 0.5 FTE on each campus with dedicated budget

- Simulation Center needed on all campuses
- Continuity Clinic is beneficial from IM and Psych perspectives
- Master Clinician teachers on all campuses can address current subject exam scores
- No clear budget for Clerkship Directors; no time for single Clerkship Director to take Lead Clerkship Director role
- Students take call in El Paso but not in Amarillo – is this a comparability issue

ED 8: Year 4 Required Rotation Directors: Suzanne Escudier MD and Kenn Freedman MD, Co-Chairs

See report from Dr. McCurdy, Reorganization of Year 4: Summary and Recommendations, in Appendix C

- Neurology requirement: problem in Amarillo
- Consider adding 2 weeks to year 4 to accommodate ambulatory requirement; 32 weeks is a short Year 4
- Need to modify Evaluation forms for Year 4
- Year 4 Directors should be specifically recruited with a clear job description
- There should be a School-wide Central Clinical Operations Committee for Year 4

ED 17: Geriatrics: Maria Ranin MD and Laura Baker MD, Co-Chairs

- Implement AAMC Competencies in Geriatrics in design of new Year 4 required geriatrics rotation
- Develop common core manual by July 1 with comparable experiences on all campuses. Pool resources from each campus for didactics and testing

PLENARY SESSIONS: KEY POINTS

- **ED 26-30: Grading Principles, Doug Hamman PhD.** Reviewed evaluation of test questions, including point-by-serial vs p value vs discrimination index. He recommends discrimination index (proportion of student scoring well minus proportion scoring poorly) to determine percentage of students getting answer right. Reviewed criterion-based grading vs norm-based grading (use of the curve). We need to know what the test covers as well as how each question performs.
- **ED 33: Education Offices Panel and Plenary Discussion: Achieving Excellence on Distributed Campuses – Perspectives from the Campus Education Offices**
 - Amarillo: Dr. Sheehan noted concerns with off-cycle students and scheduling, clerkship interruption by new Continuity Clinic, blurred margins regarding governance.
 - El Paso: Dr. Horn noted concerns with comparability on subject exams and presented analysis and plan to hire education specialist to help students with study skills and test-taking; also noted need to define lines of communication with chairs, education offices, and clerkship directors and need for training workshops for educational technology on the campuses. She asked if student problems with test-taking has been analyzed; self-report used in El Paso, which has 11 students off cycle.
 - Lubbock: Dr. Larsen noted concerns with campus comparability and space for students and teaching.

- Permian Basin: Dr. Burdine noted importance of resources and funding, need to involve chairs and clerkship directors in governance, and plans to intensify outreach to community physicians.
- **ED 33: Regional Deans and Plenary Discussion: Education – One School or Four Campuses Holding It Together – Perspectives from the Regional Deans**
 - Amarillo: Dr. Jordan noted goal of developing simulation and educational research, commented on decreasing state dollars.
 - El Paso: Dr. Schydlower commented on challenges of forging continuum from student education to residency, suggested looking at JACHO data to see how our graduate physicians perform in the community and number of board certifications and recertifications. He also suggested comparing match data by campus.
 - Permian Basin: Dr. Jennings noted goal of improved informatics and educational technology and problems with TechLink; commented on the competition for resources of the three missions, teaching, clinical care, and research.
- **ED 26-30: Program Evaluation: Is it happening? Is it adequate?** Drs. Bickley and Williams described current evaluation system (see section in Summit notebook). Regarding the Triennial Review, Dr. Williams noted need for faculty peer review and documentation of quality of teaching and the need to focus on organizing and streamlining the Triennial Review process.
- **Special Topics and Plenary Session:** mentoring process described by Drs. Larsen and T. McMahon. Attendees supported basic medical Spanish requirement, suggested how to increase radiology content in clerkships, and discussed longitudinal Year 4 capstone with alternative of block capstone in March since all students on their home campuses for the match.

APPENDICES

Appendix A - *Surgery and ObGyn Breakout Group: Full Report*

- To ensure comparability, the group felt that administrative and procedural comparability should be secured by using the same evaluation forms, same or similar goals and objectives and overall similar distribution between didactic and hands on clinical experience. An absolutely comparable experience is not achievable with the different patient populations and different surgical expertise between the campuses.
- Similar goals and objectives shared in the School of Medicine vision and between the campuses regarding syllabus objectives, lecture series and other handouts including possibly recommendation of the same textbooks is achievable and desirable.
- To ensure a prompt mid clerkship evaluation and grades within 30 days of the end of clerkship, the group felt that this was a goal that should easily be achieved. Significant discussion regarding the new evaluation forms which were uniformly disliked as being too long and cumbersome and thereby not very “user friendly”.
- Ensured observed H&P and documentation thereof. Significant discussion whether a surgery clerkship should be involved with thorough evaluation and observation of a full H&P including all organ systems rather than concentrating on expertise found within this clerkship including abdominal exam, vascular exam, trauma evaluation and so on. Currently most clerkships do observe the H&Ps during the clerkships specifically in preparation for the end of clerkship OSCEs but the main documentation of this is in the

evaluation form by individual faculty. This could possibly be included in the student's mandatory procedure and patient log lists.

- Uniform grading system. Significant discussion regarding whether an honor performance on the SHELF exam was mandatory to get honors in the rotation. Most people felt that this should either be made a rule or the grading proportions between evaluations, tests and OSCEs should be in such a way that unless you received honors on the SHELF exam, you would not get honors on the rotation. Currently, the clerkships have different grading policies and these need to be unified.
- A long discussion why the SHELF exam (subject exam) scores are relatively low for surgery. Most participants felt that by placing more attention on the exam scores with the grading system, emphasis by the faculty and possibly providing more protected study time, these scores could be improved. It was discussed and agreed upon that like any other exams of this nature, it is difficult to recommend a specific textbook or a specific way to prepare but most agreed that more emphasis should be placed on this portion of the clerkship. The clerkship in Lubbock has recently reformatted their didactic lecture series, specifically in preparation for the subject exam including more emphasis on subspecialties and topics within in general surgery, known to be a weakness by previous test scores.
- Review clerkship directors job description and ensure partial FTE for clerkship director and coordinator. A minimum discussion regarding the job description but as far as providing FTEs, this was considered highly significant as far as emphasizing the time commitment and importance of these positions. There was a long discussion regarding protected time but currently this is not available for the clerkship director. Also, significant discussion about "super clerkship director" i.e. either one of the current clerkship directors or a different person in education to oversee and supervise all of the clerkships regarding administrative work, comparability between the clerkships and overall recommendation for educational improvement. It was also felt strongly that the communication between the clerkships could be improved.
- Continuity clinics. It was uniformly felt very strongly that taking the surgery clerkship students out of their rotations half a day per week for a seven week rotation was extremely disruptive; informal feedback from the students suggests that this is not a worthwhile experience for them compared to being able to concentrate on their current clerkship. It was brought up several times that the clerkship is literally seven weeks. giving the students exposure to the vast field of general surgery, vascular surgery, cardiothoracic surgery, ENT, urology, anesthesia, orthopedics, neurosurgery, pediatric surgery, etc. and every minute counts.
- Educational technology needs. Sharing educational resources such as web site, tests, and very impressive services provided by the library - probably been an under utilized aspect of the clerkship and should be reinforced and highlighted to the clerkship directors.
- Volunteer faculty and e-mail addresses. All volunteer faculty with students should be in contact with the school either through a clinical appointment and a Texas Tech e-mail address for easy access and be privy to all bulk e-mails, mailings and other information regarding the clerkship and other educational activities.

In general, the discussion concentrated in significant amounts on ways to improve the subject exam and the clerkship rotation as a whole. Strong frustration with how short this clerkship is related to the goals and objectives both clinical and didactic. Overall, the group came away with renewed enthusiasm, many excellent ideas shared between the campuses and optimism regarding the future of surgical education at the Texas Tech School of Medicine.

Appendix B: Internal Medicine and Psychiatry Breakout Group: Full Report

Participants: Internal Medicine: Drs Nutis (El Paso), Neilson and Jumper (Lubbock), Urban (Amarillo). Psychiatry: Drs McGovern, McMahon (Lubbock) and Hooper (Permian Basin).

- Comparability of experience. IM: same manual (linked to vision, goals, objectives), curriculum, clinical responsibilities (i.e. % of inpatient vs outpatient experience) across campuses. CDs meet via TechLink every 1 to 2 months, write the same OSCE for each campus, and review comparability of experience. Lectures similar. Clinical experiences similar (Amarillo has VAMC, El Paso has Beaumont, but total inpatient time is the same)
- Psych: Same manual, grading policy, OSCEs across 3 campuses. Some differences in clinical rotation (i.e. no inpatient ward in Amarillo). Observed H&P generally not being done. Lack of full time faculty on Amarillo campus represents a problem.
- Promptness of mid clerkship evaluations: not a problem in either clerkship. Promptness of post-clerkship grades: needs improvement partly due to receiving NBME scores 2 weeks after end of rotation, partly to difficulty getting both clinical evaluation and professionalism evaluations from the faculty, partly due to lassitude of CDs in internal medicine.
- Observed H&Ps. see above. Being done and documented in students charts in IM (does office of curriculum need copies for each student?), residents participate on Lubbock IM but not on El Paso and Amarillo (important or not?), not being universally done in psych
- Grading. Uniform, explicit, and reproducible across campuses in both clerkships. We would NOT favor increasing the failure criterion to 10%. 75% okay for honors.
- Low subject exam scores. Possible factors: decrease from 12 to 8 weeks in IM, we have not been “teaching to the boards” Possible remedies: more board review sessions? more “reading time” for students? (but this takes away from the clinical experience where medicine is really learned). More resident involvement in teaching. Explicit instruction/feedback for residents’ teaching skills. Psych in Lubbock has benefited from Master Clinical Teacher (MCT) who has dedicated time for teaching and board review. Could this be extended to other campuses and clerkships? How can this be funded?
- Job description. With all the added responsibilities, the group would favor increasing to 0.5 FTE for CD. Budgeting for medical student education is NOT being done by the CD or even with much input from the CD. Most CDs don’t know if any dollars are being specifically allocated to MS education. (Re: CD job description, essential resources #1. The clerkship director has a defined budget for personnel, materials, training and travel sufficient to meet the educational requirements of the clerkship and the professional development of the Clerkship Director). Need goal-directed budgeting? Need for specific line item for student education? Again, monies for MCT in all departments would be a boon for student education. Full-time faculty in psych (Amarillo) and more committed clinical faculty on all psych campuses would really help the CD.
- Translational research. 2 projects have been done in last few years (El Paso, Lubbock) and presented at the CDIM meeting in the fall. Educational technologies: need high-level simulation centers on all campuses.

- Lead clerkship director. Improved intra-campus communication would be useful, especially in psych, but several concerns were expressed: just another strand of spaghetti in an already confused pasta bowl of administrative lines of command? How would it actually work in the day-to-day allocation of time and resources for teaching? Would the LCD travel from campus to campus? How often? Can we empower members of the already existing bureaucracy to carry this out? Overall, tepidity toward the idea.
- Continuity clinic: this item was discussed. Uniformity of experience across campuses would be ideal. In general, this experience enhances what is taught about patient care both in IM and in psych.

Appendix C: Report from Dr. McCurdy, Reorganization of Year 4 – memo submitted for Summit VII February 22 2008

The Liaison Committee on Medical Education (LCME) standards places a substantial responsibility on a medical school to effectively implement and manage a comprehensive curriculum that expands all four years. In the face of an impending LCME site visit in 2009, the EPC has encountered continual difficulties in managing/assessing the 4th year experience of Texas Tech medical students. This fact serves as the primary driver for carefully redesigning the 4th year at the TTUHSC School of Medicine.

There have been two previous reviews of the 4th year curriculum during educational summits. The first was in December of 2005. The recommendations from that working group report were:

1. Provide a career oriented personal learning plan before the 4th year begins
2. Demonstrate the capacity to admit and manage patients...
3. Demonstrate the ability to perform procedural and clinical skills...
4. Under supervision, perform an academic project of sufficient expertise...
5. As senior students, demonstrate the ability to teach their junior colleagues...
6. Demonstrate proficiency in basic survival skills for residency...
7. Agreement that the current objectives for geriatrics/neurology should be affirmed...

The second working group report came from the summit in August of 2006. The recommendations were:

1. Lengthen the year to 34 weeks
2. Have four – four week required rotations in the areas of critical care, sub-internship, neurology/neuropsychiatry, and ambulatory clinic.
3. Have a two week capstone experience with the goal of personal management.
4. Continue the integration seminar tied into the 4th year for required 4th year rotations.

The final work group met in August of 2007 and made the following recommendations:

1. Lengthen year 4 to 34 weeks
2. Continue the year 3 integration seminar
3. Affirm the need for 4 – 4 week rotations in ambulatory care, critical care, neurology, and a sub-internship
4. The electives should be 4 “real” weeks
5. Institute a capstone experience which is not optional. The goal should be personal management and items to be covered include: effective communications, time management, conflict resolution, evidence-based medicine, substance abuse, personal finance, and ACGME competencies.

I have attached all of these reports along with a summary of the literature on capstone experiences, a manuscript from the peer reviewed literature detailing a managing care student project that was done as a capstone experience at another medical school and the August 17, 2007 Educational Policy Committee Retreat Year 4 Subcommittee report on Year 4 Triennial Review. These are all offered as background information.

The remainder of this memo will deal with summarizing a series of focus groups that were done in Lubbock, Midland/Odessa and Amarillo with Year 4 Clerkship and Course Directors. The methodology that I employed in this focus group was to ask each group of faculty some very specific questions which will be detailed as I go through the analysis of the information. I provided these groups of faculty with background information in the form of written communication as well as an initial dialogue about what is currently the situation with Year 4 as well as issues that have been identified over the course of the last eighteen months about Year 4. From my perspective, the issues in Year 4 have been the length of the 4th Year, whether or not the school should require neurology rotation in Year 4, in which portion of the 4th Year should Geriatrics reside, the continuing difficulties that the EPC has in gathering data about Year 4 selectives and electives, whether or not a capstone experience should be a part of Year 4, and whether or not the continuity clinic should continue in Year 4.

- The first question that I asked each group is **what do you think about Year 4**. All of the faculty were generally positive about the 4th Year. Things that came out of this portion of the focus group process were things like the students need to have time for electives. They have to have time to explore career alternatives and they need to have time to look at residencies elsewhere. Another general comment that was made in a positive vein was that we are graduating an undifferentiated medical school graduate who seems to be well prepared. Other things of a less positive nature were faculty questioning the 32 week 4th Year. Many faculty expressed concern that the 4th Year should be longer. Problems of coordination have been experienced on all of the campuses particularly as it pertains to elective experiences that occur within a specific discipline but happen on the separate regional campuses. There seems to be no communication or only limited communication between the 4th Year Course and Clerkship Directors in this area. Another less positive thing was that students are strategic and they learn where the easy rotations are. Those who want to work will work and those who do not will not. It is very hard to maintain a level of accountability with this degree of loose affiliation that currently exist.

Regarding the specific needs for a neurology elective of four weeks duration, there was general unanimity of opinion that this is something that we need to have in the 4th year. The faculty also go on to say that these efforts need to be coordinated across campuses with uniformed goals and objectives as well as a uniform evaluation process. The downside of that is on at least one of the regional campuses, many of the 4th year electives are done by non-paid faculty and it is very difficult to get equivalent evaluation when dealing with non-paid teachers. This type of concern generalized into other parts of the conversation such that community based rotations are difficult to make comparable when there is very little that the medical school can do in terms of strongly influencing the choices that non-paid faculty make regarding their teaching and the overall educational experience.

- The next question was **what do you believe is right or good about year 4?** The faculty demonstrated wide agreement on the required selectives. Areas that were affirmed multiple times were the sub-internship, neurology. There was much discussion

around having reasonable flexibility in the 4th year being a distinct advantage to the students. People mentioned doing off campus rotations in the form of “auditions” electives. As an aside, this was felt to be most important for those people who were going into highly competitive or heavily procedurally oriented subspecialties.

- My third question was **what needs changed?** Having clear goals and objectives for the common electives across all the campuses was something that virtually everyone favored. Another topic of conversation was a general sense that the governments of the 4th year was very “loose”, difficult to discern, and hard to understand by some. Another item that was embedded in this is that there needs to be a greater degree of rigor, more accountability and less of an ability for students to “blow off” rotations. This line of conversation moved into the area of providing consistent feedback. There was a general belief that feedback was not being given on a regular basis to both the students as well as the faculty. At this point in a couple of the focus groups, the question of geriatrics came up. There seemed to be a split in the faculty about where geriatrics should be placed. There was general agreement that geriatrics should be a part of the curriculum but having it in the ambulatory selective would result in having some students do two weeks of pediatric ambulatory selective and two weeks of geriatrics. This seemed to be a bit problematic. Some people favored adding an additional two weeks to the overall curriculum making it 34 weeks and placing geriatrics as its own stand alone two week rotation.

The other thing that many faculty commented on was that at the beginning of the year many students are vying to get into certain rotations because of their high degree of interest in a particular specialty. This puts a strain on certain departments. One department that experiences that a lot is the OB Department in Amarillo. Within that part of the conversation, it was also mentioned that with the increased numbers of students anticipated in 2009 and beyond on the regional campuses, this may become even more of a problem. A number of the faculty felt that having places for the medical students requires a real serious look at the infrastructure of the medical school to include staff, faculty, and space. This lead to another theme which is that there may be certain specialty rotations that have to have their numbers limited or another solution needs to be found to accommodate more students in certain areas.

Returning to the issues of governance and structure, many of the 4th year rotations do not have an orientation. Many faculty are still overburdened with clinical demands and it makes this process very difficult. Year 4 directors, who are currently not meeting need to meet more regularly, the other thing that a number of faculty noted was that the year 4 students need to also meet regularly just as they do on some campuses during year 3.

When I asked the question about having continuity clinic continue during year 4, there was much concern voiced by all of the faculty about whether or not there was clear educational benefit. They also asked many questions about operational issues.

The last thing that came up during this conversation about what needs changed is faculty development. Many of the faculty continue to be quite overburdened with clinical demands. They feel that their teaching skills need further development. Many of them articulated that they were not taught how to teach except through good and bad role modeling during their residency and medical student years. They voiced concern about the resources needed to become educators (i.e. time, money, equipment, etc.) does not

seem to be fully committed on their campuses. Going a bit in more detail along that line, a number of faculty asked me how decisions are made in terms of allocating resources across the campuses for such things as faculty development and teacher support. One idea that came up on one campus but not address by any of the others was the creation of a combination subspecialty rotation (e.g., combine dermatology and something and something and something). Other areas that were emphasized on this particular campus were the need for further training in radiology, ophthalmology, ENT, and orthopedics.

- Moving to the last item, I asked the faculty about **what their thoughts were about a capstone experience**. Many faculty first asked me what is a capstone experience. I showed them what little exists in the peer reviewed literature about capstone experience; also I either showed them or gave them a verbal summary of a capstone experience that was instituted at another medical school. Other examples that I used were capstone experiences from other professional educational programs such as graduate school, and business school. As a general comment the faculty thought that having something that brought a degree of focus for the students at the culmination of their fourth year was an important experience. Many of them commented that it would be a lot of work for both the faculty and the medical student but they felt that the trade off was important and believed that it could be done. The caveat in this part of the conversation is that the clinical faculty may already be heavily over burdened and this may be a very difficult thing to pull off. There was discussion around having a two week experience at the end of the 4th year with the alternative being some kind of longitudinal project that started either at the beginning of year 3, sometime during year 3 or at the beginning of year 4. Most, but not all, faculty favored the longitudinal experience over a block rotation. Again, the issue was staffing, space, effort, and money were brought up. While this was a “great idea”, many faculty said that this will be difficult to implement.

As we explored the idea of having a two week block experience, a number of the faculty questioned what can really be done in two weeks. If you do this at the end of year 4, most of the medical students are going to have a “short timer’s syndrome”. An in depth integrative process is not going to be very easily done in two weeks.

It was noted that some schools appoint a mentor in year 1 and this person is present in the medical student’s life for the entire duration of the curriculum. This person could easily be one to advise the student on a capstone experience. Ideas that were floated and discussed were things like a research project, a case report, some type of longitudinal experience to incorporate patients that the student followed in the continuity clinic. There was a general agreement that this was good for the students to give them an opportunity to revisit a major topics or some basic science. In one focus group, it was noted that this could be a way to include geriatrics. The student could approach this from the stand point of a multisystem failure review with ethical concerns, financial issues, managing disease and social issues. The major focus of this person’s comments was on the student creating a portfolio. When this was presented to other faculty on other campuses, this met with some favorable response. Integrating the capstone experience into the construct of a clinical review of ongoing patient care was affirmed by many. The other thing that was mentioned multiple times was the development of a portfolio as a part of this capstone experience. One of the cautionary notes that I heard more than once was that for the capstone experience to be sustainable, there needs to be a change in perceptions on both the part of the faculty as well as the students.

Summary

- In summary it is my opinion, based upon the comments of many faculty on three of the regional campuses (Amarillo, Odessa as well as Lubbock) is that there are some things that need to be maintained in the 4th year and there are some things that need to be changed. Those things that the faculty generally agree upon is the four required selectives (ambulatory, sub-internship, neurology, and critical care). There is not unanimity of opinion about what each one of those rotations should specifically focus on. The majority of the faculty felt that there needed to be greater degrees of collaboration across the regional campuses as these four selectives are further developed and strengthened.
- The governance of the 4th year needs to be referred back to the Education Policy Committee in order for this to be strengthened. The year 4 clerkship directors would like to have the opportunity to interact more with their colleagues on the other campuses. The 4th year students should be meeting more regularly as a group and interacting with the faculty. The exact nature of this interaction is yet to be defined.
- The capstone experience, as a stand alone two week block is not heavily favored by the faculty that I interviewed. What these faculty do favor is having a longitudinal experience that takes on the construct of a portfolio, involves a critical analysis of ongoing patient care, incorporates their experience in their 3rd year continuity clinic, and points the students toward a better understanding of the interrelationship of improved patient care interfaces with the ACGME competencies. Items such as continuous quality improvement, managed care, the business of medicine and other matters that pertain to personal management, were not heavily subscribed to. There was much more unanimity of agreement and much more of a strongly voiced affirmation of having a capstone project that focuses on continuity of care and continuous care management.

Recommendations

1. That the four required selectives that are currently in place be affirmed and strengthened.
2. Bring together the clerkship directors for each of those selectives to develop a set of uniform goals, objectives as well as an equivalent evaluation system.
3. Strengthen the coordination of electives on the regional campuses (i.e., orthopedics in Amarillo, El Paso, Odessa, and Lubbock). Lengthen year 4 to 34 weeks and use those additional two weeks for the geriatrics requirement.
4. Create a capstone experience using the concept of continuity of care, continuous management of care, and employing a portfolio. This portion of the 4th year needs a small subcommittee that involves faculty from the regional campuses organized in such a way that this issue can be resolved quickly.
5. Once these changes are put in place to have the year 4 subcommittee revisit the matter of the triennial review process with a yearly review of the 4th year.

SUMMIT EVALUATION
Renaissance VII Medical Education Summit Evaluation Survey

(n=27)

	AVG (STD DEV)
1. This summit met the following objectives:	
a. Increased faculty knowledge of LCME standards and priorities for improvement for Year 1-4 in our School and on all campuses.	4.04(.90)
b. Promoted vertical and horizontal integration, ensured that all sessions linked to SOM Vision, Goals, and Objectives.	3.67(.88)
c. Achieved consensus on grading for 2008-2009 for Years 1 and 2 and Years 3 and 4.	3.00(1.02)
d. Years 3 and 4: Ensured comparable experiences and equivalent evaluation; ensured prompt mid-clerkship evaluation and post-clerkship grades within 30 days.	3.46(1.07)
e. Improved educational governance, evaluation, support and communication.	3.50(.99)
2. Summit materials in the notebook were useful.	4.30(.78)
3. Summit objectives were clear.	4.26(.76)
4. Breakout group leadership was effective.	4.17(.94)
5. Summit/faculty developed plan for next steps.	3.79(1.02)
6. Overall rating of Summit accomplishments.	3.93(.92)

Comments:

Grading talk was not that helpful; I actually had much more higher expectations. Continuity clinic feedback & results was an excellent & very interesting presentation. The last topics discussed at the meeting were very relevant, more time needed for it.
Idea of a Medical Student Education Director - for each discipline/dept will substantially achieve several of the LCME deficiencies/standards.
When speakers referred to documents, did not always give enough detail to find in Book.
Discussion was not always useful; Leaders often seemed to have their own agendas without any interest in hearing multiple viewpoints. Discussion was opened to more topics than possibly be covered. Attendance was spotty from clinical departments in Lubbock. More people would make discussion more meaningful; Schedule's weren't posted; Attempts should be made to encourage teachers as well as leaders to attend. Few junior faculty were present. In many departments, junior level faculty will do much of the teaching/direct clinical contact. Their voices should be encouraged and valued; Some attainable solution should be reached.
Dr. Hammon presented 2 min worth of information in 30 mins. Breakout groups very effective. Good changes and instruction for leader. Strive for more effectiveness in presentations.
One day sufficient, evening dinner and share ideas; Shorter sessions; focused 5 to 10 minute presentations; Simon Williams was an outstanding moderator. A model for others. "Art of Medicine" as essential part of formative. Need microphones in audience. Many questions and following discussion inaudible.

<p>Suggest: Re Case Logo - include in formative (Q2 wk)(other) evaluations discussion CC student of what they need still to see re 'breadth' with changes as necessary for rest of rotation. When you get all these online orientation, teaching programs, etc.. together, put in one space on-line. Electives Year 1/2...Spanish again (good idea). Also remember law school; Q1 - Re community in involvement for Year 3/4 teaching, Q1c,d. Don't think this summit can ensure anything but educate/encourage, yes; Q1e. Clear that organizational tree branches confusing and unclear. Major discussions of dept. chair's unclear role of governance enabling education. Needs clarification; Q2 - Some MS1's note that their resident preceptors in ECE experience are not teaching/evaluating well, more interested in getting out than teaching. Not sure if widespread problem, but teaching residents to teach and evaluating them is very important. Re: Radiology: Also a problem is Residency training at institutional level .</p>
<p>(cont'd) Should address as group. Despite discussions, Radiology Big Problem (Kenn's internet/online great, clear); 4th Year - give it to the subspecialists who want us to teach what they should be teaching there interns - "Pre-Surgery AI's); Also Simon - the Family/Community Dept. has lots of experience in past soliciting/wining/dining local M.D.'s Also Cynthia Jumper is/was President Lubbock/Medical Society and has lots of contacts too.</p>
<p>Please make sure that all of the 3rd & 4th Year Clerkship Directors attend. This is one time when we can really get some work done.</p>
<p>I really enjoyed this summit. 2. The discussions were balanced and the summit was quite useful for me. 3. I'm in favor of showing appreciation, but the summit time could be a little better used without everyone thanking everyone quite as much. 4. Keep streamlined panel discussions with Q&A discussion time. 5. Clearly identify action items. 6. Chips may not be healthy, but how many carrots and cabbages must die in vain before the other chips at lunch? 7. 2 days are better than 3</p>
<p>Have conferences during the week only. No Saturday schedule! W-F</p>
<p>It's a shame that our students are victims of the faculty's need to write papers. They are very much aware that papers are being written on these new curricular changes.</p>
<p>Overall rating of Summit accomplishments = 6 if this score were possible!</p>
<p>Q1c - Lots of discussion, but I'm not sure I heard consensus.</p>