



**Texas Tech University
School of Medicine**

**Renaissance II
Medical Education
Summit**

May 13-14 2004

Summary Report

**Prepared by Office of Curriculum
July 12 2004**

TEXAS TECH UNIVERSITY SCHOOL OF MEDICINE

Renaissance II Medical Education Summit: Summit Report

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* See http://www.ttuhschool.edu/som/curriculum/summit_form.htm

Principal Summit Outcomes

- **Dean's Charge – February 25, 2004**
- **Summit Goals and Agenda**
- **Proposed Summit Curriculum Template with Discussion Summary from Consensus Team Presentation**
- **Summary of Methods of Evaluation and Related Teaching Formats from Day 2 and Plenary Discussion**
- **Dean's Team Report**
- **List of Summit Attendees**



TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

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February 25, 2004

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Charge to the SOM Faculty for Curriculum Redesign

To All School of Medicine Faculty:

Texas Tech University School of Medicine is committed to excellence in the medical education of generalist physicians in preparation for training in any clinical specialty. We have come to a time for the future of our School when we must review our curriculum in light of the national movement and accreditation standards toward competency-based education, integration of clinical and basic sciences, and early introduction of clinical care. Development and implementation of innovative and modern teaching methodologies are necessary for our students to become self-directed learners, capable of managing and using the constantly changing best evidence for practice. This is an unparalleled opportunity for our dedicated teaching faculty to reshape our curriculum so that our students are the best prepared doctors and our faculty members are the best educators.

Therefore as Dean, I charge our faculty with a comprehensive review and redesign of the curriculum, with a mandate to put into place an evaluation system that will ensure excellence and guide future change. I specifically charge the Educational Policy Committee, Lynn Bickley, M.D., Associate Dean for Curriculum, and the Educational Summit Planning Team approved by the EPC in January 2004, to plan and execute an Educational Summit to develop recommendations necessary for establishing a dynamic and exciting curriculum characterized by:

- ◆ Active management of vertical and horizontal curricular content across all four years, with continuous integration of basic science and clinical medicine and early introduction of clinical experiences;
- ◆ Application of contemporary principles of self-directed adult learning, in conjunction with varied teaching formats, with a distribution of contact hours that approaches 50-60% didactic and 40-50% other teaching methodologies, such as small group tutorials, labs, problem-based learning, team-learning, and web-based formats;
- ◆ Student assessment programs that encourage learning and ensure the achievement of the qualities and competencies of humane and well-trained physicians; and a curriculum evaluation system that ensures continual improvement of the curriculum.

I affirm the leadership of the Summit Planning Team, namely the Co-Chairs, Kathryn McMahon, Ph.D., Chair of the Educational Policy Committee, and Lynn Bickley, M.D., Associate Dean for Curriculum. This team will report recommendations from the Educational Summit to the Dean's Office and the EPC. The EPC will receive the recommendations of the Summit as the recommendations of the faculty and student body for curriculum change, and to make final recommendations to the Dean for the new curriculum and the policy changes needed to achieve that reform.

A handwritten signature in black ink, appearing to read "Richard V. Homan".

Richard V. Homan, M.D.
Vice President for Clinical Affairs
Dean, School of Medicine

RENAISSANCE II MEDICAL EDUCATION SUMMIT
TTUHSC—Academic Classroom Building
May 13 – 14 2004

AGENDA

SUMMIT GOALS: The Summit attendees will:

GOAL 1: Develop a four year curriculum template based on the Institutional Educational Vision, Goals, and Objectives of the TTUHSC-SOM adopted in the Spring of 2003 which will provide:

- Vertically and horizontally aligned integration of curricular content
 - *vertical: the course or clerkship builds on prior and connects to future curricular experiences. *horizontal: the course or clerkship builds on and connects to same year curricular experiences
- Continuous integration of basic sciences and clinical medicine

GOAL 2: Generate a list of formative and summative evaluation methods which will be paired with the Institutional Objectives and used in:

- Student assessment-tracking individual student achievement in the courses/clerkships and validating the attainment of the Institutional Objectives
- Program evaluation-incorporating faculty and student input to answer questions about the effectiveness of the curriculum and the relative merits of different educational approaches

GOAL 3: Develop a "tool box" of teaching methodologies which are based upon contemporary principles of self-directed adult learning and are to be used in courses and clerkships across the curriculum to optimize **active** learning

GOAL 4: Develop plans for integrating the submissions of the Curriculum Theme Teams into the proposed curriculum templates

GOAL 5: Develop a time line for submission of the above Summit outcomes to the TTUHSC-SOM Education Policy Committee which will make ultimate recommendations to the Dean regarding proposed changes to the curriculum

**RENAISSANCE II MEDICAL EDUCATION SUMMIT
THURSDAY – MAY 13 2004**

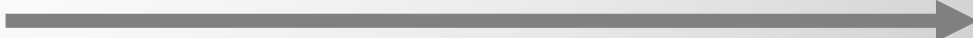
- 8:00 – 8:30** **Registration and Light Brunch** (ACB 100 Foyer)
- 8:30 – 8:45** **Dean’s Introduction & Charge** (ACB 100)
- 8:45 – 9:15** **Overview of Day 1 Summit Activities and Tasks**
Lynn Bickley MD, Associate Dean for Curriculum
and Kitty McMahon PhD, Chair, Educational Policy Committee
- 9:30 – 11:30** **Breakout Meetings of 8 Curriculum Teams** (see Registration
packet for Team and Room assignments)
- Objective:* Design a 4-year curriculum, submit recommendations
by 3:00 pm Plenary (Goals 1 and 4)
- 11:30 – 1:00** **Lunch & Presentation: “Evaluation: Catalyst for
Curriculum Redesign”** (ACB 100)
Linda Perkowski PhD, Director, Office of Educational Programs,
University of Texas –Houston Medical School
- 1:00 – 2:30** **Breakout Meetings of Combined Curriculum Teams:
1 and 2, 3 and 4, 5 and 6, 7 and 8**
- Objective:* Finalize recommendations for 4-Year Curriculum
Template (Goals 1 and 4)
- 2:30 – 3:00** **Coffee Break** (ACB Foyer)
- 3:00 – 5:00** **Plenary Session: Presentations by Combined Curriculum
Teams (15 min each) and Discussion** (ACB 100)
- Objective:* Consensus* on Common and Disparate Elements for
Curriculum Redesign (Goals 1 and 4)
- 5:00– 5:30** **Brief Meeting with 8 Curriculum Team Chairs** (ACB250)
- 5:15 – 6:00** **Reception with Hors d’Oeuvres** (ACB 100 Foyer; dinner not
arranged)
- 7:00 – 9:00pm** **Consensus Team** (Kitty McMahon, Pete Davis, Lynn
Bickley, representative from each of the 4 groups,
Tim Hayes) finalizes Curriculum Template (ACB 250)

* Definition of consensus: not unanimous agreement, but “what you can live with”

**RENAISSANCE II MEDICAL EDUCATION SUMMIT
FRIDAY - MAY 14 2004**

- 7:45 – 8:00** **Light Brunch** (ACB 100 Foyer)
- 8:00 – 9:00** **Plenary Session: Consensus Team Presentation**
(ACB 100)
- 9:00 – 10:15** **Breakout Meetings: 8 Curriculum Teams** (4 Black and 4 Red
- same rooms as Day 1) **and Dean's Team** (ACB 260C)
- Objective:*** Identify methods of student assessment and program evaluation for Years 1 and 2 and Years 3 and 4 and related teaching formats (Goals 2 and 3) (refer to Pre-Summit Report on Methods of Evaluation and Education: Process of Learning handout)
- 10:15 – 10:30** **Coffee Break** (ACB 100 Foyer)
- 10:30 – 12:30** **Breakout Meetings: 8 Curriculum Teams, Dean's Team**
- Objective:*** Finalize methods of student assessment and program evaluation for Years 1 and 2 and Years 3 and 4 and related teaching formats (Goals 2 and 3)
- 12:30 – 1:15** **Lunch and Dean's Team Report** (ACB 100)
- 1:15 - 2:45** **Plenary Session: Black and Red Team Reports**
(10 minutes each) (ACB 100)
- Objective:*** Summary of recommended methods of evaluation and related teaching formats (Goals 2 and 3)
- 2:45 – 3:00** **Coffee Break** (ACB 100 Foyer)
- 3:00 – 3:30** **Plenary Session: Timeline (Goal 5)** (ACB 100)
- 3:30 – 3:45** **Dean's Wrap-up** (ACB 100)

**Educational Policy Committee & Office of Curriculum
Curriculum Template – Working Draft #1 – 07-12-2004**

The Engine for Curriculum Redesign	Year 1	Year 2
<p>Institutional Educational Mission, Vision, Goals and Objectives</p>	<p>Planned redundancy </p>	
<p><u>Basic Premises</u></p>	<p><u>Foundations of Medicine*</u></p>	<p><u>Fundamentals and Application of Basic Sciences*</u></p>
<ul style="list-style-type: none"> Continued integration of basic and clinical sciences 	<ul style="list-style-type: none"> Core Basic Science Introduction to Clinical Medicine 	<p><u>Fundamentals and Application of Basic Sciences Integrated Basic Science/Systems-based approach (Pharm, Path, Micro, Neuropsych, Disease Processes)</u></p> <p align="center">OR</p> <p align="center">(Systems covered as aggregate (normal & abnormal combined))</p>
<ul style="list-style-type: none"> Themes - incorporated throughout 	<p>*Length of time to be determined.</p>	
<ul style="list-style-type: none"> Complexity of problem-solving increases with educational experience 	<p><u>Early Clinical Experience</u></p>	<p><u>Structured Clinical Experience</u></p>
<ul style="list-style-type: none"> Faculty teams (basic & clinical science faculty) – involved throughout the curriculum 	<ul style="list-style-type: none"> Early structured clinical experiences with objectives 	<ul style="list-style-type: none"> Hands-on clinical experiences with objectives
<ul style="list-style-type: none"> Normal and abnormal aspects of systems taught together with planned redundancies 	<p>*Driving Force is <i>basic science</i>. Clinical experiences will provide application examples to reinforce Basic Sciences.</p>	
<ul style="list-style-type: none"> Increased involvement by community physicians - Lubbock campus 	<p>*Driving Force is the <i>clinical experience</i>. Basic Science will reinforce Structured Clinical Experiences.</p>	
<p><u>Parking Lot Issues</u></p>	<p><u>Required Clinical Rotations</u></p>	
<ul style="list-style-type: none"> Patient as teacher (quantitative aspects of medicine based upon presenting patients) 	<ul style="list-style-type: none"> Redesigned clerkships of equivalent lengths Longitudinal clerkships – Neuropsychiatry? Family Medicine? Basic science integration 	
<ul style="list-style-type: none"> Research / Database experience 	<p>Redesign Year 4 curriculum (Sub-Internships, Neurology, Critical Care/ER, Geriatrics, Ambulatory, Away rotations) to include:</p>	
<ul style="list-style-type: none"> Curriculum calendar (Y2 start date) 	<ul style="list-style-type: none"> Written objectives for each component Capstone Experience <ul style="list-style-type: none"> Experience designed to bring the learning experience full circle Focus is on final preparation for residency 	
<p>Themes:</p>	<p>Cultural Competency, Genomics, Geriatrics, Medical Information/Evidence Based Medicine, Nutrition Science, Population Health, Professionalism-Communication</p>	

May 14: Morning Plenary Session--Consensus Team Curriculum Template— Key Discussion Points

- Judicious pruning of information from the current content – replace with problem- solving
- Refer to medical students as “Student Doctors” to reinforce Professionalism training.
- Students expressed concern re ethics and professionalism – suggested “Physician in Training” rather than “Student Doctor” (some noted legal issues with the term “Student Doctor”)
- Earlier clinical experience – see patients in supervised setting with clear objectives/expectations
- Integration: need Clinical Correlations within basic sciences and Basic Science Correlations within clinical experiences
- Year 1 & 2: integrated system-based approach
- Life-long learner (skills in informatics & application of science method for problem solving)
- Themes – vertical throughout, especially Professionalism, also longitudinal social sciences

Student reaction and faculty comments to those reactions

- Continuity clinic in Years 1 & 2: if ½ day per week, in Year 3 this would mean less time on other clerkships
- Family Medicine includes elements of all the other clerkships; faculty comments: Will this type experience be measurable? Easily?
- Continuity clinic would conflict with current MD/MBA schedules
- If Family Medicine and Neuropsychiatry have longitudinal clerkships, this would allow the 4 remaining block clerkships to have increased length in Year 3 or have 5th rotation in the year
- Bioterrorism could be taught within a Community Health experience
- Themes need to be taught throughout the curriculum (make sure that this is clear on the paper reports of Summit)
- Year 4 curriculum needs to be rethought so that the content is in line with the Year 3 curriculum (Geriatrics & Neurology)
- Basic Science concern – What is the impact of this proposed curriculum on Graduate School training of MS & PhD students? There may need to be an impact study on this.
- Family Medicine and Psychiatry showed interest in the longitudinal experience in Year 3. There might need to be a “Launch Pad” experience of about 2 weeks for that. Concern: Will this decrease interest in Family Medicine? (ie, do we need some Family Medicine hospital experience?)
- Is there a legislative requirement that Family Medicine must be in Year 3?
- Continuity experience—may not teach chronic care of 1 patient. If this is 4 hours per week in a 40 hour week, “bonding” will be slight
- Regarding a longitudinal Year 3 Neuropsychiatry experience – do we still need Year 4 Neurology? Answer: Yes
- Would there be time in Year 3 for electives?
- Capstone experience should include life-long learning as issue
- If student plans to go into Pediatrics could they replace Geriatric requirement with additional Pediatric training?

May 14: Friday PM Plenary Session—Next Steps—Key Discussion Points

- Timeline: Wait on timeline until faculty respond to summary of Summit
- Differences on various campuses need to be worked on – how to implement on all campuses.
- Need forum for continuation of conversation
- Consensus Team report needs to be expanded. Consensus Curriculum details were only quickly (superficially) discusses
- Need to recognize all 4 campuses in Next Steps as Odessa gears up for taking students.
- Residents input (our students that have left TTUHSC and our residents) would be helpful
- Process – need involvement of a greater breadth of faculty
- Begin basic science/clinician design teams – begin to look at details soon
- Theme teams need to next begin the vertical integration of the themes
- Need further exploration of literature & other schools on evaluation methods is needed (especially for cultural competency)
- Need a complete inventory of resources (example of how to increase use of Teaching Academy)
- Broaden horsepower (Use more resources to accomplish this?)
- Need to incorporate 3rd and 4th year students more than Summit has done.
- Continue to build foundation for OSCEs (at all campuses using standardized methods and validations)

Renaissance II Medical Education Summit
Day 2: Curriculum Evaluation -- Worksheet Summary for Teams 1 - 4
(These Teams focused on Years 1 & 2)

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Knowledge: The student will demonstrate an exemplary and contemporary fund of knowledge in basic and clinical sciences essential to the practice of medicine, to include:</p> <ul style="list-style-type: none"> • Problem solving • Analysis & EBM • Differential diagnosis • Legal & ethics • Behavioral & Social Sciences 	<p>Exams</p> <ul style="list-style-type: none"> • Shelf exam (1, 2,3) • USMLE (1, 3) • MCQ's (1,3,4), essay(4) • Oral Exam(2,3) • NBME(2,3) • OSCEs (2,3,4) • Web/computer based exam (2,4) <p>Assessment</p> <ul style="list-style-type: none"> • Student assess of each other (1,3) • Student assessment of simulated patient (OSCE) (1) • Online quizzes as a formative measure of self-assessment (3) <p>Evaluation</p> <ul style="list-style-type: none"> • Student self-evaluation (1) • 360 evaluation (1) • On-line, interactive, web-based evaluation (1,3) • Feedback on evaluation (Changes made in curriculum/teaching) (3) • Patients' evaluation (3) • Faculty evaluation- Critical appraisal of literature, oral pres., patient interactions (3) • Peer Review (3) <p>MISC</p> <ul style="list-style-type: none"> • Group Orals (2,4) • Essays (3,4) • Observation (1) • Portfolios(1) • Logbooks(1) • Use of laptops, PDA's and other technology tools(1) • Standardized patient (3) • End of year dinners (3) 	<p>Across all courses, blocks &/or clinical experiences; with some suggestions:</p> <ul style="list-style-type: none"> • Integrate assessment & teaching methods to be regular & expected (1) • Integrate more formative assessment & feedback (1) <p>Believe these knowledge areas must be introduced and practiced. (3)</p>	<p>Lecture intro major concepts w/clinical cases w/in lecture setting (1,4) time for engagement (30 minutes + Q&A) (2), less focus on integrating & applying of independent learning (3), interactive large groups (4)</p> <p>Exams Practice oral/mock exams, internal exams w/clinical vignettes, web-based tutorials, interactive mode with branching logic. Topics based on student's knowledge. (2)</p> <p>MISC</p> <ul style="list-style-type: none"> • mentoring (2,3) • role playing (3) • Laboratories (1,3) • Small group sessions (1,2,3,4) • Problem-based learning. (1,2,3) • Encourage self-directed learning (2,3) • Team learning (1,3,4) • Combination of teaching methods(1) • Web/computer based delivery(1,3,4) • Demos/Workshops/Seminars(1) • Uselaptops, PDAs, other tech tools(1) • Peer to peer(1) • Early notification of expectations.(2) • feedback of overall performance (2) • Shadowing (3) • Standardized patients (3) • Mini-OSCE (3) • Skills labs w/learning to document (3) • Exposure in <i>various</i> clinic settings (3) • Patient/Instructional videos (3) • Live patient interviews (3) • Journal reviews (3) • Self-reflective journaling. (3) • Projects - group, individual, EBM (4)

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Skills: The student will demonstrate excellence in patient care, including:</p> <ul style="list-style-type: none"> • Effective communication • Physical exam • Dx & TX • Life-long (should be <i>self-directed</i>? NB list of objectives) learning • Interpret data • Perform procedures 	<p>Exams</p> <ul style="list-style-type: none"> • MCQ (1) • OSCEs (2,3,4) • written exams (4) • practicum (4) <p>Assessment</p> <ul style="list-style-type: none"> • Student assess of each other (1) • Student assess. of sim. patient (1) • Assess. of database searches (4) <p>Observation</p> <ul style="list-style-type: none"> • ability to perform activities (1) • H & P (2) • Role playing (2) • competency on mannequins (2) • Criteria-based Observation (3) • observed medical interview, phys. exam, microscopy etc. (4) <p>Evaluation</p> <ul style="list-style-type: none"> • Student self-evaluation (1) • 360 evaluation (1) • On-line evaluation of DX, TX (1) • Patients' evaluation (3) • Peer Review (3) • Faculty/Resident evaluation (3) • formative evaluation (4) <p>Presentation</p> <ul style="list-style-type: none"> • case presentations (2) • Oral presentations (3,4) <p>MISC</p> <ul style="list-style-type: none"> • write-ups H & P, SOAP (4) • Portfolios (3,4) • Logbooks (3) • Chart review (3) • Use of laptops, PDA's and other technology tools (3) • Videotape review (3) • Standardized Skills Labs (3) • Journal clubs (3) • computer-based comm. (4) 	<p>Across all courses, blocks &/or clinical experiences; with some suggestions:</p> <ul style="list-style-type: none"> • Integrate assessment & teaching methods to be regular&expected (1) • Integrate more formative assessment & feedback (1) <p>Believe these skills must be introduced and practiced. (3)</p>	<p>Role Playing</p> <ul style="list-style-type: none"> • Experiential learning (2) • role playing (4) <p>Skills</p> <ul style="list-style-type: none"> • Skills lab (2,3) • Skills taught by nursing staff (2) <p>Video</p> <ul style="list-style-type: none"> • Video patient interaction (2) • Patient/Instructional videos (3) <p>Simulation/Demos</p> <ul style="list-style-type: none"> • Demonstrations (1,4) • Simulations 2 • Exposure in <i>various</i> clinic settings(3) <p>MISC</p> <ul style="list-style-type: none"> • Laboratories (1,2,4) • Small group (1,2) • Formalized mentoring (2,4) • OSCE (1,2,3) • Ask Ques./Socratic method (1,4) • Correlation with basic sciences (2,4) • Lecture (1) • TL (Year 1), PBL (Year 2) (1) • Peer to peer (1) • Workshops/Seminars(1) • Use of laptops, PDA's and other technology tools (1) • Observed H & Ps with feedback (2) • Teaching rounds, case pres.(2) • Shadowing (3) • Standardized patients (3) • Journal reviews (3) • Hollywood film vignette critiques w/ trigger questions (3) • Problem-based learning (3) • LOTS of self-study! (3) • Team learning (3) • refinement of database searching(4)

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Behaviors: The student will model the professional behaviors of a skilled and competent physician, including:</p> <ul style="list-style-type: none"> • EBM-based reasoning • Compassion & empathy • Cultural sensitivity • Professional standards • Ethical standards 	<p>Exams</p> <ul style="list-style-type: none"> • MCQ's (1) • Texas Jurisprudence Exam(2) • Cultural competence testing (2) • OSCEs (3) • Oral examinations (3) • written exams (4) <p>Assessment</p> <ul style="list-style-type: none"> • Student assessment of each other (1) • Student assess of sim patient (1) • Rate promptness, attendance (2) • peer/self assessment (4) <p>Observation</p> <ul style="list-style-type: none"> • ability to comm. and empathize (1) • Criteria-based observation (3) • feedback on obs. of pt encounters(4) <p>Evaluation</p> <ul style="list-style-type: none"> • Student self-evaluation (1) • 360 evaluation (1,2,3,4) • On-line evaluation of DX, TX (1) • Patient satisfaction surveys (2,3,4) • Peer Review (3) • Faculty/Resident evaluation (3) <p>MISC</p> <ul style="list-style-type: none"> • Portfolios (1,2,3) • Logbooks (1) • Chart review (1) • Videotape review (3) • Standardized skills review (3) <p>Team 4</p> <ul style="list-style-type: none"> • feedback from simulated patients (4) • structured scenarios (4) 	<p>Across all courses, blocks &/or clinical experiences; with some suggestions:</p> <ul style="list-style-type: none"> • Integrate assessment & teaching methods to be regular & expected (1) • Integrate more formative assessment & feedback(1) <p>Believe these behaviors must be introduced and practiced.(3)</p>	<p>Mentors</p> <ul style="list-style-type: none"> • Formalized mentoring (3) <p>OSCES</p> <ul style="list-style-type: none"> • OSCEs (1,3) <p>Video</p> <ul style="list-style-type: none"> • Patient videos (3) • Student-patient interaction (3) • Instructional videos (3) <p>Simulation/Demo</p> <ul style="list-style-type: none"> • Demonstrations (1,4) • Workshop/Seminars (1) <p>Humanities</p> <ul style="list-style-type: none"> • humanities in small groups (3) • Humanities project (3) • cultural immersion (4) <p>MISC</p> <ul style="list-style-type: none"> • TL (Year 1), PBL (Year 2) (1,3) • Small group sessions (1) • Peer to peer (1) • Developing portfolio (2) • Professionalism (2) • Journal Club (2,3) • Library assist. in searching, EBM. (2) • Encourage self-inquisitiveness (2) • Lectures (2,4) • risk management, ethics (2) • Grand Rounds on Curriculum Themes. (2) • role playing (3,4) • Shadowing (3) • Standardized patients (3) • Exposure in <i>various</i> clinic settings (3) • Live patient interviews (3) • Self-reflective journaling (3) • Hollywood film vignette (3) • direct observation of pt encounters with immediate feedback (4) • case-based presentations (4) • group discussions (4) • early exposure to pt care guidelines with evidence-based assessment (4)

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Attitudes: The student's attitude will exemplify the highest ethical standards, including:</p> <ul style="list-style-type: none"> • Respect for patient's values • Recognition of social nature of health care • Commitment to life-long learning 	<p>Exams</p> <ul style="list-style-type: none"> • MCQ (1) • Written exams (3) • Oral exams (3,4) <p>Assessment</p> <ul style="list-style-type: none"> • Student assess. of each other (1,4) • Student assess. of sim. patient(1) • Assessment of student papers (1) <p>Observation</p> <ul style="list-style-type: none"> • ability to communicate/empathize (1) • observe in "natural environment" (4) <p>Evaluation</p> <ul style="list-style-type: none"> • Student self-evaluation (1) • 360 evaluation (1) • On-line evaluation attitudes (1) • Faculty/Resident evaluation (3) • Peer evaluation (3) • 360 evaluations (3,4) <p>MISC</p> <ul style="list-style-type: none"> • Portfolios (1,2,4) • Measurement of participation (1) • patient mentor program (1) • Videotape review (3) • problem solving scenarios involving interrelationships between health care professionals (4) • focus groups participation & activity (4) 	<p>Across all courses, blocks &/or clinical experiences; with some suggestions:</p> <ul style="list-style-type: none"> • Integrate assessment & teaching methods to be regular & expected (1) • Integrate more formative assessment & feedback (1) <p>Believe these attitudes must be introduced and practiced. (3)</p>	<p>Small Group</p> <ul style="list-style-type: none"> • Small group sessions (1,4) • lit based pres. to small groups (4) <p>Mentors</p> <ul style="list-style-type: none"> • patient mentor (1) • Formalized mentoring (3) • Role modeling– faculty & residents (3) <p>OSCE</p> <ul style="list-style-type: none"> • OSCE (1,3) <p>Video</p> <ul style="list-style-type: none"> • Patient videos (3) • Instructional videos (3) <p>Simulation/Demo</p> <ul style="list-style-type: none"> • Demonstrations—clinical • Exposure in <i>various</i> clinic settings (3) • observed pt interviews and exam (4) <p>Humanities</p> <ul style="list-style-type: none"> • Humility, respect(2) • Humanities project (3) <p>MISC</p> <ul style="list-style-type: none"> • TL (Year 1), PBL (Year 2) (1) • Peer to peer (1) • Workshops/Seminars (1) • Introductory lectures (1) • Exposure during ambulatory exp. (2) • Reflections on observation of professionalism in nurses, doctors (2) • Shadowing (3) • Standardized patients (3) • Live patient interviews (3) • Journal reviews (3) • Self-reflective journaling that a faculty member reads and responds to. (3) • Hollywood film vignette critiques w/ trigger questions (3) • Experiential learning including role playing (3) • Problem-based learning (3) • Team learning (3)

Comments From Teams Presented to Plenary Session

Team2

FACULTY/CURRICULAR EVALUATION:

Outcomes: Motivation, defining expectations, engagement, use of technology.

Professional development appraisal system

Teaching Academy to assist in defining the best teaching methods and methods of evaluation.

FOCUS Groups

Identification of effectiveness of teaching on basis of student performance on exams.

USMLE Steps I and II and III

Residency positions and performance

Student evaluations

Resident surveys

Correlation with standard of care.

Need to decide on a few best tools.

OTHER IDEAS:

Using web-based evaluation tools to avoid identification of evaluators.

Need to introduce evaluation on basis of the six ACGME competencies.

Global evaluations (commonly done in residencies) may be helpful but are logistically difficult in undergraduate education.

Team 4

Parking lot:

self-assessment

change the objectives (rather than pt care → “proposed pt care”

change the wording from negative to positive in regards to cultural sensitivity, etc.

use of LCME nomenclature is a problem: i.e. we cannot express attitudes (only the behaviors)

Renaissance II Medical Education Summit
Day 2: Curriculum Evaluation -- Worksheet Summary for Teams 5 - 8
(These Teams focused on Years 3 & 4)

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Knowledge: The student will demonstrate an exemplary and contemporary fund of knowledge in basic and clinical sciences essential to the practice of medicine, to include:</p> <ul style="list-style-type: none"> • Problem solving • Analysis & EBM • Differential diagnosis • Legal & ethics • Behavioral & Social Sciences 	<p>Exams</p> <ul style="list-style-type: none"> USMLE (5) Shelf Exams (6, 7) NBME (7) Oral Exams (5,6,7) Written Exams (7) Multiple Choice Exams (5, 8) OSCE (2/yr/schoolwide; Dec-June) (7) Video examinations—communication skills and professionalism (5) <p>Assessments</p> <ul style="list-style-type: none"> Patient assessment (7) Student self-assessment (7) <p>Observation</p> <ul style="list-style-type: none"> H&P (6, 7) Direct & indirect observation - frequency is important to reduce anxiety – could be via video, audio means (6) <p>Evaluation</p> <ul style="list-style-type: none"> Residency Programs evaluation (5) Compliance with the evaluation (5) Peer relationships /evals (6) 360 degree evals (6) <p>Ability to teach others (6)</p> <ul style="list-style-type: none"> Logbooks (7) Portfolio (electronic template) (7) Case Presentations (7) Current grading system doesn't need to be revamped (8) 	<p>Clerkship</p> <ul style="list-style-type: none"> Legal (5) Ethics (5) Practice management (5) <p>Vertical and horizontal – use throughout the 4 years (6)</p> <p>Standardized across experiences and campuses (6)</p> <p>Quick and easy forms (6)</p> <p>Strategic evaluations in addition to LCME reg. (6)</p>	<p>Connecting the curriculum with the teaching process. (5)</p> <p>Increase direct contact time between attending and MS3-4 (5)</p> <p>Full-time Directors (5)</p> <p>Small groups (5, 6, 7)</p> <p>Case studies (5, 6)</p> <p>Keep library of paper cases to supplement the clinical experience (5)</p> <p>Web site with problem based learning associated with the objectives (5)</p> <p>Telemedicine across the 4 campuses (5)</p> <p>Reach out to community physicians</p> <p>Role modeling (6, 7)</p> <p>Hands on (6)</p> <p>Oral exams (6)</p> <p>Standardized patients : Live and Paper (6, 7)</p> <p>Presentations by students (6, 7)</p> <p>Fundamentals lectures (6)</p> <p>Directive lectures (7)</p> <p>Web-based lectures (7)</p> <p>Workshops/ labs/ demonstrations/ (6) Practical demonstration (6)</p> <p>Rounds (7)</p> <p>Bedside Inpatient/Outpatient (7)</p> <p>Logbooks (7)</p> <p>Journal Club (7)</p> <p>Film Clips (7)</p> <p>Peer Tutoring/Teaching (7)</p> <p>PDAs (7)</p> <p>Project/Workshop (7)</p> <p>Seminars (7)</p> <p>Practice guideline (7)</p> <p>Resident teachers (7)</p> <p>Written Exam (7)</p> <p>Library E-reserve (7)</p> <p>Lunch/Learning w/Basic Scientist (7)</p> <p>Grand Rounds for students (7)</p>

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Skills: The student will demonstrate excellence in patient care, including:</p> <ul style="list-style-type: none"> • Effective communication • Physical exam • Dx & TX • Life-long learning • Interpret data • Perform procedures 	<p>Exams USMLE 5, 7 OSCE 5, 6, 7 Oral 5 Video 5, 7</p> <p>Assessments Patient</p> <p>Evaluations Residency Programs 5 Peer relationships /evals 6 360 degree evals 6</p> <p>Observations Direct & indirect observation 6 H&Ps 6, 7, 8 Models 8</p> <p>Log book – with clear expectations 6 Ability to teach others 6 Checklist 6 Portfolio 6 Logbooks 7 Case Presentations 7 Capstone experience 7</p>	<p>Clerkship 5 Journal club during the clerkship 5 Vertical and horizontal 6 Standardized across experiences and campuses 6 Quick and easy forms 6 Strategic evaluations in addition to LCME reg. 6</p>	<p>Connecting the curriculum with the teaching process 5 Increase direct contact time between attending and MS3-4 5 FULL-TIME DIRECTORS 5 Log Book 5 Patient/student contact 5 Life-long learning 5 Revisit the literature 5 Role modeling 6, 7 Quick and easy for the evaluator 6 Timely feedback for the learner 6 Hands on 6 Oral exams 6 Standardized patients : Live and Paper 6 Presentations by students 6 Cases/Case based curriculum 6 Lectures of fundamentals 6 Small group discussions 6 Workshops/ labs/ demonstrations/ Practical demonstration 6, 7 Focused questioning 7 Communication 7 Cultural Competency/Sensitivity 7 Artificial 7 Telemedicine 7 PDAs 7 Resident teachers 7 Videotaping 7 Tasks/assignments 7 Web-based 7</p>

Institutional Objective	Outcome Measures / Assessment	Learning Block, Course, or Clerkship	Teaching Methods & Settings
<p>Behaviors: The student will model the professional behaviors of a skilled and competent physician, including:</p> <ul style="list-style-type: none"> • EBM-based reasoning • Compassion & empathy • Cultural sensitivity • Professional standards • Ethical standards 	<p>Residency Programs evaluation (5) Oral examination (5) Video examinations (5) OSCE (5, 6, 7) Observance of the student (5, 6, 7) Compliance with the evaluation (5) Peer relationships /evaluations (6, 7) 360 degree evaluations (6) Standardized surveys (6) Checklist (6) Portfolio (6) Quality of presentations (6) H&Ps (6) Patient's assessment of encounter (7) Role Play (7) Student self-assessment (7) Balint Groups (7) Feedback (8) Mentoring (8) Professional & Communication pre-summit form (8)</p>	<p>Clerkship Legal (5) Ethics (5) Practice management (5) Professional standards (5) Vertical and horizontal – use throughout the 4 years (6) Standardized across experiences and campuses (6) Strategically placed throughout the clerkship (6) Quick and easy forms (6)</p>	<p>Connecting the curriculum with the teaching process (5) Increase direct contact time between attending and MS3-4 (5) Full-time Directors (5) Small groups (5, 6) Case studies (5, 6, 7) Web site with problem based learning associated with the objectives (5) Mentor/student contact (5) Expand patient satisfactions surveys (5) Nursing staff evaluation of medical student behavior (5) Role modeling (6, 7) Quick and easy for the evaluator (6) Timely feedback for the learner (6) Hands on (6, 7) Oral exams (6) Standardized patients : Live and Paper (6) Presentations by students (6) Lectures (6, 7) Workshops/ labs/ demonstrations/ Practical demonstration (6) Film clips (7) Mutual respect - (faculty/student/patient) (7) Personal (student) counseling (7) Balint Groups (7) Determination and defense of patient care plan (EBM) with references (7)</p>

Institutional Objective	Learning Block, Course, or Clerkship	Outcome Measures / Assessment	Teaching Methods & Settings
<p>Attitudes: The student's attitude will exemplify the highest ethical standards, including:</p> <ul style="list-style-type: none"> • Respect for patient's values • Recognition of social nature of health care • Commitment to life-long learning 	<p>Residency Programs evaluation (5) Oral examination (5) Video examinations (5) OSCE (5, 6) Observance of the student during patient interaction (5, 6, 7) Compliance with the evaluation process (5) Peer relationships /evaluations (6, 7) 360 degree evaluations (6) Standardized attitudinal surveys (6) Checklist (6) Portfolio (6) Quality of presentations and H&Ps. (6) Improvement of scores (boards) over time. (6) Continues scholarly activities (6) Necessary to eval attitude in approach to teaching (6) Role Playing (7) Written assessment of film clips (7) Student self-assessment (7) Professional & Communication pre-summit form is good, but use it formatively only (8) Formative verbal feedback (8) Mentoring (8)</p>	<p>Clerkship (5) Legal (5) Ethics (5) Practice management (5) Professional standards (5) Vertical and horizontal – use throughout the 4 years (6) Standardized across experiences and campuses (6) Strategically placed throughout the clerkship (6) Quick and easy forms (6)</p>	<p>Connecting the curriculum with the teaching process (5) Increase direct contact time between attending and MS3-4 (5) Full-time Directors (5) Small groups (5, 6) Case studies (5, 6) Web site with problem based learning associated with the objectives (5) Mentor/student contact (5) Expand patient satisfactions surveys (5) Nursing staff evaluation of medical student behavior (5) Role modeling (6, 8) Quick and easy for the evaluator (6) Timely feedback for the learner (6) Hands on (6) Oral exams (6) Standardized patients : Live and Paper (6) Presentations by students (6) Lectures of fundamentals (6) Workshops/ labs/ demonstrations/ Practical demonstration (6) Film clips (7) Modeling (7) Lectures (7) Exposure (7) Mutual respect (faculty/student/patient) (7) Balint Groups (7) Videotaping (7)</p>

Comments From Teams Presented to Plenary Session

Interaction between Course Directors from years 1-2 and clerkship directors from years 3-4 to ensure two way exchange of expectations regarding the students' abilities as they enter the clerkships and that the necessary knowledge base is being taught

Resource files (lectures) on computer to supplement the students' clinical experiences with relevant basic science components

Faculty Testing Groups a function of Curriculum Office
Developing objectives, exam questions, computer-based material

Evaluation tools should be on the web to facilitate use

Full-time clerkship directorship would take care of many problems regarding consistency of experience, meeting objectives of clerkships, timely evaluations. This should include dedicated secretarial staff to ensure timely and adequate record maintenance. Outcome-based assessment used for special augmentation/promotion for these persons.

Evaluation of overall curriculum and its components finally devolves on the USMLE and Residency Program Evaluations; we need the USMLE Step 3 results and knowledge of residency completion to fully evaluate how each student fared

Evaluation of behaviors and attitudes should begin in first year/day 1

Set up consequences and remediation for students falling below a certain threshold

Teach faculty how to give feedback constructively and how to use evaluation forms

How do we develop an institutional culture which promotes a positive attitude in students and faculty

Case studies - presentations designed to teach skills for Life long learning

Set criteria so that not all need to be met (3 out of 5)

Different settings are more appropriate for learning set skills – need specific learning objectives for each “rotation”

Settings should be non threatening

Set a minimum standard for rotation and academic year promotions (ENFORCED!)

Attitudes and Behaviors are just as important as Knowledge and Skills!!

4th Year Assessments

Senior Year Electives:

1. competencies
2. objectives
3. assessment tools

Student self-assessment and plan

Summary Portfolio directed toward residency

Journal of Reflection

Students' assessment of curriculum at end of each year

Focus Groups of students and faculty

Curriculum assessment:
EPC Triennial review of courses
USMLE performance
Improvement in residency director's evaluations
AMA Graduation questionnaire
LCME site visits

Needs:
Improved HealthNet technology
Separate faculty for students and residents

General Evaluation Principles:

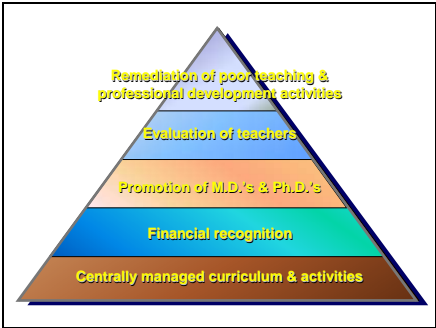
Creating the General Undifferentiated Medical Practitioner
Encouraging/Expecting Class Participation
Frequent (ie: weekly) evaluations = formative (immediate) feedback
Evaluations have to correlate with objectives
Faculty Development is imperative
 Every one needs to be taught how to evaluate
Keep department exams
Assigned mentor as evaluator
360 degree evaluation: include nurses, other students, self-evals
 established criteria for evaluations

General Teaching Methods Principles:

Has to be more interactive
Emphasis on self-learning and using informatics
Faculty Development (especially for the less-skilled teachers)
Faculty Development for community physicians
We ought to develop our own faculty development program (like El Paso)
Good teaching needs to be rewarded with incentives and removing Departmental disincentives to teach
Identify the good teachers - make them the teachers
Find faculty who are good teachers but are not teaching
Separate students from residents in teaching situation, but retain the student's exposure to the residents
 - centralized standards and individualized implementation
Keep wet labs (ie: histology) in first two years
Find time and resources to support wet lab experience in years 3 and 4
Use technology to bring images (biopsies, radiologic studies, etc) into the teaching environment
Return to cooperative learning between departments
Have each student do a case presentation
Scholarly effort to be finished in 4 years – approved by a committee
 - broad definition of types of scholarly activities
 - to be completed in the Capstone experience
Utilize Community resources beyond the Medical School (community Physicians, community health departments, etc)

Dean's Team Report

Renaissance II
Medical Education
Summit
Dean's Team Report
May 14, 2004



Dean's Team
Current State

Current State
Centralized managed curriculum and activities

- Office of Curriculum has been established
 - Continuing to move to centralize management
 - Perceived as successful
- Continuing challenges to communicate – lack of timely communication
- Limited mission-based budgeting

Current State
Financial Recognition

- Limited reward structure for teachers
 - No tightly allocated budget to recognize teaching
 - Criteria for incentive bonuses vary by department
 - Confusing T&P policy to support teaching
- Some \$ support for teaching has been beneficial

Current State
Promotion of M.D.'s and Ph.D.'s

- Faculty awards are in place
 - Individual faculty recognition
 - Educational Innovation Grants

Current State

Evaluation of teachers

- Evaluation of teaching is lacking
 - Need for better evaluation tools
 - Need set standards
 - Measure interpersonal skills/outcomes

Current State

Remediation of poor teaching and professional development activities

- No course for remediation for suboptimal teaching – at ground zero
 - No process to fix the problems
 - No accountability
- Tension between clinical, teaching, and research responsibilities

**NO
new State
money**

Dean's Team

Desired State

Desired State

Centralized managed curriculum and activities

- Education Budget
 - Clearly identified standardized education budget
 - Reallocation of State \$ to compensate department teaching activities - % may vary by department

Desired State

Financial Recognition

- Clerkship Directors
 - Financially backed protected time (20%)
 - Measurable outcomes
 - Stipend
 - Universally approved job description

Desired State

Promotion of M.D.'s and Ph.D.'s

- Develop Medical Educator Track that is consistent between Basic/Clinical Sciences

Desired State

Evaluation of teachers

- Measurable expectations of faculty
 - Teaching
 - Research
 - Patient Care
 - Professional/Career Development
 - Community Services

Desired State

Remediation of poor teaching and professional development activities

- Viable faculty support structure
 - Strong faculty development program leading to T&P
 - Continuous career mentoring
 - Support of faculty for work-related activities, i.e., grant writing assistance, poster presentation development, etc.
 - Easily identifiable good teachers for students/junior faculty (Example: Golden Apple)

Dean's Team

Filling the Gap

Filling the Gap

Centralized managed curriculum and activities

- Continue centralized curriculum activities
 - Add funding to support FTE as full-time evaluation specialist in the Office of Curriculum
 - Charge EPC to develop improved communication of policy changes

Filling the Gap

Financial Recognition

- Mandate 20% protected time for clerkship directors
- Reallocate \$30,000 for individual clerkship cost centers (revenue credit)
- Review clerkship and course director stipends
- Universal approval & acceptance of clerkship job descriptions

Filling the Gap

Promotion of M.D.'s and Ph.D.'s

- Propose reallocation of indirect cost recovery \$
 - 75% to program development and research incentive
 - 25% to education and teaching incentives

Filling the Gap

Evaluation of teachers

- Charge the Teaching Academy to develop a peer review evaluation system of educators
 - Provide feedback to Dean, Chairs, and Faculty
 - Reinforce/remediate
- Move the evaluation process to December to allow consideration prior to budget process

Filling the Gap

Remediation of poor teaching and professional development activities

- Develop faculty support system for scholarship and teaching
 - Identify faculty resources for writing grants, templates for case studies, mentoring, etc.
 - Work towards campus-specific resources
- Move toward a comprehensive faculty development program
 - 1st Step – Mandatory Orientation
 - Continued lifelong development in academic medicine

May 14: Noon Plenary Session—Dean's Team Report—Key Discussion Points

- Support education by fundraising
- Removing incentives from department for teaching causes further shift away from teaching
- Uninsured health care – Do we need to approach state about this?
- Student question: Do new tuition dollars (from recent increased tuition) go to education?

**RENAISSANCE II MEDICAL EDUCATION SUMMIT
SUMMIT ATTENDANCE LIST ***

Amarillo

1. Steven L. Berk, M.D.
2. Dennis B .Dove, M.D.
3. William (Bill) Davis, M.D.
4. Ronald Hodges, M.D.
5. Mubariz Naqvi, M.D.
6. Marita Sheehan, M.D.
7. Jim Van Hook, M.D.

El Paso

1. Christine Brandl, M.D.
2. Patty Crocker, M.D.
3. Harry (Pete) Davis, M.D.
4. Manny De La Rosa, M.D.
5. Gilbert Handal, M.D.
6. Kathryn Horn, M.D.
7. Barry Irons, M.D.
8. Arthur (Tony) Islas, M.D.
9. Anthony Jesurun, M.D.
10. Teresa Knott, Medical Librarian
11. Marie Logvinoff, M.D.
12. Brian Nelson, M.D.
13. Bahij Nuwayhid, M.D.
14. Manuel Rivera, M.D.
15. Prabtibha Shirsat, Ph.D.
16. Manuel Schydlower, M.D.
17. Mary Spalding, M.D.
18. Daniel Terreros, M.D., Ph.D.
19. Darryl M. Williams, M.D.

Odessa

1. Terry Allbright, M. Ed.
2. Robert Bennett, M.D.
3. Dan Hendrickson, M.D.
4. Sam Hooper, Ph.D
5. Donald Loveman, M.D.
6. Dannen Mannschreck, M.D.
7. Robert Marcus, M.D.
8. Tom McHattie, M.D.
9. Sabyasachi Mohapatra, M.D.
10. Nelly Otero, M.D.
11. Anthony Talbert, M.D.

* Due to varied arrival times, list may be incomplete.

Lubbock

1. Ahmed Arif, M.D., Ph.D.
2. Lynn Bickley, M.D.
3. Tyrone Borders, Ph.D.
4. Michael Bourgeois, M.D.
5. Robert Bright, Ph.D.
6. Tammy Camp, M.D.
7. Katherine Chauncey, Ph.D.
8. Mauizio Chiriva-Internati, Ph.D.
9. Jane Colmer-Hamood, Ph.D.
10. Bernell Dalley, Ph.D.
11. Donald Davies, Ph.D.
12. Dale Dunn, M.D.
13. Tommie Farrell, M.D.
14. Arthur Freeman, Ph.D.
15. Victor Gonzales, Jr., BGS, MSCIS
16. Suzanne Graham, M.D.
17. Ernestine Gregorcyk
18. John Griswold, M.D.
19. Ari Halldorsson, M.D.
20. Tim Hayes
21. Robin Hilsabeck, Ph.D.
22. Richard V.Homan, M.D.
23. Jim Hutson, Ph.D.
24. Herb Janssen, Ph.D.
25. Betsy Jones, Ed.D.
26. Ron Kennedy, Ph.D.
27. Richard Lampe, M.D.
28. JoAnn Larsen, Ed.D.
29. Vaughan Lee, Ph.D.
30. Gwynne Little, Ph.D.
31. J. Barry Lombardini, Ph.D.
32. Lorenz Lutherer, M.D., Ph.D.
33. Tom McGovern, Ed.D.
34. Kathryn McMahan, Ph.D.
35. Terry McMahan, M.D.
36. Christy Meriwether
37. Jennifer Mitchell, M.D.
38. Reid Norman, Ph.D.
39. John Orem, Ph.D.
40. Kim Peck, M.D.
41. John Pelley, Ph.D.
42. Barbara Pence, Ph.D.
43. Linda Perkowski, Ph.D.,
University of Texas at Houston
44. Mike Ragain, M.D.
45. Rial Rolfe, Ph.D.
46. Randolph B. Schiffer, M.D.
47. Colleen Silva, M.D.
48. Kathleen Stanley, M.D.
49. Howard Strahlendorf, Ph.D.
50. David Straus, Ph.D.
51. Gary Sutkin, M.D.
52. Tom Tenner, Ph.D.
53. Surendra Varma, M.D.
54. Ron Warner, DVM
55. Anthony Way, M.D., Ph.D.
56. Simon Williams, Ph.D.

Observers:

1. Barbara Ballew, Preston Smith Library (Lubbock)
2. Penelope Coates, Ph.D., Cell Biology & Biochemistry (Lubbock)
3. Carol Felton, M.D. Ob-Gyn (Lubbock)
4. Eldo Frezza, M.D. (Friday only) Surgery (Lubbock)
5. Paula Marshall-Gray, Ph.D., Anthropology, TTU
6. Shoei K. Stephen Huang, M.D. , Internal Medicine (Lubbock)
7. David McCartney, M.D. (Friday AM), Chair, Ophthalmology (Lubbock)
8. Robert Schutt, MD, Orthopedic Surgery (Lubbock)
9. Richard Wood, Executive Director, Preston Smith Library (Lubbock)

Students

1. Claudia Cardenas, MS III (El Paso)
2. Eric Cherng, MS I (Lubbock)
3. Sarah Bezek, MS II (Lubbock)
4. Shelly Hook, MS I (Lubbock)
5. Travis King (Lubbock)
6. John Parker, MS II (Class President –Elect) (Lubbock)
7. Chase Thebault MS II (Lubbock)
8. Michelle Tran, MS I (Class Sec/Treas & MSG Treas) (Lubbock)
9. David (Nick) Wilson, MS II (Lubbock)

Additional Curriculum Documents

- **Curriculum Templates from Teams 1 and 2, 3 and 4, 5 and 6, and 7 and 8 with Key Points from Plenary Presentations and Discussion**
- **Pre-Summit Reports * : Cultural Competency, Genomics, Geriatrics, Medical Information/Evidence Based Medicine, Nutrition Science, Population Health, Professionalism-Communication**
- **“Education: The Process of Learning” *
(Wilson and McCurdy)**
- **Bibliography**

* See http://www.ttuhscc.edu/som/curriculum/summit_form.htm

Renaissance II Medical Education Summit
Day 1 Curriculum Teams 1 & 2
Day 1 Curriculum Template

The Engine for Curriculum Redesign											
Institutional Educational Mission	Year 1	<ul style="list-style-type: none"> • Emphasize the “Normal” patient—including developmental, etc. • Implement an organ/systems-based structure to the curriculum • Begin with micro & macro overview from Clinical Anatomy—big overview of human body • Parallel track: IPA & Foundations of Medical Practice where students see application of organ-based & anatomy content into patient diagnosis & assessment, along with opportunities to address physicians’ interaction with patients (touching, empathy, professionalism, communication, cultural competency) <p>Opportunities for students gain clinical experiences in primary care ambulatory clinics for continuity (beginning with 2nd month)—could begin with OB experience, follow to Peds, FM, IM, etc.</p>									
	Anatomy, Physiology & Physical Exam Skills (1/2 year?)										
Vision	Year 2	Month 1: Intro to Medicine , incorporating intro to all 7 theme team topics History Taking	Structure & Function of Cells & Tissues	Endocrine	Nervous System	Immune	Cardiovascular	Respiratory	GI	Renal	Science Skills (Biostat, critical appraisal of lit, etc.
	<ul style="list-style-type: none"> • Continue the organ/systems-based structure to the curriculum <p>Begin clerkships in Y2 & reduce time elsewhere?</p>										
	Pathology (with Integrated ICM)										
	See Year 2 Integration Schedule—Systems-based Pharm										
Goals (<10)	Continuity Experiences Once per Week 2 faculty members w/case-based experiences as noted in 1 st Year										
	Year 3	<ul style="list-style-type: none"> • Case-based basic sciences content delivered for MS3’s—small group settings most effective • Incorporate geriatrics & adolescents into cases • Clerkships continue, but re-design—consider reallocation of time (all 8 weeks?), consider design for both continuity rotations (FM, Psych, other primary care?) & block rotations 									
Measurable Objectives	Year 4	<ul style="list-style-type: none"> • 1-month courses in population health, community health, etc.—consider web-based delivery • Geriatrics elective • If relocation of time (8-week clerkships), then move mandatory clerkship experiences to Y4 									

Curriculum Defined: Content of information delivered to students; what & when

Ideas/Models

- Early exposure to clinical experience
- History-taking may need to wait until students can make differential diagnoses
- Listening & other communication skills + developing professional role should be addressed early
- Case-based basic sciences content delivered for MS3's—small group settings most effective

Unresolved Issues related to clerkship/clinical training

- Begin Clerkships in Year 2?
- Make all MS3 clerkships 8-week with additional required clerkship experiences in MS4?
- Replace some primary care clerkships with 4-year longitudinal experiences and give additional time to other clerkships?
- Ensure consistency across campuses/ accommodate geographic distances & disparities
- Ensure exposure to clinical disciplines to allow students to make career selections

May 13: Plenary Session—Combined Curriculum Team Presentations (1 & 2): Key Discussion Points

Group 1 & 2 (Presenter: Dr. Mannschrek)

- Anatomy – regionally taught rather than by organ systems; intergrate with MRI images?
- Number of hours in class per day—current target is 10-15 lecture hours per week
- Structure & Function course → teach general terminology? Yes
- Microbiology? Can't do in a system based approach; concentrate in 2nd yr.
- End shadowing in Foundations Course—change to “doing”, replace with structured clinical experience. “Make curriculum visible” and matched with clinical experience.
- 36-40 weeks in Years 1 and 2 too little; consider 18 months basic science, 18 months clinical science, then 1 year of advance training with capstone experience
- More public health is needed in Years 1 and 2

Renaissance II Medical Education Summit
Day 1 Curriculum Teams 3 & 4
Day 1 Curriculum Template

Year 1 10-20 hrs scheduled time per week Multiple evaluations (weekly)	80%--Foundations of Basic Sciences (FBS) - Multidisciplinary systems-based - Themes (all of them!)
	20%--Foundations of Clinical Sciences (FCS) Principle: Early clinical experience with patients DRIVES adult learning - Themes (all of them!) - Relationship skills - Patient assessment skills - Clinical questions / knowledge
Year 2 10-20 hrs scheduled time per week Multiple evaluations (weekly)	60%-- Foundations of Basic Sciences (FBS) - Multidisciplinary systems-based - Themes (all of them!)
	40%-- Foundations of Clinical Sciences (FCS) - Themes (all of them!) - Relationship skills - Patient assessment skills - Clinical knowledge
Year 3	20%-- Foundations and Applications of Basic Sciences (FBS) Themes (all of them!)
	80%-- Foundations and Applications of Clinical Sciences (FCS) - Themes (all of them!) - Relationship skills - Patient assessment skills - Clinical knowledge - Clerkships Preceptorships/Clinical Electives
Year 4	10%-- Foundations and Applications of Basic Sciences (FBS) - Multidisciplinary systems-based - Themes (all of them!) Basic Science Electives
	90%-- Foundations and Applications of Clinical Sciences (FCS) - Themes (all of them!) - Relationship skills - Patient assessment skills - Clinical knowledge Preceptorships / Clinical Electives

**May 13: Plenary Session—Combined Curriculum Team Presentations
 (3 & 4): Key Discussion Points**

Group 3 & 4 (Presenter: Dr. Tom Tenner)

- Medical Spanish: admission prerequisite vs. requirement during Years 1 and 2; faculty also needs medical Spanish competency
- Clinical cases and patients: “examples” in Years 1 and 2; “teachers” in Years 3 and 4. Early clinical experience drives application and integration of basic science content.
- Curriculum can compete with student focus on USMLE and residency
- Train faculty to be able to present themes & to be effective preceptors
- Think outside of box: ie, Ambulatory (Yr 1-2) and Hospital based (Yr 3-4)
- How many lecture hours now in Year 1 ~26
- Where do students learn research methodology? –not identified...

**Renaissance II Medical Education Summit
Day 1 Curriculum Teams 5 & 6
Day 1 Curriculum Template**

The Engine for Curriculum Redesign	Produce the best physicians to serve society as expected by society	
Institutional Educational Mission	Year 1	1. Begin patient experience early in year 1 with longitudinal experience of following same patient/family 2. Integration of basic science with clinical science earlier and in planned manner (basics [normal] for the basis of knowledge; then move to clinical [abnormal]; working as a team; <u>Basics first</u> 3. Mentoring, master teacher, facilitator (clinical and basic scientist together) 4. Longitudinal social science curriculum incorporating professionalism, cultural competency, communication, ethics, informatics 5. Interaction of community and students—service of students to community; involvement of community resources (physicians, social programs) with the students 6. Research/evidence based medicine beginning early and continuing throughout
	Year 2	Basic science with clinical integration Continue 1-6
	Year 3	Clinical science with basic integration Continue 1-6
	Year 4	Disagreement about dealing with the clerkships; retain as they are (ie, departmental—discipline related) or change clerkships as now practiced to broader based course; e.g. growth and development, acute medicine, preventative medicine that would still provide the necessary experiences Synthesis course—complicated cases, multiple disciplines, basic and clinical; end of 4 th year Continue 1-6 Opportunities for away electives and exploration of interest; electives
Measurable Objectives		MEASURABLE COMPETENCIES / OUTCOMES

May 13: Plenary Session—Combined Curriculum Team Presentations (5 & 6): Key Discussion Points

Group 5 & 6 (Presenter: Dr. Robin Hilsabeck)

- Gross Anatomy – Doesn't need to be a separate course—can be combined with social sciences & physical exam course
- In addition to Spanish, cultural competency can involve assessing the medical and institutional cultures on each campus
- Don't have blinders – re: clerkships
- Should there be a research component for students?
 - * Research helps some students with critical thinking by doing research –make some opportunities available – leave flexible
 - * Mentoring – previously used 10 stud/1 clinician & 1 basic scientist
- Service of students to community in Year 1?
 - * Throughout Years 1 to 4 – gradually increase responsibilities
 - * May not need to require – leave flexible
- Competency-based progression of responsibility and problem-solving

**Renaissance II Medical Education Summit
Day 1 Curriculum Teams 7 & 8
Day 1 Curriculum Template**

The Engine for Curriculum Redesign			
Institutional Educational Mission	Year 1 Start July 1	<p align="center">Core Course 1: Anatomy, informatics, biostats, community health Core Course 2 - principles of basic sciences: (genetics, pharmacology, micro, physiology, etc) Block System (normal + pathology + H&P + clinical + EBM + FMP + research) Friday afternoon continuity clinic 1 to 2-week mini-clerkships in between blocks Reviews at regular intervals</p> <p align="center">Summer: arranged clinical or research experience</p>	
	Year 2	<p align="center">Review of Year 1 Continuation of Blocks later into 3rd year Final Review of Years 1 and 2+ (USMLE review)</p>	
	Year 3	<p align="center"><i>starting later into 3rd year</i> Clinical clerkships (8 weeks) with Basic science integrated Separate many MS3 experiences from the residents and focus them more on specific clerkship objectives</p>	
	Year 4	<p align="center">Start with elective experience to explore desired specialties Keep SubI, Neuro, Critical Care End with Capstone Project</p>	MEASURABLE COMPETENCIES/ OUTCOMES

Big Idea: Integration Themes, Separate physicians for student teaching
 All clerkships get equal time, Theme managers help integrate each block, Faculty Development

May 13: Plenary Session—Combined Curriculum Team Presentations (7 & 8): Key Discussion Points

Group 7 & 8 (Presenter: Dr. Tommie Farrell)

- Clinical training: ambulatory vs hospital experiences? Clerkships – currently dependent on hospital-based experiences
- Group proposed teaching normal and abnormal together, with planned redundancy and use of reviews
- Yr 1 Anatomy & informatics --- how do they do together?
- How is history taking taught in a curriculum based on Systems blocks? Can occur in Year 1 and 2 mini-clerkships, also in continuity clinics lasting all 4 years
- Should summer work be elective or required? Required (1 month vacation)
- This proposal larger leap of integration. Not everyone in Group 3 - 4 liked this proposal due to need of redundancy.
 - * Others thought redundancy good, especially as refreshers later.
 - * See sick people early so normal becomes more relevant.
 - * USMLE 1 now more integrated so this is good approach.

Student feedback

- Agreed that we could decrease vacation time between Years 1 and 2. A faculty member noted - but MBA program may be a problem.
- Make contact time meaningful
- Students need flexibility to pursue individual interests

Additional Comments

- Length less important than quality
- Make the Anatomy lab available to students throughout training
- Less is more (teaching/contact time)
- Students may need more time between Years 2 and 3 (for move & Step 1)
- How many contact hours during clinical training? How do you count them?

Renaissance II Medical Education Summit Curriculum Team 2 Report

All Curriculum Team leaders asked to submit any additional key discussion points from their teams – please see responses below from Teams 2, 6 and 8 (other teams did not respond)

Key Stakeholders of Medical Education:

Patients
Public at large (citizens of the region)

Points to Consider:

- Early emphasis to the students that society (the public) is the major stakeholder in their education.
- Stress patient safety
- Think in terms of educational blocks, not semesters
- Mentoring is a key

1st Month of Medical School:

- Introduction to medicine course where some of the above concepts would be introduced within the framework of the theme team topics.
 - * Cultural competency
 - * Genomics
 - * Geriatrics
 - * Medical informatics/Evidence Based Medicine
 - * Nutrition Science
 - * Population Health
 - * Professionalism-Communication
- Key to this month is that attendance is expected
- Core history taking skills would also be taught in this month so as to prepare for future early clinical experience
- Although this month would be an introduction to these theme topics and history taking skills, this would be only providing the foundation for future experiences to build upon, as the themes would continue to be incorporated throughout the curriculum for **ALL four years**. This integration plan would be best determined by the individual theme teams or a coordinating curriculum committee.
- As a foundation experience, this team felt that by providing proper perspectives and expectations, future class attendance, dress, etc. could be shaped by this experience leading the class to rise to those expectations of being the colleagues and future professional physicians they aspire to be.

Continuity Experiences and Case-based Experiences:

- Integrate from after the first month into the 1st year experience a clinical experience of following a pregnant patient, well child visits, much as described by the Early Clinical Experience team.
- Very strong recommendation to stop shadowing experiences, but rather to have a meaningful hands-on clinical experience.
- Case-based experiences would be well-designed cases to integrate with current point in curriculum, and would include write-ups.

- Basic scientist and clinical scientist could be paired to mentor the case-based experiences.
- Basic scientist and clinical scientist would continue to meet with and mentor the same group of students throughout the first year.
- Same concept would continue in the 2nd year

3rd and 4th Year Rotations:

- Although the team believed that the design and format of the clerkships should be closely examined and integration of the basic sciences be performed, we ran out of time to fully discuss and submit recommendations.
- We did discuss the importance of providing sound outpatient experiences and that some clerkships would benefit from increased time (ie., 8 weeks).

Methods of Evaluation and Teaching:

- Please refer to the section turned in at the conference.
- Multiple methods of evaluation may be effective in more than one area.

Medical students Curriculum.

Emphasis on early clinical exposure along with Basic science training.

Proposal was to provide continuity clinic for Medical students once a week for all four years. Considering there are 150 students each year (total 300 students) doing continuity clinic, we need to schedule 60 students for continuity clinic daily Since the goal of this clinic is exposure to clinical medicine and not total patient care ,they could have each one hour exposure, specially during first year. This means four students can be taken by one physician in half a day. We still need 15 Family Physicians daily to teach medical students. (teaching faculty). Do we have 15 Family physicians who can dedicate their time for teaching only .(Daily)?. Continuity clinic in Psychiatry can have similar problem.

This training can be provided by other primary care physicians ,like Internist, Pediatricians, Obstetricians and Gynaecologist. Although this does not provide continuity of care to the patients, this will provide exposure to different areas of medicine. Appropriate adjustments can be done in the Clerkships in third and fourth year.

**Renaissance II Medical Education Summit
Day 1 Curriculum Team # 2
Day 1 Curriculum Template**

The Engine for Curriculum Redesign												
Institutional Educational Mission	Year 1	Intro to Medicine Incorporating intro to all theme team topics History taking	Continuity Experiences and Case Based Experiences									Science Skills (Biostats, Critical Appraisal of Literature)
			Anatomy and Physical Exam Skills									
			Structure and Function of cells and Tissues	Endocrine	Nervous System	Immune	Cardiovascular	Respiratory	Gastrointestinal	Renal		
Vision	Year 2	Pathology (with Integrated ICM)										
		See Year 2 intergration Schedule - Systems Based Pharm.										
		Continuity Experience Once per week										
		2 Faculty Members with case based experience as noted in 1st year - (combination with 1st & 2nd years)										
Goals (<10)	Year 3											
Measurable Objectives	Year 4											

Renaissance II Medical Education Summit Curriculum Team 6 Report

ADDITIONAL POINTS NOT COVERED IN SUMMARY:

1. Cover fundamentals early so all students are on the same page; not all students enter medical school with the same level of knowledge – must find a way to get everyone on an even playing field.
2. How do we make sure remediation takes place when students receive poor evaluations?
3. Consider 6-year medical school.
4. Increase non-hospital base; use community resources more.
5. Need an information system to know what is taught where.
6. Kill the old system – end “courses” and “years”.
7. Use internet technology for virtual patients.
8. Use medical students and residents to assist in teaching.
9. Hire an educational expert to assist in implementation.
10. Use adult learning literature to guide teaching techniques.
11. Set entry expectations higher – require professional dress, participation in research, etc.
12. Consider requiring course in Spanish.

IMPORTANT THEMES:

1. Begin patient experiences early, possibly having students follow a family over a couple of years; best if the primary family member has a chronic disease.
2. Provide mentors throughout medical school.
3. Add public health element.
4. Behavioral and Social Science should be taught throughout all 4 years.

Expose students to EBM and involve them in research projects throughout 4 years.

Renaissance II Medical Education Summit Curriculum Team 8 Report

You already have the main summary reports from the summit. Here are the points I feel the team would have me emphasize from each section:

Curriculum:

- 1) Starting with a core course including the core materials of every discipline being taught including the themes.
- 2) Block system with integration of normal and abnormal pathology coupled with clinical correlates
- 3) Assigning mentoring physicians (community based) for the students early in the curriculum
- 4) The early clerkship exposures with mini (2 week) pre-clerkships in all 6 disciplines (even if this meant extending into the 3rd year and having a later Step 1 exam)
- 5) Absolute agreement with a capstone experience

Evaluation:

- 1) The largest overall agreement from the group was that behaviors and attitudes were important to evaluate, but should be done as pass/fail with feedback to the students (the feeling was that there is no valid way to include it into a scaled grading system)
- 2) The use of mentors to help with evaluations of the student

Teaching Methods:

- 1) Separation (at times) of the residents from the students for learning experiences and assigning faculty for direct teaching of the students
- 2) Expanding the wet lab experience beyond the 1st year including into the clerkships and returning the students to the microscope during the clerkships

Renaissance II Medical Education Summit

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(includes Theme Team Bibliographies)

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Summit Evaluation Documents

- **Report from Dr. Linda Perkowski**
- **Report from Linda Marshall-Gray ***
- **Summit Evaluation Report**

* See http://www.ttuhs.edu/som/curriculum/summit_form.htm

EVALUATION REPORT

*Renaissance II Medical Education Summit
Texas Tech University School of Medicine
May 13-14, 2004*

Submitted by: *Linda C. Perkowski, Ph.D., University of Texas Medical School Houston*

I must begin by commending all the individuals who were involved in designing and managing the Renaissance II Medical Education Summit. The amount of preparation and planning that went into this event was heroic. I was truly impressed with the positive, collaborative atmosphere among the faculty and the sincere commitment to this process by the dean and the retreat organizers. I feel sure that this atmosphere would not have existed if there had not been extensive pre-summit work preparing faculty through educational sessions and one-on-one discussions. Although I did not read all the reports in detail, I could readily see that the materials created for the summit represented a thoughtful, scholarly approach to curriculum change. You are all to be congratulated and emulated on your approach to this challenge.

I was asked to provide some reflections on the summit from my perspective as an educator. My report is divided into several sections addressing various components of the summit and ending with some recommendations. Please feel free to contact me on any of the issues I raised if you wish further clarification.

Pre-retreat Planning

It is essential for any curriculum change process to identify and involve the key stakeholders and to provide all those involved in the process with a rationale/justification for change. Both these goals appear to have been accomplished. Many individuals were actively participating in the pre-summit theme reports and well as in the planning of the retreat. To provide a rationale for change, in addition to the issues raised by your LCME review, there appears to have been ample opportunities for faculty to become aware of national issues and priorities in undergraduate medical education. The sessions by Drs. Whitcomb and Nairn seem to have motivated the faculty to reflect upon educational changes in both the clinical and basic science years. Both these speakers were referenced in the groups I observed.

Change is often driven from the outside but innovation is driven from the inside and I saw evidence of movements from within TTUSOM. Information and a focus on local issues were provided in the presentations on learning by Dr. McCurdy and Mr. Wilson; on Curriculum Redesign by Dr. Bickley; and on evaluation and feedback by Drs. Lutherer, Jones, Way and Ms. Salanitro. These materials were comprehensive, well-grounded and informative. They provided an excellent foundation for the deliberations in the small groups. I would recommend making these presentations and other background information available to your faculty electronically (see Recommendation #1).

Although I did not see a formal needs assessment, the data provided in these presentations, the LCME report, the Dean's charge and the AAMC Graduation Questionnaire do provide a great deal of evidence that there are areas which could be improved. If you have concerns about the

acceptance of changes by your faculty or students, I would recommend administering surveys, holding town meetings, and/or conducting focus groups to allow these individuals to voice their opinions about the current curriculum as well as to elicit their reactions to proposed changes. Do you have a process in place to identify student needs and ideas other than course evaluations? The students involved in the summit were phenomenal and would provide a bridge to their classmates to obtain ongoing feedback (see Recommendation # 4).

The amount of material provided, although of excellent quality, was a bit daunting to read and absorb. I didn't have a clear sense of how familiar the participants were with all the reports but it was clear the team leaders were well-informed and prepared. To assist others in getting up to speed, a summary of key points might be developed and distributed. The preparatory materials included an understanding of current medical education issues with respect to teaching, learning and evaluation. The only element I found missing was an overview of principles of change and change management. If you have not addressed this area in another forum, a focus on change could be useful to the faculty at large and even more so to those faculty who will become actively involved in the process (see Recommendation #8).

Objectives

The objectives for the summit were very clear and very ambitious. The sessions were appropriately structured to focus the groups on achieving these objectives. The summit organizers acknowledged the magnitude of the tasks and were receptive to the impressive amount of work that was accomplished. I felt that Goal 1 was accomplished with the development of the Consolidated Curriculum Template. The concept of starting with fundamentals and building through integration and repetition follows sound educational principles. This should provide you with an exciting vision for your curriculum. The challenge is to operationalize this vision. Goals 2 and 3 were essentially met. Listings of assessment methods and teaching methodologies were developed. This was a good first step and challenged the faculty to think creatively. The next challenge is to prioritize what will be assessed, by which measures, and how these assessments can be used both formatively and summatively. Goal 4 was partially met. The Curriculum Theme Teams developed the visions for these areas but I didn't feel that the summit focused on how these themes would actually be integrated. This step can and must be accomplished as the actual curriculum develops. I would challenge you to create an adaptive, flexible process for theme integration that would allow for introduction of new themes as they surely will arise. Goal 5 was not specifically addressed. The change literature recommends a clear aiming point. I suggest picking a year to start implementing curriculum change soon. You want to take advantage of the enthusiasm and momentum generated by the summit. If the start of innovation is too far off, expectations will be higher and there will be less tolerance for error or experimentation. As you are well aware, the next step is critical when you detail the recommendations and then start pilot testing. Hopefully you can pilot some aspects of the template this next academic year. Choose those for which you already have a champion who is qualified and eager to start.

Summit Logistics

The summit was very well organized. Hopefully you have been able to review the evaluation forms to see how the participants perceived the event. I noted that in every small group room all the materials needed by the participants were available and well organized. This fostered the

ability of the faculty to make efficient, effective use of their time. Having everything then captured electronically should have facilitated analyzing and summarizing the team reports for common themes and concerns.

If you have not already done so, it is critical to provide the participants with feedback in terms of the next steps and how their time and efforts will be utilized (see Recommendation # 2). My initial thought was that having nearly two full days was too ambitious. Although there was some attrition on Day 2, I was impressed with the number of faculty who remained and their level of energy and interest. Since there was some attrition, the post-summit report will be critical. What are your plans for disseminating this report? I would recommend presenting this to the faculty at large as well as to specific subgroups (i.e., course/clerkship directors; each campus; educational policy committee; students; etc.).

Outcomes/Team Reports

The reports from the working groups were impressive and thoughtful.

First Day. The curriculum plans generated on Day 1 did have many elements in common including a focus on early clinical exposure and integration of the basic and clinical sciences. The individuals who worked on Thursday night did an excellent job. As noted, this is a sound educational structure and the challenge lies in working through the details. Be sure to clearly articulate the integration of your themes throughout all 4 years.

Second Day. It wasn't clear what was to be done with the discussions regarding the questions from Day 2. For example, were Testing Groups determined to be useful to the curriculum? Were the teams' responses to these questions captured by the Team Leaders? These discussions provided rich information as to faculty values and perceptions. This could be important in getting agreement for the implementation phase. A post-hoc suggestion and a recommendation for planning next steps, rather than dividing the team tasks by years, you might divide them by competencies (i.e., knowledge acquisition across the 4 yrs.). This would provide a focus on the longitudinal or vertical perspective emphasized in your objectives.

As I expected, the materials as developed did not provide a comprehensive programmatic evaluation plan. However, imbedded in the team discussions there is evidence of what sources of data might be meaningful to your faculty (i.e., residency program director surveys, student evaluations, etc.). I would use those recommendations and work with your evaluator to develop the curriculum evaluation plan (see Recommendation #6).

The Dean's report delineated all the areas I would highlight as critical to success of this plan. It is crucial to keeping the development of those plans visible. The current system must be altered to reward change and participation in that change through faculty development and recognition.

Recommendations

The Summit and activities preceding it are excellent examples of a well-designed strategic change plan. The next big effort will be to drive the change deep into the institution and amongst the various campuses. A challenge will be to keep the enthusiasm going when there are many competing demands on faculty time and interests. At the risk of repeating tasks you've already

accomplished, here are my recommendations to add to those already obtained from the group reports.

1. Set up a website dedicated to curriculum change/innovation to be used as a repository for background information and literature as well as a mechanism for communicating progress and implementation timelines.
2. Provide feedback about next steps to all stakeholders especially faculty and students.
3. Conduct interviews with your Team Leaders and any key stakeholders who were unable to attend the Summit. Ask open-ended questions about their perceptions of the reports, the Summit, next steps, and any issues you feel are pertinent.
4. Maintain input from students through reports, focus groups, surveys, and ongoing dialogues. Assign residents and students from the various years to any planning teams.
5. Document all the activities/products/processes to date. Focus on lessons learned and outcomes both intended and unintended. Publish and/or present your findings.
6. Recruit a professional educator with evaluation skills to work with faculty to enhance their assessment skills and to develop a systematic program evaluation plan. Ideally this individual should also be knowledgeable about curriculum design/development and educational research.
7. Plan to conduct pilots to test out some of the more innovative recommendations (i.e., longitudinal clerkships; portfolios; group orals, etc.).
8. Devise a Faculty Educator Development program for each campus focused on:
 - Teaching techniques (i.e., PBL, Team Learning, Case Tutorials, etc.)
 - Assessment skills (i.e., portfolios, oral exams, web-based testing, etc.)
 - Educational Research
 - Leadership skills and Understanding Change
9. Focus on what is unique about Texas Tech and what you wish to promote outside your institution. One area of strength I see is in the variety and number of your clinical sites. This will enable you to be creative with the scheduling of your clerkship years.
The idea of a longitudinal clerkship is very innovative and has both educational and research opportunities.

“To get the bad customs of a country changed and new ones, though better, introduced, it is necessary first to remove the prejudices of the people, enlighten their ignorance, and convince them that their interests will be promoted by the proposed changes; and this is not the work of one day.” Benjamin Franklin, 1781

RENAISSANCE II MEDICAL EDUCATION SUMMIT
May 13 – 14 2004

SUMMIT EVALUATION REPORT

Prepared by:
Kathryn McMahon PhD, Chair - EPC
Lynn Bickley MD, Associate Dean for Curriculum
Matthew Andersen, Office of Curriculum

June 14 2004

**RENAISSANCE II MEDICAL EDUCATION SUMMIT
May 13 – 14 2004**

**SUMMIT EVALUATION FORM
N= 49**

<p>1. Please rate (circle) and comment on the following statement:</p>				
<p>“I felt empowered to participate in the development of the curriculum”</p>				
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	2	3	4	5
<p>Mean = 1.9 ± 1.2</p>				

Comments:

<p>I was part of the planning process, but many of my colleagues who were not in this process did not feel they were able to have much influence on this curriculum.</p>
<p>agree - regarding specifically to the summit</p>
<p>Thank you for allowing me to participate.</p>
<p>Learned a great deal from the students about what was actual and their attitude to the curriculum</p>
<p>We were told to think "out of the box"; however, the box exist as discussed by the Dean at lunch on Friday. There is no new money and old money reallocation will be little: FAT ALL. Rewards for teaching, education curriculum development will be how when compared to other activities. Chair's will remain in charge of money distribution for education reward. Although the faculty are said to "own" the curriculum. Evaluation of the education process was discussed in detail but the use of the evaluation process to identify and reward faculty remains undefined. There was a general belief presented that clinical material should be presented in Basic science courses. However, without well defined objectives who really knows what is being taught in any course? Maybe some of what we are trying to accomplish is already being accomplished. This assumption also defined "the box"</p>
<p>Enjoyed interaction with other disciplines toward a common goal.</p>
<p>It has been clear that we are setting the course for the future of the medical school</p>
<p>I like the idea of the removal of "rank" at the beginning of the conference.</p>
<p>too many repetitions, sp reports in particular, maybe they could be streamlined! (as for 3)</p>
<p>Quite honestly, the <u>empowerment</u> is a bit strong - we were carried through the process very quickly without the time & reflection needed to plan for effective, sustainable, long-term curriculum development.</p>
<p>Excellent opportunities for discussion and exchange of ideas.</p>
<p>It was very difficult to find clinical coverage in order to come. I feel ___ by being here without compensation for my department. I am shorting them.</p>

<u>Problem</u> that consensus committee generated recommendations that did not appear in any of the 4 reports. Actually, I did participate in <u>process</u> but not outcome.
I brought a very narrow focus to the group - I'm a clinician not an "educator"
Sorry to see that consensus curriculum while workable, is still so conservative, with (at least on paper) many of more innovative ideas sidelined. Hope we can selectively incorporate some practical ideas/teaching methods.
all very respectful to everyone's input
Follow-up will be critical. Will faculty be empowered in implementation?
A better explanation of methodology to be used is needed.
The open attitude from the faculty toward the student input was wonderful. They listened even if they didn't agree. Thank you.
Depends on which group situation. Group 5 Thursday Scored 1. Group 5/6 joint scored 5. Friday scored 1.
Great summit!
Opportunity to contribute during small group sessions and during plenaries allowed freedom to participate. Good!

2. Did the Summit accomplish its five stated goals (circle your response for each goal):

<u>Numerical Value</u>	+1	-1	0	<u>Average + SD</u>
a) Design of an integrated 4-year curriculum	Yes	No	Not sure	+0.7 ± 0.6
b) Plan for curriculum evaluation	Yes	No	Not sure	+0.4 ± 0.8
c) Toolbox of teaching methods	Yes	No	Not sure	+0.4 ± 0.7
d) Incorporation of 7 Themes	Yes	No	Not sure	+0.6 ± 0.7
e) Implementation timeline	Yes	No	Not sure	-0.2 ± 0.7

3. Please list the strengths and weaknesses of:

- Summit process (materials provided; effectiveness of plenary sessions and/or small groups; effectiveness of small group leaders and Summit organizers)

Strengths

- Very well prepared - notebook & theme team pre-summit work was invaluable. Good small groups
- I truly enjoyed the dynamics of the small group. I hope as team leader the members agree.
- Materials provided demonstrated a direction to summit was to take. This drove the ideas to a large extent. This defined the "box". Leaders were great.
- Very effective small groups with a good mixture of scientist, clinicians etc... Group leader quite effective
- Multidisciplinary think tank groups. Computer support.
- Good discussions creative ideas. Good direction as to tasks. Liked the combination of groups to winnow down the number of curriculum proposals
- A good job, no overt weaknesses.
- Good systems. Empowerment of younger faculty.
- very effective small groups. Ample time for Q&A in plenary sessions
- allowed for very wide discussion, surfacing of bizarre innovative ideas
- Great small groups - good discussions.
- Overall excellent
- all the above were excellent. I feel that one of the strengths of the summit was that all opinions were respected.
- very effective
- Interesting, provocative, creative discussion, excellent small group leaders: it was great to meet and work with students/faculty from other departments and campuses.
- well organized
- Mat. provided
 - plenary session
 - best was small group and exchange of ideas
- Theme articles were fantastic. Who wrote them?

Weaknesses

- Day 2 was difficult to focus because the Day 1 curriculum was not sufficiently specific. Probably not a good use of our time.
- Would have been nice to have material earlier. Our small group leader seemed to have difficulty staying on task and keeping the group on task and moving forward.
- Redundancy - too much.
- The process was fine. The question is "will recommendations & suggestions given, be used by EPC etc?"
- Plenary session on evaluation, etc. was a COMPLETE waste of time. I feel like it was reiteration of reiteration of reiteration. @ least ___ preferably ___ different evaluation modalities.
- Maybe a way to speed up ___ to combine the ___ would be to assign different themes or topics to interested individual (by choice maybe) and avoid so many repetitions.
- Positive overall, although the templates seemed artificial Day 2 activity - very duplicative don't need 8 presentations on the same content.
- Too little time for theme teams to do work. Then not really included in small groups - was told that was done and is in the manual - don't need to talk about it again in small groups.
- Great concept for "brainstorming only" not a way to achieve a result
- Basic science team leaders not effective discussing 3rd/4th yrs. Mergers did not work well
- Day 2 - combined Red/Black presentations - lots of repetition of similar ideas from groups - next time only point out new/unique ideas
- Evaluation plenary session was ineffective in highlighting new and innovative methods. Too much info too little time! Hopefully the innovative ideas will not be lost in the amount writing on each topic.

Strengths

- Small groups worked well & leaders tentative to encourage equal participation. Impressive speed of delivery of written copies of summaries
- Small group excellent. Leadership of groups & planning good. Material presented good.
- Computer/physical support great. Our leaders were very effective because the group cooperated.
- small group interactions.
- Good small group work. Great Summit.
- Hope that Black and Red team reports are copied into final report. Otherwise all other events had copies provided. Small groups discussions were very effective.
- Material was adequate. Good start.
- The notebook was excellent! Also, the theme teams did a superb job of putting their thoughts, recommendations together. Small group leader (Tom Tenner) very effective. Summit organizers really did an outstanding job!

Weaknesses

- Small group leader stilled discussion and dominated process.
- Day 2 small groups would have been better if had put conical faculty into the Yr 3& 4 groups especially clerkship directors and the basic science faculty/course directors in groups Yr 1 & 2.
- A standard problem. Summaries of breakouts become repetitive & lose the flavor and richness of the discussion
- louder participants shouted down less aggressive people.
- Too much reading material before summit. Majority not used during summit.
- Good overall; needs a web-based "blackboard" to keep continuous improvement of the blue-print as an on-going activity through-out all campuses
- Felt our ideas were completely ignored/squashed when we merged groups
- All well done except Goals 2 & 3 not covered well in plenary summary due to time constraints. Teaching methods not discussed enough.
- consensus stopped short of innovation
- Lots of material in notebook was underutilized.
- 2nd day of reports - not effective as was 1st day.
- The charge to "think out of box" & ignore limitations of finances & resources was unrealistic. What good is it to come up with wonderful ideas that can never be implemented??

- Logistics of Summit organization (Pre-Summit activities; timing of agenda activities; support, etc.)

Strengths

- Nice facility
- Having the summaries of pre-summit activities was very useful.
- Excellent. Good _____. Well organized.
- Well conceived, organized
- No overt deficiencies. Overall a great job!
- Good!, was also good for networking purposes!
- OK
- Good sequence. Overall an outstanding meeting
- Excellent. Appreciate \$ for travel/lodging
Thanks
- good A-
- very good
- All the above were excellent [Believe "all the above" referring to question 2 – design, plan, toolbox, incorporation of themes and timeline]
- this was probably the biggest impact to the success - all of the pre-summit work was quite obvious and is reason for the overall success
- also well organized/implemented
- very good & organized. This should be organized on yearly basis.
- Good pre-summit preparations
- good preplanning
- Good logistics.
- 2 [Score based on 1 = Strongly agree to 5 = Strongly disagree?]
- Excellent
- All organization was excellent.
- Excellent. Good choice of participants.
- Many issues, new ideas needed more time to discuss but that is what a "beginning" is all about. It is a good beginning! Liked the idea of "thinking outside the Box"!!
- Timing overall good - time will tell if it was effective. Given the complexity of a 4-year curriculum - I wonder what the right amount of time really would be - longer perhaps shorter, I would say definitely no.

Weaknesses

- See 3.a comments. [3.a comment was "Day 2 was difficult to focus because the Day 1 curriculum was not sufficiently specific. Probably not a good use of our time."]
- Plenary session of evaluation methods could have been shipped and rather, the information combined as a "tool box" for the curriculum team to use as development progresses.
- I'm not sure we needed as extensive documents from the pre-summit teams, rather few pointed recommendations to guide.
- Overall, I think the Summit was well done. 2.5 days would have been a better time frame. Would give participants more time to assimilate and share.
- Think it would be much more helpful to have more 3rd and 4th year students involved. When I reviewed the comments by the 1st and 2nd year students in our group with the single 3rd year student, her comment to me was that they had not been there and done that, so they really did not have the experience to speak to the 3rd and 4th yr curriculum. I feel the 1st and 2nd years were commenting on what they assumed reality is.
- did not get hooked into pre-summit activities - _____ info about this
- Pre-summit meetings had little participation from clinicians who had to do clinical activities.
- As a clerkship director (year 3 teacher), it would help to have even greater familiarity with the existing years 1/2 curriculum as background for curriculum redesign.
- I feel that discussion of teaching methods, curriculum, etc without a frank discussion of impact on departmental finances is likely not going to produce much of anything.
- This needs to be 3-4 days!
- Far to short to accomplish objectives
- Conflicted with TMA meeting.

- I was not aware of Pre-Summit activities! In fact, I rec'd notice from Dr. Homan about this summit 3 weeks after the deadline for registration. I knew of the summit but did not know I was invited to participate! The First summit was by specific invitation only. Since I was late registering, I did not receive the notebook - so I had no idea about the "pre" work. timing fine for agenda but rushed for plenary esp. 2nd sesison. Seemed there were additions to the 4 yr curriculum that had not been mentioned in plenary session. A separate agenda?
- (Please have veggie food in future). Projected word files' font size too small
- Friday afternoon groups reports were boring & redundant - needed better time management & more sorting out of new ideas.

Other comments – not associated with specific question.

It will be challenging to implement the defined ____, specifically the upper integration with a 4 campus system! Look forward to discussed the ____ down ____ ____.

This is a good 1st step in curriculum development but major changes however "innovative" have to be weighed against reasonable & likely reactions & realities, especially our 4-camps system.

I feel that the summit was a good start but the difficulties that lie ahead will be in the implementation of the details. This should be phased in slowly and must be properly funded. Do you realize that you will need more MDs to help teach in years 1 & 2? This will be very expensive. Do we have the money to hire them? What about basic scientists to teach in Amarillo and Odessa? Where are they going to come from? Don't give us more work to do without the appropriate help.

We talk of educating generalists. I would like to think this (is) what people want. But some recent lay responses to HMO/Medical care system (ie NY Times magazine recently) note the shift again to specialties, with denigration of generalist to gate keeper. ____? Not sure. But our curriculum has got to be able to change as needs for most specialist or not, also, change. USMLE 1 timing - more leeway - so end reasonable clinical experience (end (of) "3rd" year, or after basic clinical application experience.

"Portfolio" repeatedly discussed

1. Who looks at the portfolios?

2. What goes into portfolios?

3. Can basic sci & clinical faculty have some training in how to use them? (e.g. in faculty educ seminar) (for all the discussion I couldn't find one faculty who had ever looked at one).

Clerkship Clinical Eval tool/form needs to measure the achievement/accomplishment of the clerkship objective/competences by specific clerkship. The Clin Eval needs to have more specific anchors/criteria for each grade category (FMGVG S) (faculty currently very subjective in grading)

Overall experience good... Idea exchange not necessarily idea gathering. The more innovative ideas _____ only them, were never introduced for consideration thus possibly _____ for not stimulating other ideas.