BMP Program

Ed Klett
Program Director
8/8/14

Biomedical Problems Program

- Preclinical curriculum
- Biomedical science
- 11 disciplines
- 12 assessed components
- Parallel with Clinical Skills program
- In series with Community Medicine program

BMP Program - Disciplines

- Anatomy-Embryology
- Behavioral science
- Biochemistry-Nutrition
- Genetics
- Histology, Cell biology
- Immunology
- Microbiology
- Neuroscience
- Pathology
- Pharmacology
- Physiology

BMP Program - Components

- Cellular Basis of Medicine (6)
- Devel. Basis of Medicine (6)
- Host Defense (6)
- Hematology (6)
- Neurology (7)
- Musculoskeletal (6)
- Brain & Behavior (5)
- Cardiology (6)
- Pulmonology (6)
- Gastrointestinal (6)
- Renal (5)
- Endocrine (6)

BMP Program - Instruction

- Each of 12 phases is taught primarily with a group tutorial format:
  - 6 to 9 students per group
  - 1 faculty member for an entire phase
  - 9 hours of group time per week
  - 6 to 17 cases per phase, "case based" but with some continued discussions similar to "problem based"
- Supplementary resource (large group) sessions average 3 to 4 hours per week.
- Laboratory sessions are primarily in gross anatomy and neuroanatomy, and the bulk of gross anatomy is in the MS phase.
**BMP Program - Assessments**

- Multiple choice question (MCQ) examinations
  - Single exam comprehensive for a phase (conjunctive)
  - All phase disciplines represented (compensatory)
  - Campus comparability: rare outliers
- Oral examination
  - Must be passed separately from the MCQ exam
  - Content representative of the phase
  - Assess competencies other than knowledge
- Tutorial group evaluation
  - Must be passed separately from the MCQ exam
  - Assess competencies other than knowledge

**BMP Program – SOCA Outcomes**

- Since moving from a formative to summative scoring format, <5% of students fail.
- Agreement among examiners (+/- 1) is at least 80%.
- It is labor intensive: at least 1250 faculty hours required.
### BMP Program - Tutorials

- Scores for students (>4 of 5) and ratings for faculty (>90% positive) are high.
- A third of the class struggles with the format (despite what is said in the admissions process).
- Though faculty tutors agonize over students’ examination outcomes, the distribution of exam scores in groups is Gaussian.
- It is labor intensive: over 8000 faculty hours.

### BMP Program – Outcomes

- Up to 2/3 of a class fails some component of a major exam.
- Up to a third of a class is remediating something after 2 years.
- Up to a fourth of a class drops back.
- But...of those remaining, the USMLE Step 1 pass rate and average are close to national norms.

### BMP Program – Self Assessment

- "It is a discipline-based program masquerading as an integrated curriculum."
- The basic tenet of the program, the "biomedical problem" with associated learning issues, is weakened by:
  - Examination focus
  - Large numbers of broad discipline objectives
  - Large amounts of material assigned
  - Variable clinical input

### BMP Program – Assignments

- The amount of textbook reference reading assigned:
  - 4800 hours at 50 wpm
  - 2400 hours at 100 wpm
- That’s 34 to 68 hours per week of instruction.
- Compare with the article “Great Expectations” by C.R. Taylor from 1992, calculating 175 hours needed per week for all activities by preclinical medical students.

### BMP Program - Resourcing

- The original goal of student-generated and learning issue targeted supplementary sessions has largely evolved to a faculty-driven lecture series.
- If I were giving the standard resource session, this ppt would have >100 slides.
- MUSM has experienced what every school on earth has experienced: 21st century students don’t come to lectures.

### BMP Program - Integration

- Though Clinical Skills runs concurrently with the BMP Program, and there is overlap in subjects...
  - Evaluations often reveal that students see CS as an imposition.
  - The assessments are separate.
- Community medicine is viewed by students as having lesser importance, and they may sandbag CM for remediation.
BMP Program - Issues

- What is the core content when biomedical knowledge expands exponentially?
- Is there sufficient clinical focus and emphasis to guide the process?
- The assessments suffer from:
  - Construct underrepresentation
  - Construct irrelevant variance
- True integration horizontally across programs is lacking.

Competition vs Incompetence

<table>
<thead>
<tr>
<th>Assessment Standard</th>
<th>Concept of Incompetence</th>
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</thead>
<tbody>
<tr>
<td>Textbook knowledge</td>
<td>Ability to recall</td>
</tr>
<tr>
<td></td>
<td>Failure to interpret data, synthetic contextual information, poor non-knowledge competencies</td>
</tr>
<tr>
<td>Skills performance</td>
<td>Ability to perform</td>
</tr>
<tr>
<td></td>
<td>Lack of integration of knowledge with performance, superficial displays of skills</td>
</tr>
<tr>
<td>Assessment reliability, statistics</td>
<td>Ability to score highly on standardized measures</td>
</tr>
<tr>
<td></td>
<td>Lack of development of expert reasoning and behavior</td>
</tr>
<tr>
<td>Reflective practice</td>
<td>Ability to produce convincing self-assessment</td>
</tr>
<tr>
<td></td>
<td>Specified self-assessment marks deficiencies, development of reflective abilities in the absence of knowledge and skills</td>
</tr>
</tbody>
</table>

Factors affecting outcomes

- Admissions process
- Instructional process
- Assessment process
- Non-academic issues

What they’re saying...

- It wants to be a mainland version of an offshore school.
- A “one-star” medical school.
- Students approach it like an online school.
- You apply there if you can’t get in anywhere else.
- Up to half of program directors may not consider our graduates viable.

Reality Check

- Things have gotten a lot more competitive.
- 500 unmatched U.S. grad last year, 1000 this year, and a doubling of that number each year into the near future.
- There soon will be 1,500,000 medical students worldwide.
- The imports have a third of the market, and increasing.
- Knowledge alone is available 24/7 outside the institution for any motivated student.

Moving Forward

- Exam outcomes are approaching national averages, and the passing standard can be increased to drive competency.
- Reduce overall basic science content to clinically relevant content (NBME moving in this direction).
- Integrate meaningfully—to the point where a conjunctive (test as a whole) scoring standard is used, not a compensatory (single subject) standard.
- Increase the number and improve the value of non-knowledge assessments.
Barriers

- Everyone seeks the easiest pathway:
  - Students engage in "strategic learning"
  - Faculty just copy forward the same old stuff
  - Clinicians just talk about what they do
  - Failure takes minimal effort
- Developing the skills takes time up front.
- There must be meaningful cooperation with shared goals (biggest problem at MUSM).
Fundamentals of Clinical Practice (FCP) Program Review

Presented by: Blanca Lopez, M.D.
at CIC Retreat, Macon GA., August 8, 2014

FCP Program Goals
- Teach fundamental clinical knowledge and skills necessary for students to participate in the care of patients encountered during Community Medicine and Clerkship rotations.
- Specific skills include
  - Communication skills
  - Physical Exam Skills
  - Documentation/Differential Diagnosis Skills
  - Behavioral (Professionalism) Skills

Pre-Clinical Programs
Macon Campus

Clinical Skills (CS) Course
- Year 1: Basic CS Course Curriculum
  - Designed to teach:
    - Interviewing skills
    - Basic Exam Skills with a focus on normal findings
      - Head, Eyes, Ears, Nose, Throat & Neck exam
      - Blood Pressure, pulses and cardiac exam
      - Lungs and Chest Exam
      - Abdominal Exam
      - Cranial and peripheral nerve exam
      - Musculoskeletal exam
    - Basic: Note documentation skills: H&P and SOAP notes (Subjective i.e. Patient history; Objective: P.E; Assessment and Plan)

Clinical Skills (CS) Course
- Year 2: Advanced CS Course
  - Designed to reinforce basic skills and introduce advanced skills with a focus on pathology
    - Interviewing skills: Mental Status Exam and Discussing Bad News
    - Physical Exam Skills focus on pathological/findings
      - Advanced Cardiovascular Exam
      - Advanced Pulmonary Exam
      - Advanced Abdominal Exam
      - Male GU/Prolacta Exam
      - Female Breast, and GYN Exam
      - OB Exam
      - Pediatric Exam
Clinical Skills (CS) Course

- Year 2: Advanced CS Course:
  - Designed to reinforce basic skills and introduce advanced skills with a focus on pathology
    - Documentation Skills: H&P and SOAP notes
    - Assessment and Plan documentation required including laboratory differential diagnosis (USMLE CS II format)
    - Proposed diagnoses requires justification based on history and PE findings

CS Instructional Modalities

- Overview Lecture
- Student Partner Practice Sessions
- Practicum Sessions:
  - Standardized patient encounters
  - Note documentation exercises
- Post Practicum Self-Assessment
  - Students review & grade their videotaped patient encounter*
  - Students grade their patient notes*

*Using faculty generated standardized grading forms

Lesson Overviews (Lectures)

- Scheduled on Tuesday (1-5 p.m.) Attendance is required
- Prior to Overview:
  - Pre-Overview Quiz:
    - Assess reading comprehension of assigned objectives (including medical terminology, and clinical interviewing and exam techniques)
    - 15-20 questions: 15-20 minutes
- Overview:
  - Power-Point Presentation
  - Clinical Faculty will cover key concepts and exam techniques delineated in the lesson objectives and reading assignments
  - Live demonstration of the exam

Student Partner Practice Sessions

- Students choose same-sex partner to practice interviewing and instrument skills
- Specific skills checklists are posted on Blackboard for each lesson
- CDAC exam rooms are available each Wednesday following the lesson overview
- Faculty are available to answer questions and help with exam techniques as much as possible

Practicum Sessions

- Scheduled in CDAC each Thursday afternoon following each overview
- Intended to provide students the opportunity to perform:
  - Interviews
  - Physical exams
  - Generate patient notes in WebSP that will be placed in your designated standardized patient’s (DSP) chart
- Each student is assigned a time (by CDAC via WebSP email) to interact with the Designated Standardized Patient (DSP).
- Most encounters (from start of interview to completion of the chart notation) require 1.5-2 hours.

Practicum Session Format

- Brief Pre-Encounter Orientation
  - Provides encounter information/instructions
- Individual Patient Encounters
  - Are videotaped
  - Students interview and examine their DSP, who serves as their continuity care patient and “P.E. coach” throughout each year.
Post-Practicum Documentation Exercise
- Using WebSP software, students transcribe written notes obtained during their patient encounter into chart notes (H&P for first encounter followed by SOAP notes for subsequent encounters) and submit these prior to leaving the CS center (CDAC on Mecon Campus).
- Standard note format, including medical terms, acronyms and abbreviations taught in the CS course and depicted in sample notes (on blackboard) are required.

Post-Practicum Student Self-Assessment
- Tuesday afternoon, following a Thursday practicum Students return to CDAC (from 1-5 p.m.) to:
  - Review and grade their videotaped practicum performance*
  - Grade their chart note*
  *Using grading checklist provided

Medical Knowledge Assessment Modalities
- Pre-Overview Quizzes:
  - Designed to assess comprehension of reading assignment, prior to lectures
- End-of-year (Final) Knowledge Exam:
  - Designed to assess medical knowledge obtained from combination of reading assignments and lectures, where important concepts and patient evaluation techniques are highlighted.

Communication and Physical Exam Assessment Modalities
- Year 1 (Basic Clinical Skills) Course:
  - Mid-Year Assessment Clinical Skills Assessment (CSA 1A)
    - Designed to assess instrument use proficiency, before students attend their Community Medicine Rural Office visits
    - Testing stations involve SP encounters & include use of:
      - Stethoscope
      - BP measure measuring equipment
      - Ophthalmscope
      - Otoscope

Communication and Physical Exam Assessment Modalities
- Year 1 (Basic Clinical Skills) Course:
  - Final Clinical Skills Assessment (CSA) 1B:
    - Summative exam* designed to assess:
      - Basic interviewing skills
      - Basic physical exam skills
      - Use of instruments
      - Manual techniques
      - Basic documentation skills:
        - Documentation of Comprehensive History and Physical Exam
      - Student Self-Assessment:
        - Constructive critique
        - Professionalism
      *Includes neurological and musculoskeletal exams, learned after Community Medicine visit

Communication and Physical Exam Assessment Modalities
- Year 2 (Advanced Clinical Skills) Course:
  - Final Clinical Skills Assessment (CSA) 2:
    - Summative exam designed to assess:
      - Basic & Advanced interviewing skills
      - Basic & Advanced physical exam skills
      - Use of instruments
      - Manual techniques
      - Advanced Documentation Skills:
        - Documentation of Comprehensive History and Physical Exam including:
        - Assessment including differential diagnosis justification
        - Plan including work-up and treatment
      - Student Self-Assessment:
        - Constructive critique
        - Professionalism
Grading of Student Performance

- Pre-Overview Quiz: Average quiz grade will constitute 40% of Final Knowledge Component Grade
- Practicum Sessions
  - DSP and Faculty Evaluation
  - Satisfactory/Unsatisfactory
- Documentation Exercises
  - Complete H&Ps
  - SOAP Notes
  - DSP/Faculty Evaluation
  - Satisfactory/Unsatisfactory

*Passing = ≥ 70%

Grading of Student Performance

- Mid-Term Exam
  - Interviewing and Instrument Use Skills Exam (CSA 1A)
  - Faculty Evaluation
    - Satisfactory/Unsatisfactory
- Final Exams
  - Knowledge Exam* (Comprehensive multiple-choice exam)
  - (CSA 1B) Exam: Performance of Comprehensive H&Ps
  - DSP/Faculty Evaluation
    - Satisfactory/Unsatisfactory

*Passing = ≥ 70%

Grading of Student Performance

- Professional Attire
  - Clean White Coats with ID badges (Practicum Encounters only)
  - Appropriate hygiene
  - Clean and trimmed fingernails
  - Groomed and trimmed facial hair
  - Groomed hair: avoid hair interfering with physical exam
  - Clean and conservative dress:
    - Women should avoid mini skirts, low-cut blouses, or other provocative attire
    - Men should wear a dress shirt and tie and shoes with dress shoes
    - All should refrain from wearing halter tops, caps, sports shows, flip flops, jeans, chewing gum, tobacco or candy.
- Professional Competence
  - Respect
  - Diligence
  - Compassion
  - Honesty

Professionalism Grade

- Satisfactory/Unsatisfactory
- Based on student
  - Attendance (of all overviews, practicum sessions & exams)
  - Participation (for quizzes, overviews, practicum sessions & exams)
  - Attire/grooming/hygiene
  - Compliance with the University Honor Code
  - Compliance with:
    - Patients
    - Faculty
    - Staff
    - Colleagues

Graded Clinical Skills Components

- Clinical Knowledge (CK) Remediation
  - Required if CK score is ≤ 70%
  - Students are required to submit multiple choice questions* pertaining to deficient subject areas
  - Each question must:
    - Identify and justify correct answer including referenced page number where information may be located in textbook (Mosby's Physical Examination)
    - Include at least 3 reasonable options

*Number of questions determined based on number required to afford the student a 70% score
Remediation

- Clinical Skills (CS) Remediation
  - Required if any of the following CS grade components are unsatisfactory:
    - Interviewing/Communication skills
    - Physical Exam skills (Instrument use and/or manual exam skills)
    - Note documentation skills

Note: The professionalism remediation protocol exists. However, students receive timely SP and faculty feedback/counseling. If professionalism issues remain by the end of each academic year, students are referred to the Professionalism Committee for consideration and recommendations.

Year 1 CS Lessons

<table>
<thead>
<tr>
<th>Lesson</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
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<tr>
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<tr>
<td>Smart Format</td>
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<tr>
<td>Basic Resp Exam</td>
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Year 1 CS Lessons/Summative Assessments

<table>
<thead>
<tr>
<th>Lesson</th>
<th>Objective</th>
<th>Format</th>
<th>Procedure</th>
<th>Joint</th>
<th>Fall Phase</th>
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<tr>
<td>Nerve Exam</td>
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<td>✓</td>
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<td>✓</td>
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<td>Mid-Year CSA 1A</td>
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Year 2 CS Lessons

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<th>Procedure</th>
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<td>Advanced Resp</td>
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<td>NS Phase</td>
</tr>
<tr>
<td>Algo Resp</td>
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<td></td>
<td></td>
<td>NS Phase</td>
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<tr>
<td>Oral Exam</td>
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<tr>
<td>Pediatric Exam</td>
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Year 2 CS Summative Assessments

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<th>Format</th>
<th>Procedure</th>
<th>Joint</th>
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<tr>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>End Phase</td>
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Clinical Skills Course Strengths

- Students learn...
  - Using a continuity care model where they encounter the same standardized patient experiencing different problems
  - Provides an experience that Community Med, COP and clerkship rotations often fail to provide
  - Facilitates doctor-patient relationship
  - Engenders cooperation and sense of accountability
  - Allows designated SP (DSP) to assess their students' growth and provide them and faculty with feedback
  - Because the DSP is able to "coach" the PE, students get one-on-one help during formative practice sessions
  - Developed to address limited clinical faculty availability.
Clinical Skills Course Strengths

- Students learn medical terms required for verbal and written medical communication
- Students learn how to manage uncomfortable/difficult patient encounters both in Years 1 & 2
- Students are prepared to interview and examine "real" patients as early as the winter of Year 1, when they attend their CM rural practice visit.
- Students are well prepared for Year 3 Clerkship rotations
- Because patient encounters are modeled (as much as possible) after USMLE CS Exams, students are well prepared for CS II exam encounters.

Clinical Skills Course Challenges

- Ever-increasing shortage of clinical faculty to participate in small group sessions.
- Lack of clinical faculty support to resource students
- Lack of clinical faculty to help grade student notes and provide written feedback:
  - Macon campus has 2 full-time and one part-time faculty to grade 1,030 SOAP notes and 360 H&Ps (based on 60 students/class)
  - Inconsistent AE system for overview ppt presentations
  - Inability to show web videos
  - Problems with audio projection of heart, lung and bowel sounds
  - Lack of overhead projection equipment to show close up views of patient during live exam demonstrations
  - Inconsistent overview teleconferencing capability
  - Audio often fails between campuses
  - Difficulties administering exams using available software
  - Difficulty delivering standardized curriculum without program director oversight of all campuses

Community Office Practice (COP) Course

- Like the Community Medicine Rural Practice experience, the COP course provides students with the opportunity to work with physician preceptors in an office setting.
- The purpose of the COP course is to provide timely practice of skills introduced in the Advanced Clinical Skills course.

Community Office Practice (COP) Course

- Students attend a half-day session (4 hours) usually one-two weeks after the following CS practicum exercises:
  - Mental Status Exam practice NEENT & Nervous
  - Advanced Cardiovascular practice screening for bruits, heart murmurs, AAs
  - Advanced Pulmonary practice screening for abnormal lung sounds (whistling, crackles, egophony etc.)
  - Advanced GI practice screening for hepatosplenomegaly, masses, hernias etc.
  - Male GU/Rectal exam
  - Female GYN/Breast Exam

COP Instructional Modalities

- Students are provided a hard copy Learning Prescription to review and share with their preceptors that:
  - Identifies the most recent skill(s) taught in the skills in addition to listing all skills taught previously
  - Identifies specific clinical skills practice goals
Instructional Modalities
- Preceptors are asked to facilitate practice opportunities and supervise students while they perform at least one exam, where they practice their new skill.

Assessment Modalities
- Students skills are assessed by their preceptors and written feedback regarding their session is usually provided by the preceptor on the Learning Prescription

Student Performance
- Assessed by the preceptor during each visit and at the end of the 6 visits
- Passing the COP course depends on
  - a satisfactory grade from students' preceptors
  - timely student submission of completed and signed
  - Learning Prescriptions
  - Pre and Post course SVS's self-assessment forms
  - preceptor and course evaluation forms.
- Students earn:
  - 10 points/session for attending scheduled visits
  - 10 points/session for returning their completed and signed (by preceptor and student) Learning Prescriptions by the Monday following their scheduled visit.

Remediation
- Remediation is required
  - If a student receives an unsatisfactory assessment from a preceptor
  - If students fail to earn a minimum of 84 out of 120 possible points due to late or incomplete form submissions.
- Remediation requires students to attend additional sessions to remediate skill deficiencies or earn the minimum number of points.

Faculty Evaluations
- Faculty evaluation of students are rarely negative
  - When students have received poor evaluations it has been due to lack of attendance or participation
- Faculty evaluation of the course is very positive
  - Faculty feel that course expectations are clearly defined and reasonable
  - Most faculty wonder why students don't attend more frequently

Student Evaluations
- Student evaluations of preceptors are for the most part very positive
- Student ratings are provided to the preceptors, without sharing confidential student comments.
- Preceptors that are rated poorly on more than three consecutive occasions are not re-invited to participate.
- Students evaluations of the course are generally positive
  - Students enjoy seeing patients and discovering pathological findings.
- Negative feedback usually involves students preferring to group COP sessions at the end of the course as opposed to attending these after specific CS lessons.
COP Course Strengths

- Provides students timely opportunities to practice their clinical interviewing and exam skills
- Because the Year 2 CS course, and BMP phases correlate, students have an opportunity to exam patients with conditions that appear in the BMP and CS cases, and readings.
- Students have the opportunity to assess different specialties and practices.

COP Course Challenges

- Recruitment of qualified faculty
- Maintaining preceptors
- Student travel

Questions
THE COMMUNITY MEDICINE CURRICULUM

OBJECTIVES
- Programmatic Goals
- Instructional and Assessment modalities
- Student Performance
  - Internal
  - External
  - Remediation
- Faculty and Student Evaluations
- Challenges

CM-MVG (2/12/12)

CM-PHASE GOALS (1/17/14)

INSTRUCTION / ASSESSMENT
- Community Medicine I & II
  - PBL, Large Group, TBL
  - MDE, Tutor Evaluations
- MS 1, 3, 4 Visits
  - Clinical Shadowing / Participation
  - Preceptor Evaluation
  - Experiential / Academic Projects
  - Project Scores
THE CURRICULAR QUESTION

Longitudinal Curriculum

CHALLENGES

- Authenticity of the Message, from the Student's Perspective, Relative to the MUSM Mission
- Integration of Community Medicine with Medical Ethics and Family Systems; MUSM Curriculum
- Issues of Organizational Culture
- Data Management and Utilization
- Preceptor Recruitment / Maintenance
MUSM Professionalism and Medical Ethics
Richard L. Elliott, MD, PhD
Professor and Director
Professionalism and Medical Ethics
Adjunct Professor of Law

2008
- Professionalism – White Coat ceremony
- Ethics – no lectures or written exams
- No overview of history of medicine
- No overview of US healthcare “system”
- No MUSM Professionalism statement

Acknowledgements
- Dean Bina
- Dean Malan
- Dean House
- Dean Thompson
- Dr. Roy Russ
- Dr. Martin Greenberg
- Dr. Steve Williams
- Drs. Grimsley, Ignatoff, Baxter, Davis and others
- Members of the Professionalism subcommittee
- Many students

Medical Ethics and Professionalism at MUSM
First Year
- Orientation week
  - Introduction to professionalism for the new RMP student (Macon)
  - Introduction to licensure and physician impairment
  - Creation of class oath (Savannah)
  - Letter to self
  - White Coat ceremony and making/taking of oath
- In combined (February) phase
  - Introduction to medical ethics
  - Introduction to professionalism
  - History of medicine part I
  - Overview and evolution of the US healthcare “system”
- Summer Scholars - 20 papers published
- Student Interest Groups
- Other? Career choices, stress management

Medical Ethics and Professionalism at MUSM
Second Year
- Relationships with pharmaceutical industry and medical device manufacturers
- Impairment among trainees and physicians
- Mistreatment of trainees
- Medical ethics and clinical research
- Malpractice and risk management
- History of medicine part II
- Continuing career choices etc
Medical Ethics and Professionalism at MUSM

Third Year

- White Coat pinning ceremony and medical humanism
- Macon - Professionalism in clinical clerkships
- Macon - Ethics and professionalism relating to each clerkship mixture of ethics and case conference
- Macon - Reflective writing Internal Medicine
- Longitudinal curriculum (e.g., safety)

Fourth Year

- Senior paper on topic of student's choice in professionalism or medical ethics (pass/fail)
- Senior elective papers on medical ethics, professionalism, faith and medicine, healthcare policy, humanities (pass/fail)
- Ethics and professionalism in emergency medicine - case conference (Macon)
- Special topics in ethics and professionalism in Capstone (e.g., licensure, social media)

Evaluations

- Of students
  - First and second year - multiple choice exams
  - Third year - no evaluation
  - Fourth year - senior and elective papers P/F
- Of faculty and curriculum
  - First and second year debriefings, written evals
    - IT main concern
  - Third year - written evaluations

Strengths

- Increased level of satisfaction among students
- Increased participation in electives
- Increased participation in published research
- Broader inclusion in curriculum, e.g., history, malpractice and risk management, social media, overview of U.S. healthcare “system”
- Growth in non-curricular opportunities - humanism, SIG, research

Challenges

- Create uniformity/coordination across campuses?
  - Clerkships
  - Orientation
  - Capstone
  - If
  - Integration into RMP?
  - Placement in curriculum - thread vs blocks vs ?
  - Annual self-reflection as self-assessment tool?
  - Incorporate humanities into curriculum?
  - Reporting/addressing unprofessionalism?
  - Ombuds program?
  - Addressing hidden curriculum/faculty development?

ABMS

Medical professionalism is a belief system in which group members ("professionals") declare ("profess") to each other and the public the shared competency standards and ethical values they promise to uphold in their work and what the public and individual patients can and should expect from medical professionals.
ACP 10 Responsibilities

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

ACP Three Principles

1. The primacy of patient welfare: This principle focuses on altruism, trust, and patient interest. The charter states: "Market forces, societal pressures, and administrative exigencies must not compromise this principle".
2. Patient autonomy. This principle incorporates honesty with patients and the need to educate and empower patients to make appropriate medical decisions.
3. Social justice. This principle addresses physicians' societal contract and distributive justice—that is, considering the available resources and the needs of all patients while taking care of an individual patient.
Understanding and Assessing Families in Primary Care Medicine

"Family Systems"
"Family Assessment"

Family Systems Overview and Goals

- "I can treat this myself."
  - ...In many instances you can provide supportive counseling and for appropriate medication to help your patients.
- "I need to refer this."
  - Much like a primary care physician who refers a patient with a cancer to an oncologist, you will learn to recognize when psychosocial issues are too complex to be managed, and how to make appropriate referrals to family and mental health care professionals.
- "I can treat this collaboratively."
  - Many of your patients will need to be referred to a mental health professional, but you will share in their care to provide supportive counseling and medication.
- "I need a consultation to help me decide on a treatment plan."
  - Often the psychosocial issues are complex and difficult to evaluate. You will learn to refer patients to appropriate family and mental health professionals for consultations. These consultations will make your practice easier and improve the quality of your patient care.

Family Systems Instructional Modalities

- Two primary mechanisms
  - Identical formats, contexts, projects, assessments, etc across courses
  1. Class time (MSI only)
    - Tutorial during Community Medicine I Phase
    - Small group format
    - Total of 9 hours (3 hour session)
    - Case based model consistent with other FAP programs
    - Large group lecture and question/answer session during orientation to each community visit
  2. Two Family Medicine rotations during community visits
    - Longitudinal assessment of patient and family members during MSI, MSII, and MSIV Community Medicine Visits
    - Direct Relief
    - United Access Primary Care Resources
    - Interview based on knowledge and skill gained during tutorial sessions
    - All course materials delivered through Blackboard
    - All assignments submitted through Blackboard

Family Systems Student Assessment Modalities

- MSI
  - Tutor evaluation
  - 20 questions included in phase exam
  - Family Assessment Reports (passing score = 70%) * Approximately twenty pages papers documenting findings from the internships
- MSII
  - Updated Family Assessment Reports (passing score = 70%) * Focused on change since first interview and increasing family dynamics
- MSIV
  - Updated Family Assessment Reports (passing score = 70%) * Focused on change since second interview and further analysis of family dynamics

Family Systems Remediation

- Tutorial and Large Groups
  - Absent - Submit a written summary of the readings discussed during the missed session. Include a section in which the concepts discussed that day are applied to the case study. Due noon on the day following the absence.
- MDE
  - Community Medicine policy regarding retake of exam
- Family Assessment Reports
  - Requires revision of the reports to passing grade of 70%
Student Performance: MSI Family Systems Projects
Rubric Statistics Report

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Average Score</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Project Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Project Proposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Project Deliverables</td>
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<td></td>
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<tr>
<td>Group Project Reflection</td>
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<td>Group Project Finalized</td>
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Family Systems Faculty Evaluation

<table>
<thead>
<tr>
<th>MSI Class of 2017</th>
<th>Strongly Disagree (1)</th>
<th>Strongly Agree (5)</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutor was prepared with regard to small group context.</td>
<td>4.17</td>
<td>.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor acted in a professional manner.</td>
<td>4.10</td>
<td>.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor presented opportunities for students to openly discuss phase content.</td>
<td>4.90</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor was available outside of class for questions and clarification.</td>
<td>4.29</td>
<td>.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor kept the group focused.</td>
<td>4.62</td>
<td>.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor offered constructive feedback and guidance during group discussions.</td>
<td>4.66</td>
<td>.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor modeled critical assessment skills during small group.</td>
<td>4.63</td>
<td>.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor was able to answer questions about topics covered in large group.</td>
<td>4.58</td>
<td>.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor was respectful of students ideas and opinions during group discussion.</td>
<td>4.60</td>
<td>.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutor covered material in small group which was not covered in other groups.</td>
<td>4.09</td>
<td>.70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please give the tutor an overall numerical grade (0-100) based upon his/her ability to help you learn. 94.37 7.22

Family Systems Course Evaluation

<table>
<thead>
<tr>
<th>MSI Class of 2017</th>
<th>Strongly Disagree (1)</th>
<th>Strongly Agree (5)</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors enhanced my knowledge of the role family plays in patient health and illness.</td>
<td>4.48</td>
<td>.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Course readings were well selected and relevant.</td>
<td>3.79</td>
<td>.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The study of families will be relevant to my medical practice.</td>
<td>4.20</td>
<td>.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content is arranged in a clear, logical and coherent manner.</td>
<td>3.31</td>
<td>1.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content covers most of the topics you expected to find.</td>
<td>3.69</td>
<td>.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content optimizes the knowledge and concepts well.</td>
<td>3.93</td>
<td>.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content of appropriate difficulty.</td>
<td>4.19</td>
<td>.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The course has added more confidence in the subject.</td>
<td>3.96</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The materialsiske wory have helped me learn how to analyze real-life situations using the theories and/for concepts presented.</td>
<td>4.02</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family Systems Strengths

- Addresses numerous MUSM Competencies (see list provided)
- Flexible/Innovative
- Develops clinical interview and assessment skills
  - First solo encounter with real patients and their family members
  - Reliance on primary care medicine
- Opportunity to hear patients and their family members describe their lived experience with illness and how it affects and is affected by so many aspects of their lives
- Strong introduction to non-biological determinants of health and illness
- Complements and supports community medicine curriculum and visit
- Excellent led to brains and behavior, 1st phase of year two
- Excellent introduction to clerkship experience in family therapy where the learning is reinforced (Macon campus only)
- Facilitates/encourages enrollment in fourth year electives in which students get more exposure to behavior science (Macon campus only)

Family Systems Challenges

- Initial student confusion regarding 3 in 1 model of CM
- Separating the case from the family
- Requires small group and thus more human resources
- Limited time spent in classroom learning
- Administrative maintenance
- Responding to email and phone calls during visits
- Tracking student assignment submissions
- Student "buy in" - struggle to see relevance so early in their education
  - "I wish I had paid more attention to this material"
- Communication with preceptor about project and the need to identify appropriate families
- How to influence across curriculum?
- Lack of exposure to basic interviewing skills prior to family interviews
CIC Retreat

Year 3
J. David Baxter
Patrick Roche

Year 3
- Traditional Model
- Six Clerkships
- 48 Weeks
- Three Campuses
- Longitudinal Course - Director Bruce Marshall

Longitudinal Course

- September 30: Clinical Reasoning
- October 28: Team Training
- December 9: Patient Safety
- February 3: Chronic Disease Management
- April 7: US Healthcare System
- June 9: Medicine

Third Year Clerkship

Overview

- Leaders
- Teaching Methods
- Assessment Tools
- Feedback to Students and how documented
- Summative Feedback and how calculated
- Student feedback (You have all of this in an email)
Internal Medicine

- Leaders
  - Rosanna Carter Macon
  - David Baxter Savannah
  - Acting Directors Samuel/Parvel Columbus
- Issues:
  - Columbus' stability and leadership
  - Teaching IM in a Family Medicine town

Teaching Methods
- Lecture
- Clinical Rotations
- Presentations
- Student Morning Report (Macon)
- CS 2 Prep on Clinical Reasoning (Savannah)
- 8 weeks In-patient on teams
- 4 weeks out-patient
- (Macon specific issues)

Assessment Tools
- Tools are in your packet for your review
- OSCE (formative)
- Shelf

<table>
<thead>
<tr>
<th>Macon</th>
<th>Savannah</th>
<th>Columbus</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>73</td>
<td>75</td>
</tr>
<tr>
<td>90</td>
<td>88</td>
<td>83*</td>
</tr>
</tbody>
</table>
Comments from Columbus

"First, my schedule for out-patient IM was completely wrong. The lady in charge of scheduling my out-patient weeks thought a cardiologist was a general internist. She had me scheduled for 3 weeks with him, then 1 week with another, different cardiologist, and the last week with a nephrologist. The first day I realized this was the case, I tried multiple times to get in touch with her via email, phone, and office visits. None were successful. After three weeks of this, I finally got in touch with her and she informed me that "cardiology was part of IM" and that was considered an out-patient general IM service. I explained to her that a cardiologist is not an general IM, but a specialty of IM."

Not a very good start

"Second, the attending during in-patient IM, (faculty member), was not even accredited MUSM faculty at the time. He had absolutely no understanding of MUSM's expectations or standards in medical education. These issues were brought up in Columbus Regional Hospital and appropriate MUSM representatives but the issues were not resolved; the attending had a poor attitude regarding being compliant to learning and teaching MUSM's IM minutiae and learning MUSM's expectations for a successful rotation. He had a great understanding and knowledge of medicine but had absolutely minimal participation and teaching skills. There was zero guidance from the beginning, middle, and end. There was a total lack of orientation to this clerkship. I was in utter disbelief at the disorganization and I legitimately doubted whether I was getting any sort of education. It was during my fifth week (and 1st week on in-patient service) I learned of the HPE weakly work hour laws, journaling, etc. I believe this is a poor, poor showing of MUSM's teaching standards."

Columbus

"Third, the teaching team for in-patient service was simply too crowded. At one point, there were 5 students, 3 interns, 1 resident, and 1 attending on a team. That's a total of 10 people on one team. There were about 15-20 patients on the census and I was only seeing 1 or 2 patients a day. There was simply not enough patients to "go around."
Additionally, we sometimes had to be in the hallways while the attending and residents talked to the patients. In such a crowded space, it was even hard to see the attending, much less listen to him. It was impossibly hard to learn and gain knowledge."

Columbus comments

"Organization and administration of Columbus campus is absolutely terrible. Because there is not an IM clerkship director here, all of MUSM's expectations for this clerkship are forfeit. The quality of FP residents at this campus is also a weakness; I believe. There were so many times I felt that this hospital's patients were not represented well during rounds because of the residents."

Questions—there are plenty

- What should we do
  - Full time Dean in Columbus will help
  - Should we change to 10 weeks?
  - Should we go in-patient all for IM?
  - Should we "require" IM to do at least two weeks of sub-specialty out-patient?
  - ?.....

Reasons for struggle???

- Two hospital town— we are "required" to send students to both for political reasons? St. Francis evals are more positive in general
- No IM residency
- Not that many ABIM certified physicians in the town which are generalists.....
Family Medicine

- Leaders
- Teaching Methods
- Assessment Tools
- Feedback to Students and how documented
- Summative Feedback and how calculated
- Student feedback

Family Medicine

- Leaders
  - Patrick Roche, Macon
  - Cynthia Carter, Savannah
  - Janine Burglar-Jones, Columbus

Family Medicine

- Teaching Methods –
  - In-patient rotations
  - Out-patient rotations
  - Lecture
  - Presentations
  - Video

Family Medicine

- Assessment tools
  - Mid term exam In house exam
  - Shelf (Here we have issues)
  - OSCE (summative) Patrick to discuss the OSCE grading  Reliability and validity

Medteam OSCE: Case Evaluation by every student
follows testing
1. How believable was the patient scenario?
2. Rate the overall difficulty of the case tasks for your level of medical training:
3. For this case, was the time allotted for the actual patient encounter:
4. For this case, was the time allotted for the written assignment:
5. Several other questions...

CHOOSING CASES AND SCORING
Students Getting a Score on OSCE

Students Getting a Score on OSCE

Typical Case Checklist recorded by our Standardized Patient after Encounter

Alcohol Abuse/Dependence

CHECKLIST/MEASURABLE OBJECTIVES

Students (N=103)

Students (N=103)

History (Cont’d):
5. Has the student asked if they had ever felt a need to cut back on their drinking? 53%
6. Has the student asked if they had ever sought help for their drinking? 27%
7. Has the student asked if they had ever gotten drunk? 55%
8. Has the student asked if they had ever gotten drunk? 55%
9. Has the student asked if they had ever gotten drunk? 55%
10. Has the student asked if they had ever gotten drunk? 55%
11. Has the student asked if they had ever gotten drunk? 55%
12. Has the student asked if they had ever gotten drunk? 55%
Typical Case Checklist recorded by our Standardized Patient after Encounter

**Alcohol Abuse/Dependence**

*Checklist Parameters: BRIEF-O-CAT (OAT-14) objectives
Communication:
13. The student communicated concern about my pattern of alcohol use.
14. The student carried out follow-up for my alcohol use.
15. The student recommended I engage in alcohol or anti-anxiety follow-up.
16. The student told me my blood work may be deferred due to OAT-14.
17. The student made me feel like he/she cared about me.

**PATIENT’S PERCEPTION OF STUDENT’S INTERACTION SKILLS**

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting you to talk, being friendly, never intrusive.</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>2. Not &quot;all talking at&quot; or &quot;talking too.&quot;</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>3. Making eye contact, ability to answer questions, letting you know you did a good job answering.</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>4. Not being critical orensitive to your lasting sentence or pause in speech.</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>5. Encouraging your questions, asking clearly, never dismissing your questions.</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>6. Using comprehensible language explaining medical treatment in easy language.</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>7. Acknowledging your personal losses or directions.</td>
<td>0 0 0 0</td>
</tr>
</tbody>
</table>

Grading the Post Encounter Note

- Notes are scored by faculty—M.D. or PA or Ph.D.
- They are graded online from any computer with web access.
- They are graded against a standard template, so the standard is uniform from one faculty to another.
- PEN "counts" 25 percent of the overall case score.
- Grading is done within 48 hours, so the student feedback can be merged and returned to the learner (best case scenario).

Family Medicine

<table>
<thead>
<tr>
<th>Category</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Excellent</th>
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</thead>
<tbody>
<tr>
<td>The overall quality of the didactic teaching by faculty (5 pt scale)</td>
<td>4.1</td>
<td>3.5</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>The overall quality of the didactic teaching by residents (5 pt scale)</td>
<td>3.8</td>
<td>3.5</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>The overall quality of the clinical teaching by faculty (5 pt scale)</td>
<td>4.3</td>
<td>4.0</td>
<td>4.3</td>
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<tr>
<td>The overall quality of the clinical teaching by residents (5 pt scale)</td>
<td>3.8</td>
<td>3.5</td>
<td>3.9</td>
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</tr>
<tr>
<td>What’s your overall evaluation of this clerkship? (5 pt scale 1Poor/4 Excellent)</td>
<td>3.8</td>
<td>3.5</td>
<td>3.1</td>
<td></td>
</tr>
</tbody>
</table>

FM In house test

- Exam is based on the textbook, Essentials in FM. Until 2 years ago, a question bank was used, that was supplied by the authors of the book. The test bank was deleted, and the department developed their own questions. There are about 200 questions written by departmental faculty from across the state.
- These questions were submitted to the clerkship directors, then vetted or edited, and placed in the bank. The selected 50-60 questions are chosen from the bank for tests, and have about 3 separate test forms.
- The tests are rotated so that most rotations will have different test questions.
- Monitoring performance of the test questions is as simple as giving each question that has been missed by over half of our student groups is scrutinized by the three clerkship directors.
Savannah-student comments

- "I would've liked more study time and more lectures on clinical topics. There needed to be more lectures from the attendings. We only had one lecture from a FM attending and one lecture from a neurologist. We had 3 resident lectures and then an innumerable lecture from the 'life style' attending in the FM office. The 'life style' attending did not provide any great insight into matters nor provided students with information to help us expand and solely medical knowledge of prepare for the shelf. I enjoyed working with the attendings as they were very open, spent time teaching us during our clinical rotations and were very approachable. I wish I could have gotten more during my time at FM. I also enjoyed my time at the hospital house with Dr. Smith. I only saw one child and no OB/GYN. I believe that needs to be addressed since FM staff covers OB/GYN, pediatrics, and general Internal medicine principles. If the department will not provide more basic knowledge lectures, then the department should coordinate with the other disciplines of OB/GYN, Peds, and Internal medicine to do some joint lectures especially if students will not see a wide variety of patients during the clerkship. Too much down time, I wanted to see more patients."

Columbus-student comments

- "Evaluating the Columbus campus is always difficult because the nature of the campus is split between two hospitals. The St. Francis part of the clerkship is always exceptional. They are always passionate about teaching, dedicate ample time for didactic teaching, and encouraged me to have direct patient contact. Dr. Sims was absolutely a great attending and teacher. He showed me how valuable and precious family medicine truly is.
- Midtown Medical Center/Columbus Regional was not as good as St. Francis. They are used to having many students so we are "lost in the crowd". Of course, students are usually on the bottom of the hierarchy but the residents and some beginners really make that known. I don't feel very respected or valued as a team at the Medical Center. Certain residents (not all) are just poor teachers in general and very concerned about making their point."

Surgery

- Leaders
- Teaching Methods
- Assessment Tools
- Feedback to Students and how documented
- Summative Feedback and how calculated
- Student feedback

Surgery

- Leaders
- Danny Vaughn - Macon
- Oliver Whipple - Savannah
- Jim Majors - Columbus

Surgery

| The overall quality of the didactic teaching by faculty (5 pt scale) | 4 | 4.2 | 4.1 |
| The overall quality of the didactic teaching by residents (5 pt scale) | 4 | 3 | NA |
| The overall quality of the clinical teaching by faculty (5 pt scale) | 3.9 | 3.3 | 4.0 |
| The overall quality of the clinical teaching by residents (5 pt scale) | 4 | 3 | NA |
| What is your overall evaluation of this clerkship? (4 pt scale) 1 poor/4 excellent | 3.2 | 2.6 | 3.0 |
Surgery

- Assessment Tools-(on-line)
- Oral Exam-
- Shelf

12 Points: no prompting required, displayed a thorough understanding of the disease process, generate a complete and an accurate differential diagnosis, and institute a concise and appropriate treatment plan.

9 Points: some prompting required, displayed an understanding of the disease process, generate a complete and an accurate differential diagnosis, and institute an appropriate treatment plan.

6 Points: significant prompting required, displayed only a basic understanding of the disease process, incomplete but accurate differential diagnosis, and institute a safe treatment plan.

0 Points: FAILURE, did not understand the disease process, cannot generate an appropriate differential diagnosis, and cannot describe a safe treatment plan.

Psychiatry

- Leaders
- Teaching Methods
- Assessment Tools
- Feedback to Students and how documented
- Summative Feedback and how calculated
- Student feedback

<table>
<thead>
<tr>
<th></th>
<th>Macon</th>
<th>Savannah</th>
<th>Columbus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>63</td>
<td>81</td>
<td>64</td>
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</table>

Psychiatry

- Leaders
  - Grady Carter/Richard Camino-Macon
  - Stephen Yost-Savannah
  - Jaya Johns-Columbus

Psychiatry

- Teaching Methods
  - In patient
  - Out patient
  - Georgia Regional
Psychiatry

<table>
<thead>
<tr>
<th>The overall quality of the didactic teaching by faculty (5 pt scale)</th>
<th>3.7</th>
<th>3.6</th>
<th>4.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall quality of the didactic teaching by residents (5 pt scale)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>The overall quality of the clinical teaching by faculty (5 pt scale)</td>
<td>4.2</td>
<td>4.2</td>
<td>4.8</td>
</tr>
<tr>
<td>The overall quality of the clinical teaching by residents (5 pt scale)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>What is your overall evaluation of this clerkship? (4 pt scale: 1poor, 4excellent)</td>
<td>3.3</td>
<td>3.4</td>
<td>3.8</td>
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Psychiatry

- Assessment tools
  - *Observed physical exam* -- new
  - Shelf
  - Faculty evaluations (none from residents)

Pediatrics

<table>
<thead>
<tr>
<th>Macon</th>
<th>Savannah</th>
<th>Columbus</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
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<td>78</td>
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<tr>
<td>89</td>
<td>88</td>
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</tbody>
</table>

Pediatrics

- Leaders
- Edward Clark-Macon
- Natalie Hogan- Savannah
- Joe Zanga- Columbus

Pediatrics

- Teaching Methods
  - Lecture
  - In-patient
  - Out-patient
  - Sub-specialty exposure
  - Nights required
**Pediatrics**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Interns</th>
<th>Non-rats</th>
<th>All-time</th>
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</thead>
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<tr>
<td>The overall quality of the didactic teaching by faculty (5 pt scale)</td>
<td>4.4</td>
<td>4.0</td>
<td>4.7</td>
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<tr>
<td>The overall quality of the didactic teaching by residents (5 pt scale)</td>
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<td>3.7</td>
<td>3.9</td>
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<tr>
<td>The overall quality of the clinical teaching by faculty (5 pt scale)</td>
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<td>4.1</td>
<td>4.2</td>
</tr>
<tr>
<td>The overall quality of the clinical teaching by residents (5 pt scale)</td>
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<td>3.6</td>
<td>3.8</td>
</tr>
<tr>
<td>What's your overall evaluation of this clerkship? (4 pt scale 1poor/4 excellent)</td>
<td>3.5</td>
<td>3.0</td>
<td>3.3</td>
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</tbody>
</table>

**Mid-term scores**

**Pediatrics**

- Assessment Tools
  - Mid term
  - OSCE
  - Faculty and resident assessments

**Ob/Gyn**

- Leaders
  - James Burke-Savannah
  - Tina Hawkins-Macon
  - Jeff Jones-Columbus

**Ob/Gyn**

- Teaching Methods
  - In patient
  - Out patient
  - Lectures
Ob/Gyn

<table>
<thead>
<tr>
<th>The overall quality of the didactic teaching by faculty (5 pt scale)</th>
<th>3.6</th>
<th>4.4</th>
<th>4.8</th>
</tr>
</thead>
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<td>4.1</td>
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<td>4.1</td>
<td>4.4</td>
</tr>
<tr>
<td>What is your overall evaluation of this clerkship? (4 pt scale: Poor/4 excellent)</td>
<td>3.2</td>
<td>3.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Ob/Gyn

- Assessment tools
  - Shelf
  - Faculty and resident assessments

Clinical Skills

» Feedback about clinical skill is given in the OSCE program and now in the observed clinical encounter in psychiatry
» Mid-rotation feedback
» End of rotation feedback
» Each student has access to their eDossier
» Comments are formative and summative

Recent Changes

- eDossier – students allowed to see comments edited by clerkship director
- OSCE- Surgery and Ob/Gyn not using -- Continuing to fulfill course objectives
Recent Changes

- Psychiatry: Eliminating the OSCE and utilizing an observed examination
- All evaluations on all disciplines allow the evaluator to separate coaching and grading
- Clerkship director still chooses what goes into the Dean’s letter

Recent Changes

- Surgery – utilizing two oral exams and examiners
- FM – changing their numbers and kinds
- IM – changed the assessment tool. More like FM and OB. More specific instead of generalities

For discussion

<table>
<thead>
<tr>
<th>Shelf exam performance summary</th>
</tr>
</thead>
</table>

Thoughts

1. Is MOM having an impact on our clerkships which is negative?
2. EMR and its impact? Preparing our students for the future...
3. Should we ask for more specific objectives?
4. How can we improve and document communication between campuses?
MISSION

- Prepare students for entry into clinical practice through required and elective experiences which facilitate reflection on career goals and choice and enhancement of skills in patient assessment, evaluation, and treatment. The fourth year should provide students with a broad-based, rather than specialized, medical education.

VISION

- The fourth year programs are planned as a mix of elective rotations, time for interview and reflection, and demanding clinical rotations which will enhance the confidence and competence of the student in preparation for entering clinical practice.

GOALS

- 1) The program will prepare students to confidently and competently assess patients with undifferentiated disease, identify their problems, design a plan for diagnosis and treatment and communicate findings to the patient.
- 2) The program will assist students in selecting their career focus and identifying programs which match goals.
- 3) The program will facilitate student understanding of the role of the physician in patient care and health of the community.
- 4) The program will prepare students for entry into clinical training programs.
- 5) The program will base learning objectives on MUSM curricular competencies.

YEAR IV REQUIREMENTS

- 42 Academic weeks
- 8 Weeks of Vacation to be used for Interviews
- 34 Weeks of Academic Work
  - 17 weeks of mandatory electives
  - 8 weeks of SELECTIVES
  - 4 weeks of Sub - Internship
  - 4 weeks of Community Medicine
  - 1 week of Capstone

SELECTIVES

- Selectives
  - Predesigned required courses most of which have set dates that must be adhered to without exception
  - These are required for graduation
  - ICU, EM*, Geriatric/Palliative Care
  - *may be taken off campus
SUB-INTERNSHIPS

- This is to be an inpatient experience
- Must function as primary care provider
- Supervised by upper level residents and/or attending physicians
- Not all VSAS electives describing themselves as Sub-internships meet MUSM requirements.
- If the Sub-I is questionable you must talk with LoQuanta, Leigh Ann, or Lisa on their respective campuses.

SUB-I

- The general eligibility requirements for a Sub-I experience include:
- The intern will be responsible to the Sub-I Director and will be assigned for the duration of the summer.
- The Sub-I experience is to be undertaken at one of Adelante Medical Centers or the main campus.
- The same schedule will be followed as the 1st year residents.
- Skills to be included:
  - Administration of medications
  - Administration of IV fluids
  - Injection administration
  - Performance of procedures
  - Medical record documentation
  - Observation of patient care
  - Assessment of patient
  - Nursing skills

ELECTIVES

- Are predesigned rotations that are in the student catalog, along with the electives, that you may choose from:
  - Some are patient care oriented
  - Some are research oriented
  - Some are teaching oriented
  - Some are self-study/reading oriented

STUDENT GENERATED ELECTIVES

- As the name implies these are electives that you have designed with specific goals and objectives in mind.
- You must have a faculty representative, approve your advisor, and approval from an outpatient physician that person is involved.
- These forms must be typed or they will not be considered.
- They are reviewed by the YIV committee to determine their value and may or may not be approved.
- The more specific you are the greater the likelihood of approval.
- SGE's must be approved 8 weeks prior to the start of the elective.

INTERNATIONAL ELECTIVES

- All international electives will be handled via a dual department decision:
  - Year IV Committee
  - Office of International Programs
- These offices will work in concert to determine the educational merit and safety of the intended travel.
- Forms will be filled with the OIP via Gayle Bona, or Dr. Elic Spears.
- There will be a $50.00 charge for the OIP assistance and with this each student is assured of a 24/7 manned hotline in the event that in country trouble should occur.

CAPSTONE

- The fourth year capstone course is a required one week course offered at the end of the fourth year of medical school. This course will complete the student's medical school experience by allowing the student time to reflect and to develop specific knowledge and skills relevant to the transition from medical student to resident.
**CAPSTONE - GOALS**

- Allow students to identify and refine key, high yield clinical skills in preparation for their first weeks of residency. [Topics 1, 7]
- Help students apply key principles of ethics and professionalism to the types of cases and clinical settings they will face in the first months of residency. [Topic 3]
- Provide students an opportunity to reflect on the importance of self-care in residency as an element of professionalism. [Topics 3, 4]
- Provide students with leadership, teaching, communication, and learner assessment opportunities that prepare them to be teachers and leaders in residency. [Topic 2, 5]
- Review key patient safety concepts in the context of developing leadership, communication, and team building skills. [Topic 5]

**CAPSTONE GOALS**

- Allow students to reflect on their experiences in medical school and how they will shape their attitudes and behaviors as physicians. [Topic 7]
- Educate students about medical licensure, appropriate prescribing, and behaviors that can jeopardize their medical license. [Topic 4]
- Review key medical legal issues relevant to residency. [Topic 4]
- Familiarize students with end of life issues and allow them to reflect on how physicians process illness and death. [Topic 6]
- Allow students to reflect on their clinical education and patient care in a creative manner. [Topic 7]

**CAPSTONE - OBJECTIVES**

- Topic 1. Clinical Skills
- Topic 2. Residents as Teachers/Giving Feedback
- Topic 3. Professionalism
- Topic 4. Professionalism, Licensure, Controlled Substances, Impaired Physician, Malpractice/Risk Management
- Topic 5. Communication, Teamwork, and Leadership
- Topic 6. End of Life, Dying, Death
- Topic 7. Reflection/Self-Assessment

**CLINICAL SKILLS**

- All rotations require the Standard MUSM Evaluation sheet to be completed.
- Without this sheet in Academic Records, students will not graduate.
- It is of most importance that these evaluations be filled out on One45.
DEVELOPING OPPORTUNITIES

- Piedmont Hospital - Atlanta
- Carl Vinson Memorial VA Hospital - Dublin
- Universidad de Antioquia - Medellin, Columbia

LONG TERM GOALS

- To curtail multiple international electives into a few pre-approved options from which to select
- Further develop the elective programs in Columbus
- Develop a means by which students can give feedback on Year IV rotations
- Continue to develop the Capstone course

PCR EVALUATION

- Medical Knowledge
  - Knowledge base
  - Problem solving
- Patient Care
  - History
  - Physical Exam
  - Information Management
- Practice Based Learning
  - Interpersonal and Communication Skills
  - Human relationships
  - Communications
  - Professionalism
- System Based Practice
- Scale 1-4 (Fail, Satisfactory, Good, Excellent)

PCR EVALUATION

- For Evaluator:
  - Did you have an opportunity to meet with this trainee to discuss their performance?
- For Evaluatee:
  - Did you have an opportunity to discuss your performance with your preceptor/supervisor?

NON-PCR EVALUATION

- Student Knowledge
- Medical Knowledge
- Responsibility
- Skills
- Patient Relationships
- Interpersonal Relationships
- Independent Learning
- Scale (N/A, US, Below Expectations, Satisfactory, Above Average, Outstanding)

PCR EVALUATION

- For Evaluator:
  - Did you have an opportunity to meet with this trainee to discuss their performance?
- For Evaluatee:
  - Did you have an opportunity to discuss your performance with your preceptor/supervisor?
Charge to Task Force

1. Develop Principles and Goals of Curriculum.
   These will include the following expectations:
   - The curriculum will be competency based
   - The curriculum will be integrated across basic and clinical sciences
   - It will include early clinical education
   - It will involve student-centered, active learning
   - It will include opportunities for interdisciplinary education

2. Develop Curricular Structure
   - Curricular hierarchy (alignment and interplay of programs, courses, disciplines, etc.) including curricular governance
   - Define purpose and goal of assessments
   - Threads (for ex. Clinical skills, professionalism, diagnostic imaging, humanities)

3. Develop Evaluation Process
   - Define performance indicators to monitor
   - Create evaluation policies and procedures including administrative responsibilities

Purpose of Year 1, Year 2 Curriculum

Provide the foundation for clinical medicine in order for students to gain the knowledge, skills, and attitudes required to become competent and successful physicians.

Components of Foundation of Medicine

- Basic Sciences
- Social Sciences
- Behavioral Sciences
- Clinical Skills
- Genomics
- Cell Biology
- Professionalism
- Ethics
- Humanities
Health Care System

Clinical Medicine is linked to the features of the Health Care System.

Features of the Health Care System must be incorporated into the components of the medical curriculum.

Pre - Flexner

- High school education
- Minimal admission standards
- 16 weeks of lecture
- 8 months of instruction
- No patient contact
- All students graduated
- Teachers were physicians
- No certification

Flexner Era – 1910 – 2010

Scientific Emphasis
- Basic Sciences Discipline-based
  - Anatomy
  - Microbiology
  - Biochemistry
  - Histology
  - Pathology
  - Physiology
  - Pharmacology
- Hospital – Long term
- Universities
- Admission Standards
- Certification
- 4 Years of medical school (2 + 2)
- 1 year internship
- Elective Advanced Study
- CME
- Primary Care Practice

Forces Affecting Health Care Systems and Medical Education

- Growth in knowledge in cell biology
- Impact of molecular medicine and molecular genetics
- Influence of socio-economic factors
- Changes in demographics/aging/immigration
- Chronic Diseases
- Inclusion of medical ethics/professionalism
- Humanities

Future of Medical Practice

- Shorter hospital stay
- Need for outpatient
- Community based
- Full spectrum of disease
- Early clinical exposure
- Clinical skills
- Integration
  - Basic Sciences
  - Clinical Sciences
- Genomics
- Nonmedicine
- Pharmacology, patient-based
- Professionalism, Ethics
- Humanities
- Wellness vs. Illness
- Aging, population
- Demographics
- Organ replacements from stem cell growth
Major Changes

That must be included in the curriculum:

- Molecular Medicine
- Genomics
- Chronic Diseases
- Ageing Population
- Socio-economic Forces
- Behavioral Sciences
- Professionalism
- Humanities
- Integration of sciences and clinical medicine

Result of Socio-economic Forces on Medical Education

- Shorter hospital stays
- Shift from inpatient to outpatient care
- Full-spectrum of disease presented in outpatient setting

Responses of Representative Medical Schools

UNC, Cincinnati, Virginia, Rochester, GWU, Johns Hopkins

- New principles
- Pre-clinical exposure to clinical medicine
- Early exposure to Clinical Skills
- Inclusion of Behavioral Sciences
- Preventive medicine/health medicine
- Integration of Basic Sciences and Clinical Medicine
- Inclusion of Professionalism, Ethics and Humanities

Socio-economic Forces

- Early exposure to clinical medicine/clinical skills
- Shift from Inpatient to Outpatient Medicine

Summary of Issues Addressed by Principles

1. General Professional Education
2. Mission of Mercer University School of Medicine
3. Competency-based
4. Accreditation Standards
5. Professionalism
6. Incorporates Broad Definition of Health (not just absence of disease)
7. Incorporates Basic sciences
8. Behavioral, Environmental, and Social Determinants of Health and Disease
9. Medical Ethics
10. Patient Safety and Quality of Care
11. Wellness, Preventive Medicine, and Health Promotion
12. Student's Personal Health

Summary of Issues (cont.)

13. Humanism
14. Interpersonal and Communication Skills
15. Cultural Sensitivity, Humility, and Competence
16. Leadership and Team Skills
17. Clinical Skills
18. Early Experience in Clinical Medicine
19. Current Content and Up-to-date Pedagogy
20. Integration of concepts and content
21. Active Learning Methods
22. Self-Directed Learning
23. Life-long Learning
24. Defined Assessment Criteria and Remediation
Overarching Principles

Principle 1: The curriculum provides a general professional education that will prepare students to enter into and excel in graduate medical education in any specialty.

Principle 2: The curriculum provides excellent experiences in areas related to the mission of MSM. These include medical specialties needed in the state of Georgia and topics related to care of Georgia's rural and/or medically underserved populations.

Principle 3: The curriculum will be competency-based.

Principle 4: The curriculum meets accreditation standards.

Principle 5: The curriculum promotes development of professional identity.

Principle 6: The curriculum incorporates a broader definition of health.

Principle 7: The curriculum incorporates basic sciences that contribute to an understanding of the basis of health, and the pathogenesis, pathophysiology, pathology, clinical manifestations, and principles of management of disease.

Principle 8: The curriculum will address behavioral, environmental, and social determinants of health and disease.

Principle 9: The curriculum will provide a strong foundation in medical ethics.

Principle 10: The curriculum includes measures to address patient safety and quality of care.

Principle 11: The curriculum emphasizes wellness, preventive medicine, health promotion, population health, and patient-centered, team-based approaches to health care.

Principle 12: The curriculum fosters promotion of students' personal health, and enables students to acquire and demonstrate an understanding of physician wellness and the application of principles of health promotion to promoting personal health.

Principle 13: The curriculum incorporates humanism.

Principle 14: The curriculum promotes interpersonal and communication skills.

Principle 15: The curriculum fosters the development of cultural sensitivity, humility, and competence.

Principle 16: The curriculum promotes development of leadership and team skills and includes interprofessional education.

Principle 17: The curriculum will result in the development of skills including obtaining an appropriate history, performing a complete physical examination, and the use, ordering, and interpretation of diagnostic procedures and laboratory testing.

Principle 18: The curriculum includes early experiences in clinical medicine.

Principle 19: The curriculum incorporates current content using up-to-date educational approaches.

Principle 20: The curriculum maximizes integration of concepts and context.

Principle 21: The curriculum emphasizes active learning methods.


Principle 23: The curriculum promotes the development of skills required for lifelong learning.

Principle 24: The curriculum defines learner performance and assessment criteria based on the competencies of the institution and consistent with national norms.