

**Moving Medical Education Forward**  
**Case Western Reserve University School of Medicine**  
**Annual Education Retreat Evaluation Results**

(50 Respondents)

1=Poor, 2=Fair, 3=Good, 4=Very Good, 5=Excellent, N/A=Not observed

	<b>Mean</b>	<b>STD</b>
<b>Key Note Address: Ralph I. Horwitz, M.D.</b>	4.6	0.6
<b>Workshops:</b>		
1. OSCEs and Standardized Patients (SP)	5	0
2. Team Learning for Interactive Large Group Sessions	5	0
3. Effective Large Group Teaching	5	0
4. Effective Small Group Teaching	3.3	1.1
5. Giving feedback	4	0.9
6. The Attending and Resident as Teaching Partners: Resident as Teacher	4.3	0.5
7. Easy Ways for Revising Your Syllabus	5	0
8. Alternative Methods of Assessment	4.4	0.5
9. Teaching Clinical Reasoning Skills	3.3	0.8
10. Preparing Abstracts and Posters for Presentation: Making Educational Work Available to Colleagues	<i>Insufficient return</i>	
<b>Educational Works in Progress Posters</b>	4.1	0.8
<b>Moving the Curriculum Forward</b>		
1. Working lunch in Small Groups	3.8	0.9
2. Dialogue with the Dean	3.9	1.0
<b>Overall Assessment of the Retreat</b>	4.3	0.7

**General Comments:**

1. The program provided the energy to move forward with the development of a unique environment for medical school education.
2. I believe we need to get rid of morning lectures – but 1<sup>st</sup> year students may not be ready to solve problems – so 1<sup>st</sup> year, seminar style, the next year solve problems
3. Perhaps two sessions of small groups in other session.
4. I would like to be able to attend all of the workshops.
5. Our original leader did not show. Our stand in was very good & I would have preferred to hear more of what she had to offer. However, she was diverted frequently by a few in the group off topic.

6. Case SOMH is in great hands with Dean Horwitz at the helm. I believe his vision of integration of research, public health education, and leadership into the core medical school curriculum is an outstanding idea. Case SOMH should be creating the leaders of tomorrow.
7. More breakfast variety – bagels!
8. Thanks for great breakfast choices. Working lunch was a good idea, too.
9. Re-energized integration of medicine and public health provides an opportunity for reclaiming education of medical students for the educators. (Henry D. Zeigler, MD, MPH for your faculty – knows Cleveland community and Community/International Health)
10. Best retreat ever!
11. This was the first extensive conversation with the Dean and that made it all worthwhile.
12. Posters and abstract summary book is wonderful. Will all faculty receive a copy? Not all faculty attended.
13. Show me the money and I'll be impressed with the initiatives.
14. I wish that the working groups were all assigned to discuss issues related to the Dean's white paper.
15. Congenial atmosphere set by facilitator (feedback), but would have liked the role playing segment included in feedback workshop. Workshop geared to clinical rotations – not highly relevant to other backgrounds. Would have liked to contribute or be involved more.
16. Team learning session was excellent!
17. Dialogue with the Dean – no dialogue...just comments from the faculty...therefore, it rates poorly as a "dialogue".
18. Start a bit later (maybe 8:30) so docs can round first.
19. Use overheads for small group reports. Good breakfast choices. Post feedback/.discussion in public forum. Have poster sessions in the future. Have the small groups present in the AM – not after lunch.
20. Good retreat! Small group discussion was very fruitful.
21. Very well done overall!
22. The lunch group lacked some focus of the goal of the small group. It was not clear how our discussion would be integrated into the challenges of the "white paper".
23. Excellent retreat – however, would like to see some emphasis given to non-MD graduate student education – they seem to be the orphans of the med school.
25. Very good overall.
26. I have always found the educational retreats stimulating and instructive. This one was no exception.
27. Interesting meeting – I really liked hearing the Dean's vision at the keynote. I don't agree with everything but it is refreshing to have a dean with an educational vision!

28. Interesting session with the Dean + workshops were excellent. Lunch session was OK, reporting session dragged. Would suggest organizing this differently in the future – possibly with a large group team learning format.
29. I would like to suggest that next year and each year, there is a part of the Education meeting devoted to emerging ideas in graduate student and post-doctoral training. We have some 400 graduate students and about 150 post-docs at the SOM and we need to include them in our educational goals. The education retreats are only capturing the faculty that teach in the medical curriculum, and many of my colleagues who thoughtfully work to train future scientists at the SOM do not attend because there is nothing for them to talk about.
30. Excellent program. Poster presentations very helpful. Great opportunity for discussion and networking. Dr. Horwitz is, I think, right on target.
31. Posters were great, a real opportunity for scholarship in medical education.
32. Would have liked workshops repeated to go to more than one.
33. Workshop – good paradigm for clinical reasoning, but it would be even better to hear how this curriculum is actually being used and how to adapt it to different settings (teaching rounds, outpatient clinic) and also how to assess it – the model seems useful but we would need more practical suggestions for implementation to make it useful.
34. Outstanding except for a few glitches, i.e. the large room setup made it difficult for those seated on the sides to see the stage. The reports from the committee chairs, written on scribbled flip charts, were poor. It should have been on PowerPoint. We certainly have the expertise to get that done quickly.

**Please identify one or two ideas from the retreat that you will try to use in your educational activities.**

1. Expand CME concepts.
2. OSCE's and SPs.
3. Appreciate the importance of developing resident as teacher because of their impact on medical students' education.
4. Improving my feedback to residents and students.
5. Team learning.
6. Find ways of stimulating student interest in topic so that they are motivated to prepare ahead of time for teaching sessions.
7. I like the summary from one of the groups of what a Case student should be able to do by graduation.
8. To involve learners in my thought process in clinical reasoning.
9. To make my clinical reasoning process more “transparent” to the learner (reason out loud). To create an environment where the learners feel they are respected.
10. I will expand the small groups in my committee.

11. Institute faculty and resident teaching/education course.
12. Point out clinical significance in basic science teaching. Suggestions to improve lectures.
13. I want to commend Mano Sangham on his "Large Group Teaching" session. I will start splitting my 50 minute lectures into 4 shorter 10-12 minute sessions with questions on each mini-session.
14. Team learning for interactive large group sessions.
15. Be the best leader I can be.
16. Attrition over the day probably unavoidable, but too bad.
17. I'm going to try and utilize a couple of ideas from the workshop on small group discussion, re: getting people to participate.
18. Improving my provision of feedback as well as my constructive use of feedback.
19. Using Team Learning as a tool for effective education; a need for cost/outcome ratio, teaching from early days of teaching medical students; Fast Track H&P teaching through observations, typical patient, not undifferentiated patient for the beginners.
20. Sharing Clinical Reasoning with current students. Re-integration of public health into my primary care teaching.
21. Developing management skills as a springboard for leadership.
22. Research skills for thesis.
23. Key words in syllabus. Request syllabus crosslinks.  
Progressive testing.
24. The CCLCM curriculum still needs to be concerned that students can pass national exams, no matter how much we dislike them as assessment tools.
25. Incorporate team learning into Mind Committee.
26. Incorporate concepts of public health. Train my colleagues in giving feedback to our fellows. Use concepts of evaluation from AM workshop to use in our fellowship program.
27. I'm very tempted to implement Team Learning or at least include components of this in the large lecture room.
28. Utilize the web portfolio for geriatric P.D.
29. Consider new assessment procedures/methods. Remember that philosophy drives teaching and assessment methods.
30. Emphasis on caring for patients. Don't lose it in the haste toward the thesis.
31. Structure of the OSCE as a formative evaluation tool.
32. Try to incorporate some of the assessment methodologies in my teaching and courses I am involved in.
33. The workshop about preparing abstracts was excellent and I will use ideas from that. We will consider more the idea of how we can assist in the mentoring of the students.

34. I gleaned some theoretical and practical tips from the large group teaching session that I will be able to use frequently.
35. Small group teaching – people remember when they hear their own voice – so I will try to get students to speak up more during small group sessions.
36. Creation of poster for national meeting.
37. I am changing my lecture format somewhat; I am pushing on a project looking at SES and outcome among CV patients; I am considering taking advanced stats courses myself, to develop my own skills.
38. The development of OSCE's – while terribly time consuming to prepare properly, these seem like an excellent way to test students and help improve their clinical skills.
39. Helpful clinical reasoning card given out in the morning session that is a good approach to clinical reasoning.
40. I plan to incorporate the team learning strategies into large group teaching formats.
41. Assign probability to differentials; Objective evaluation of small groups.
42. Large group teaching can be improved! We must get away from lectures, especially lectures with slides and lecturers “talking to the blackboard” etc. INTERACTIVE TEACHING IS THE MODERN GOLD STANDARD. Bring back Socratic Conferences

**Please write the one most important thought you would like to tell Dean Horwitz.**

1. It was 10 years ago (I graduated in 1977!) that I really realized that Schools of Public Health are separate. Right on target – Case School of Medicine and Public Health, & should say this.
2. Faculty buy-in.
3. You are a medical school – stick to you core competency ---- teaching medicine.
4. I have a program written I would be pleased to give it to them, Bob and Dean Horwitz (Jerry Leibman)
5. Integrate different aspects of medical teaching (physical diagnosis with physiology with pathophysiology) so that students may grasp the global picture.
6. Case Western has been a unique medical school – be careful not to lose some of the aspects of it which give it its personality as you overhaul the focus of the curriculum content (I'm a student.)
7. FYI, I am a student: I share your vision. I would be willing to trade some of my unscheduled time, as well as some parts of the curriculum I found less useful – (ICM, Family Clinic) in order to be competent in public health.
8. Clinicians who are pulled away from their clinical responsibilities to do an extended amount of teaching **SHOULD BE REIMBURSED** (or their institution should) for their time.
9. Move ahead with the required thesis sooner than the 2005 entering class.

10. This was a good idea. Good luck in trying to change the culture from billing RVU to educational RVUs.
11. Foster interactions between clinical and basic science departments regarding education – including better support for PhDs in clinical departments (e.g., mechanisms to fund graduate (PhD or MD. PhD) students).
12. Strongly pursue your goal of large blocks of unstructured time.
13. Patience and persistence will pay off!! Changing the philosophy (or personnel) of the clinical chairman is a daunting task.
14. Communication between clinical skills teachers in the basic science years and in the clinical years.
15. Promoting leadership and civic professionalism are key efforts in revitalizing the curriculum.
16. Good luck with all these changes.
17. Good to share ideas with people from different areas/disciplines.
18. It is important to get bi-directional communication and collaboration for teaching in the SOM between the basic scientists and clinicians!! (Just a note – at 2 pm, there were about 20 basic scientists at the retreat, the rest were clinicians. Why do you think this is? How do we get basic scientists more involved?)
19. Question: How will the University program be different from the College program once all the new developments are in place?
20. Please integrate School of Medicine with Community Hospitals for better resources and teaching of trainees – we need to clean up some mediocrities of the past administration at UH.
21. Preserve clinical “care” – i.e., additional projects cannot dilute goal of patient care).
22. The first 2 years of Case med school can be easily compressed into 18 months. We need more clinical elective time, not another restructuring of the first 2 years.
23. Will all large and small classrooms become level 2 (LCD, computer, video) capable?
24. Thanks for the inspiration.
25. Pay for teaching.
26. Stay the course.
27. I hope we don't shorten clinical experiences in 3<sup>rd</sup> year so much that they become only observational not experiential.
28. Please! – promote a new concept of health as physical health, well-being and safety, not the absence of disease.
29. Please design (have designed) the new medical education building to maximize our abilities to practice innovations in teaching and learning.
30. More resources needed for clinical teaching and evaluation.
31. Communicate your vision and passion to faculty/staff more frequently to foster/encourage your curricular champions.

32. Make sure tests of any sort serve to enhance/encourage learning in addition to assessing learning.
33. Please make sure that where we are going doesn't contradict where we came from.
34. The "master teacher" concept could be used to 1) elevate teaching at Case, 2) increase respect for the role of teaching. You are doing a great job!
35. Resources will be the key as to whether or not these suggestions in curriculum revision and development (new) (will happen).
36. His energy and enthusiasm are inspiring.
37. Educational and research leadership at Case in areas essential to public health will be every bit as important (likely more important relative to health outcomes) as our prior leadership in clinical and basic science research/education – we need to be excellent in both areas.
38. I am worried that we will work on logistics if educational change before setting specific outcome goals. I don't think we can get the large-scale effort we will need to make educational changes without establishing clear agreed-upon goals first, since some constituents will inevitably resist what they perceive as their losses. (Loss of status, loss of control, loss of influence over the students, loss of ability to recruit students to their field, etc.) But if you can get agreement on goals, you may be able to obtain buy-in when changes are instituted. Thanks for asking us our thoughts!
39. After reading the summary report/white paper, it is unclear what changes will actually be implemented to achieve the desired goals (which themselves appear fine). For the time frame discussed, I believe more concrete specifics need to be outlined.
40. I strongly agree with the comment that students need required formal training about health care economics. So many of my colleagues (I graduated in 1977) are disenchanted with the financial aspects of the practice of medicine. This often spills over to residents and students as discontent with medicine as a career choice. The solution is to teach the students about what they will be dealing with and what they can do about it in a problem solving way. This will help them not develop unreasonable financial expectations and show them what the problems are and how to intelligently influence the system. The Weatherhead faculty are excellent teachers and would be a wonderful resource to the SOM in this regard. Furthermore, so much of the public health care policy is driven by economic forces. Some basic training in health care economics would be systemic with the new public health direction planned for the SOM.
41. Forge ahead. Please do your best to maintain an outstanding working relationship with the Cleveland Clinic.
42. Writing a thesis for med school is not a big deal and is a good exercise (I had to do it), but I think the expectation should be made clear – i.e., is it for doing a circumscribed research project and writing it up (so as to go through and understand the process), rather than doing a master's level thesis (unless that is truly the expectation) --- otherwise it may sound very daunting to try and accomplish this

while competing a medical/public health curriculum, and scare away high quality potential applicants.

43. The changes he hopes to undertake at the medical school will require adaptive change – a change in the thinking and the culture of the school. Great book on leading adaptive change he may want to check out “Leadership without Easy Answers” by Ronald Heifetz at the Kennedy School at Harvard.
44. I think we need to think about ways of combining “public health” and thesis requirement. This will make everyone’s life easier, and will generate many good and new outreach programs. This could be integrated into the societies and be vertical in nature. Having students at all 4 levels involved will assure continuity. Will be happy to brainstorm this. (David McCoy)