

**Education Retreat at Landerhaven
November 28, 2001
Focus on the Liaison Committee on Medical Education (LCME)
Institutional Self-Study (Site Visit: March 10-14, 2002)**

**Welcoming Remarks by Nathan A. Berger, M.D.,
Dean of the Medical School and Vice President for Medical Affairs**

Dean Berger announced that the focus of today's retreat would be to review the LCME (Liaison Committee on Medical Education) preparation for certification by the AMA (American Medical Association) and the AAMC (American Association of Medical Colleges). All American and Canadian medical schools are certified every seven years by the LCME. Our last LCME accreditation took place in 1995. Approval by the LCME is necessary for our students 1) so that they can proceed to residency (residents must come from an LCME-accredited school), and 2) because it is a prerequisite for licensure. The LCME evaluates our educational process and what affects our process. The LCME evaluates students, faculty, facilities, and all the resources that impact on the aforementioned, such as libraries and clinical facilities. The LCME is also interested in research programs and the outcome measures of our students.

The LCME self-study consists of three parts:

1. Preparation of the database—information on all aspects of the medical school—and how different components interact and interface. Preparation of the database has been going on for over one year. We now have copious volumes of material.
2. Basis for the self-study—A committee of close to 100 people, consisting of faculty, administrators, and some students, evaluates the database. These findings are written up in another volume.
3. The site visit, which uses external reviewers from the AMA and AAMC, will take place March 10-14, 2002.

Dean Berger recognized the leadership efforts of Drs. Kent Smith, Murray Altose, Marcia Wile, Robert Haynie, and the committee of 100.

Our self-study takes inventory of where we are now and how we can be better. Dean Berger likened it to an audit. Our goal is to pass the site visit and become accredited.

Our plan today is to review the database. We want input from all those present. Dean Berger thanked today's attendees for their help thus far and welcomed their continued participation.

LCME Accreditation

**Charles Kent Smith, M.D.
Vice Dean for Medical Education and Academic Affairs
Murray D. Altose, M.D.
Associate Dean for Louis Stokes Veterans Affairs Medical Center**

Please refer to the PowerPoint handout used by Dr. Altose and Dr. Smith for an in-depth treatment of the LCME accreditation process. **Dr. Altose** began by citing the **aims of the LCME accreditation process**:

1. To certify that a medical education program meets prescribed standards
2. To promote institutional self-evaluation and improvement.

Dr. Altose covered the following additional topics:

1. **Accreditation process**

- ?? Broad-based involvement of administration, faculty, students
- ?? Collection and review of data
- ?? Identification of strengths and weaknesses
- ?? Devising strategies to preserve strengths and to address weaknesses
- 2. **Components of the self-study**
 - ?? Institutional priorities and educational objectives
 - ?? Governance and administration
 - ?? **Educational programs leading to M.D. degree—a major component**
 - ?? **Medical students (their recruitment, selection, finances and debt, support)—a major component**
 - ?? Resources for educational programs
 - ?? Graduate education in basic sciences
 - ?? Graduate Medical Education
 - ?? Continuing Medical Education
 - ?? Research
 - ?? Basic science and clinical departments

After identifying the two major components bolded above, Dr. Altose outlined what he hoped to accomplish today: 1) identify our strengths, 2) find areas for improvement, and 3) develop an agenda—using as broad an involvement as possible.

Dr. Smith continued the presentation by covering the following topics on the same handout:

- 3. **Objectives of the educational program—Requirements**
 - ?? Items of knowledge, skills, behavior, values and attitudes that are the expected outcomes of instruction
 - ?? Objectives need to be understood by faculty and students
 - ?? Data indicating that objectives are being achieved
 - ?? Strategic planning as a framework to accomplishment of goals and objectives
- 4. **Institutional priorities established in 1997-1998**
 - ?? Curriculum revision
 - ?? Expansion of educational opportunities
 - ?? Strengthening of research programs
 - ?? Faculty development
 - ?? Technology transfer
 - ?? Renovation of facilities
 - ?? Enhancement of communication system
- 5. **Educational Program Planning** (lumped together chronologically here in one section, while spread out throughout the handout):
 - ?? Curriculum revision initiated during the summer of 1997
 - ?? Advisory Committee's outline of educational objectives at the February 1998 faculty retreat
 - ?? Establishment of the Curriculum Leadership Council (CLC) in February 1998 with responsibility for development and implementation of the curriculum revision of the first two years (One slide is devoted to the CLC's educational goals.)
 - ?? Establishment of the Clinical Rotation Development Council (CRDC) in April 1999 with responsibility for developing a revised 12-month core clerkship program for the third year (One slide is devoted to the CRDC's educational goals.)

- ?? Presentation, review, and approval of planning proposals by the Executive Committee, Committee on Medical Education (CME), and faculty (at annual retreat)
- 6. **Educational objectives** listing what graduates of the medical school must master (knowledge, attitudes, self-education methods, interpersonal skills)
- 7. **Evidence of student mastery** include CAP interims and Year I Comprehensive Examination, performance-based assessments such as the OSCE, USMLE Step 1 and Step 2, NBME Clinical Subject examinations, student advancement and graduation rates, NRMP match results.
- 8. **Evaluation of educational objectives** includes AAMC Graduation Questionnaire (“exit” survey), student evaluations of courses and clerkships, and CLC and CRDC reviews and reports to the CME, Executive Committee, and Vice Dean
- 9. **Institutional strategic planning** (1997-January 2001) includes various planning initiatives/revision projects; annual faculty retreats; meetings with Executive Committee, Faculty Council, and the Washington Advisory Group.
- 10. **Mission statement**, which focuses on advancing health through the interrelated components of education, research, and service
- 11. **Educational programs for the M.D. degree—the issues:**
 - ?? balance in the curriculum
 - ?? management and oversight of the curriculum
 - ?? measuring effectiveness of the curriculum
 - ?? evaluation of students
 - ?? equivalency of clerkship experience across sites
 - ?? residents as teachers.

The LCME Accreditation Survey will take place March 10-14, 2002.

Dr. Smith concluded presentation of the overview of objectives and mission.

Medical Students: Overview

Robert Haynie, M.D., Ph.D.

Associate Dean for Student Affairs

Richard D. Aach, M.D.

Associate Dean and Director of Residency and Career Planning

Albert C. Kirby, Ph.D.

Associate Dean for Admissions

Marti Echols, Ph.D.

Director of Student Support Services

Dr. Haynie began by referring to the recent AAMC meeting that he attended in Washington D.C., chaired by former CWRU faculty member Dr. David Stevens. Fifty-five schools were reviewed for both strengths and concerns (including partial or substantial non-compliance with LCME accreditation standards). Under the “strengths” category, Dr. Haynie listed our research, electronic curriculum, financial well being, Dean’s leadership, and bright, enthusiastic students.

Dr. Haynie acknowledged the following individuals for their key roles relating to Student Affairs:

- ?? Dr. Albert Kirby, heading the Office of Admissions

?? joint efforts of Dr. Marti Echols and Dr. Haynie, combining to offer personal counseling and to help students to navigate the curriculum as well as to recruit both minorities and M.D. and M.D./Ph.D. applicants

?? Dr. Richard Aach, providing career counseling and residency planning.

Please refer to the joint handout from these three presenters for more detail.

Dr. Kirby offered an overview of the Admissions process. Although we were criticized for too much central control during the last LCME self-study, the CWRU School of Medicine has always had good students.

Dr. Kirby described the **current admissions process**. For the past seven years, there has been a steady decline in applicants, significantly greater at the national level than at CWRU. The latest CWRU figures show over 5,000 applicants, 800 interviews granted, 25 faculty interviewers, a 13-member Admissions Committee, and over 350 offers (our largest ever) to fill 145 slots.

Topics for discussion included:

?? the increasing number of offers made each year

?? inadequate need-based financial aid

There was no merit scholarship money when Dean Berger assumed his position.

Now there are 21 sizable merit scholarships.

?? the Ohio quota

Receiving the Ohio subsidy mandates that 60% of the entering class must be legal Ohio residents. This limits our ability to reach out to other students.

?? **new** definitions of under-represented/under-served populations

Under the **old** definitions, under-represented/under-served populations were only African-American, Mexican-American, Native American, and Puerto Rican mainlander.

The **new** definitions, as developed by the federal government, of under-represented/under-served populations are much broader and take social and economic status into consideration as well as race/ethnicity.

Also, under the new definitions, an individual can stipulate inclusion in more than one category. This is entirely appropriate since 12% of the babies born in the U.S. in 2000 were of mixed parentage according to the classic definitions of race or ethnicity.

Dr. Echols began by listing the **amenities for students**: study area, food, recreational facilities, housing, parking, recreation, and resources. **Academic counseling** areas cover pre-matriculation, orientation, post-examination review (which includes “proactive” counseling by meeting with students who score 70% or below), and year-end (which includes the Year I Comprehensive Examination review and testing strategy workshop for the USMLE Step 1). Dr. Echols listed **personal counseling** resources that are divided into counseling services and support groups. The **student health care** area includes insurance, immunization, and environmental safety. Dr. Echols concluded with the **learning environment**, which includes a yearly review of the policy on conduct toward students and a designation of the Office of Student Affairs as the point of contact.

Dr. Aach heads the Office of Residency and Career Planning. Its functions include:

?? **Facilitate career decision-making** via class meetings, workshops, individual meetings, resource materials

?? **Assist in the matching process** by 1) providing advice to secure the best residency position possible and by 2) by preparing the individual student sequentially for the match

?? **Write the Dean's Letter**, which is a comprehensive letter of evaluation highlighting the student's strengths that must be ready November 1 of the fourth year

Dr. Aach described the **strengths** of the Office of Residency and Career Planning as its devotion to assisting the students. **Challenges** include the Dean's Letter, meeting student needs, changes in Graduate Medical Education (GME) and the medical profession, and developing effective strategies for achieving career goals.

Opportunities include fostering increased student knowledge of clinical specialties through interest groups, the MAP (Medical Apprenticeship Program), and meetings with health care professionals as well as enhancing student awareness and use of available resources and performing outcome assessments.

Dr. Smith recognized **Ms. Minoo Golestaneh, Angela Rhinehardt, and Heather Husvar**, and **Mr. Craig Hull** for their invaluable efforts in preparing today's medical education retreat.

Educational Program – Core Academic Program: Overview

William C. Merrick, Ph.D.

Interim Chair of the Curriculum Leadership Council

Marcia Z. Wile, Ph.D.

Director of Curricular Evaluation

Dr. Merrick titled his presentation **50 Years after the Revolution** (see PowerPoint handout). Dr. Merrick concentrated on the latest curriculum reform, which was implemented during the 1999-2000 academic year. **Year I** focuses on *normal* biology and basic science. The morning deals with the basic science core programs and Introduction to Clinical Medicine (ICM). The afternoon deals with the Flexible Program electives, interviewing, Physical Diagnosis, and the Family Clinic. Dr. Merrick listed all the courses that fall under the category of Human Biology. He added that with the onset of the new curriculum, both Anatomy and Histology are now individually graded components of Year I. **Year II** focuses on pathophysiology.

Dr. Merrick listed all "**relatively new**" **developments** relating to the curriculum revision:

- ?? Establishment of the Curriculum Leadership Council (CLC) consisting of approximately 25 individuals to oversee the integration and coordination of the first two years of medical school
- ?? Restructuring of Years I and II so that the first year focus is on normal structure and function of each organ system and the second year emphasis is on pathophysiology
- ?? Coordination of basic science and clinical science components to ensure that the Introduction to Clinical Medicine activity relates to the concurrent basic science organ system subject committee
- ?? Physical Diagnosis begins in Year I.
- ?? Placement of the weekly Physical Diagnosis lecture into the morning segment of the Core Academic Program for the 2002-2003 academic year
- ?? Development of specific learning objectives for each component of the curriculum
- ?? Establishment of vertical themes, such as Genetics, Growth and Development, Aging, and Diversity, to promote integration across disciplines and across the four years of the curriculum
- ?? Expansion of the electronic curriculum to improve accessing information, self-directed learning, and integrated evaluation

Dr. Merrick projected a sample weekly schedule for Years I and II showing placement of Core Academic Program (CAP) courses, Introduction to Clinical Medicine (ICM) sessions, labs, Flexible Program, and Saturday options.

Dr. Merrick then listed all **“really new” developments:**

- ?? Integration of clinical and basic science (interface between Core Academic Program and Patient-Based Program)
- ?? Computer-based exams implemented currently for the first year only—next year (2002-2003) both first and second year exams will be online.
- ?? The “Master Schedule” listing all required student activities on a single calendar
- ?? Completion of the Core Academic Program schedule a year in advance—by January 1, 2002, the 2002-2003 schedule should be ready. This should improve small group room utilization.
- ?? Committee-assessment—response to student “standardized” evaluations
- ?? Shifting hours to minimize the current 4- or 5-hour lecture days
- ?? Make the general CAP time 8:00 a.m. to 1:00 p.m. Monday through Friday, with generally two days in the week with nothing scheduled from noon to 1:00 p.m.
- ?? Running of electives from 2:00 to 4:00 p.m. or from 4:00 to 6:00 p.m. to allow students time for lunch and travel time
- ?? Tests in progress to evaluate mechanisms for optimal exam review by students
- ?? Tests in progress to use different formats for active learning (more than Problem-Based Learning)

Dr. Merrick next delineated **tasks at hand:**

- ?? CLC subcommittee on *student* performance to evaluate student performance in the first two years and to determine if remediation in Year II is really working
- ?? CLC subcommittee on *faculty* performance to determine if the committee covered the required material, if junior faculty are being helped to improve, if the best faculty are teaching
- ?? Is there a solution to reduced class attendance at the end of Years I and II?
- ?? With the projected clinical skills assessment examination to be added to the USMLE requirements in Years III and IV, should we have real outcome/assessment measures in Physical Diagnosis and ICM?
- ?? Addition to the curriculum of a course on terrorism—biological, chemical, and psychological aspects

Later in the retreat, Dr. Mark Cheren announced to today’s attendees that Continuing Medical Education is offering a course on Biologic and Chemical Terrorism on Saturday, December 1, 2001, 8:30 to 12:30 p.m.

Dr. Merrick concluded by mentioning that there was no cause for concern over internal evaluation of our students with implementation of the new curriculum. Overall, Dr. Merrick summed it up this way: We have done no harm and maybe we have done even better.

Dr. Wile spoke on internal evaluation and outcome assessment in the Core Academic Program. She listed the various means of **student evaluation of the curriculum:**

- ?? Online subject committee evaluation form, completion of which is prerequisite for receiving interim examination score
- Dr. Wile acknowledged the efforts of Ms. Minoo Golestaneh and Mr. Craig Hull in this endeavor.
- ?? Weekly feedback luncheons
- ?? Student Committee on Medical Education reports
- ?? Weekly student lunch meetings with student representatives, Dean, and Vice Dean.

Dr. Wile next explained what comprises **quality control of curriculum: internal measures:**

- ?? Performance on **subject committee interim examinations**
 - ☞ Source of multiple-choice questions: secure (50-60%), revised, brand new
 - ☞ Comparison of performance on secure multiple-choice questions with previous year's class
 - ☞ Comparison of performance on secure multiple-choice questions with *pre-revision* curriculum (Class of 2002) and *first-year revised* curriculum (**Class of 2003**)
- ?? Sample breakdown of Year I Biochemistry and Cell Biology Subject Committee interim examination scores taken September 25, 2000. Table on handout compares performance of the previous year's class—Class of 2003 (Year III class)—with the Class of 2004 (Year II class) on secure questions, indicating number of questions and mean (percentage answered correctly). Performance by the Class of 2004 on revised and new questions for the 2000-2001 academic year is also broken down by number of questions and the mean.

Most of our exams are multiple-choice-question format only. Biochemistry, however, includes some essay.
- ?? The **Year I Comprehensive Examination** consists of 400 question. So far it has always been a paper/pencil test.
 - ☞ Source of multiple-choice questions: secure, revised, new
 - ☞ Comparison of performance of secure multiple-choice questions with previous year's class or years' classes
 - ☞ Example: Comparison of performance on secure multiple-choice questions with pre-revision curriculum (Class of 2002), **first year-revised curriculum (Class of 2003)**, and second year-revised curriculum (Class of 2004). See table on handout. Mean score for secure questions on the Year I Comprehensive Examination for each of the three classes is very close.
 - ☞ There is a high correlation between student performance on the Year I Comprehensive Examination and the USMLE Step I. Our Year I Comprehensive Examination is a better predictor of USMLE Step 1 performance than the NBME Comprehensive Basic Science Examination given in March or April.

Dr. Wile also spoke about external outcome measures during Year III, the clerkship year. At CWRU, the NBME subject examinations are given in all the core clerkships except Neurology. Pediatrics had a higher mean this year. The mean for Psychiatry, which as a result of the curriculum revision now consists of one 4-week rotation and two 1-week rotations, remained about the same. Medicine and Family Medicine have been integrated into a 16-week block due to the third year curriculum revision. See the table in the handout for a comparison of mean scores for both Medicine and Family Medicine for several classes. We rank higher than the national mean.

Dr. Wile concluded her presentation by mentioning that we need more outcome assessment.

Educational Program – Core Clerkships, Patient-Based Program Overview
Christopher P. Brandt, M.D.
Chair of the Clinical Rotation Development Council
Jay B. Wish, M.D.
Coordinator of the Patient-Based Program

Dr. Smith recalled that Dr. Marjorie Greenfield was the first chair of the Clinical Rotation Development Council (CRDC) to be followed by current chair Dr. Christopher Brandt. Dr. Jay Wish is the Patient-Based Program Coordinator, who oversees Integrated Clinical Medicine (ICM), Physical Diagnosis, the Interviewing Program, and the Family Clinic.

Dr. Wish began his overview of the Patient-Based Program (see handout) by identifying those who have **oversight of the core clerkship third year:**

- ?? Coordinator of the Patient-Based Program
- ?? Clerkship Directors, who have local responsibility and meet quarterly with the educational leadership in the medical school
- ?? Conveners Group—new this year
There is one “convener” for each clerkship discipline. He/she is chosen by consensus from the Clerkship Directors in a given discipline. It is the convener’s responsibility to bring all his/her people together to assure consistency in objectives and evaluation process at all sites (including Henry Ford). The convener meets with the Patient-Based Program Coordinator and the Vice Dean for Medical Education as a liaison between the clerkships and the Office of Medical Education. The convener and other Clerkship Directors in a certain discipline report to the academic chair at that particular site to determine how clerkship objectives are to be achieved there. Assessment mechanisms may differ at sites. Each individual site decides how learning objectives are to be met.
Conveners for the 2001-2002 academic year are:
 - ?? Family Medicine – Trish Moore/Jason Chao
 - ?? Medicine – Terry Wolpaw
 - ?? Neurosciences – David Preston/Alan Cohen
 - ?? OB/GYN – Kal Ataya
 - ?? Pediatrics – Michael Dell
 - ?? Psychiatry – Kathy Clegg
 - ?? Surgery – Margie Persons
- ?? Clinical Rotation Development Council is responsible for the overall structure of the third year. It embodies an interdisciplinary faculty-driven process.
- ?? The Committee on Medical Education looks at all four years of the medical school curriculum.
- ?? The Vice Dean for Medical Education implements the curriculum.

Dr. Brandt continued the presentation using the same handout. Components of the **third year curriculum** are 1) the Core Clinical Clerkships, 2) the Primary Care Track, 3) Macy communication skills workshops, and 4) CLICS (Contemporary Learning in Clinical Settings) small groups.

Dr. Brandt described the **revised curriculum** instituted during the 2000-2001 academic year, which reduced the original 14 months to a 12-month core clerkship third year encouraging integration and incorporating communication skills and “orphan” topics. He showed the **revised clerkship schedule**, consisting of three sets of 16-week blocks. Under the leadership of Ms. Kathy Cole-Kelly, students examine **Macy** grant communication skills. (See handout for listing

of topics covered.) Under the leadership of Dr. Linda Lewin, students study cases relating to many topics (see handout for listing) via their **CLICS** small groups.

We are now in the second year of the revised curriculum. Dr. Brandt summarized **positive outcomes of the revised curriculum**: 1) a 12-month schedule, 2) successful collaboration resulting from the integration of Medicine/Family Medicine, 3) a structured focus on communication skills, and 4) addition of new curricular material (i.e., acute illness and injury, CLICS). **Challenges** consist of addressing 1) the two 1-week rotations in Psychiatry, and 2) the limits on integration. Page 5 of the handout offers three possible alternative block schedules to replace the two 1-week Psychiatry rotations.

Dr. Brandt listed **CRDC opportunities**: 1) restructuring, integration, and expanding sites (such as the Cleveland Clinic) of the clerkships, 2) incorporating vertical themes, 3) further development of the electronic curriculum, 3) establishing continuity clinics throughout the entire curriculum, and 4) improving evaluation techniques (in response to the proposed USMLE Step 2½ Clinical Skills exam).

In **summary**, Dr. Brandt pointed to these descriptors of the revised third year: 1) high quality core clinical education, 2) increased faculty participation, collaboration, and interaction in curricular design, and 3) multiple levels of accountability.

Educational Program – Flexible Program: Overview

Tarvez Tucker, M.D., Coordinator of the Flexible Program
Charles J. Malemud, Ph.D., Co-Coordinator of the Flexible Program

Dr. Tucker began by announcing that Dr. Malemud's "musical chairs" title has now evolved to "Co-Coordinator" of the Flexible Program. Please look over the PowerPoint handout for an in-depth summary of material presented. What is contained here consists of some main points with commentary and additional information.

Dr. Tucker recognized her predecessor Dr. Tom Daniel for formulating the Flexible Program's **objectives** for student growth via the following areas:

- ?? development of critical and analytical thinking
- ?? involvement in scholarly activities—both independent and with mentors
- ?? independent and inter-disciplinary concentrated study (includes Areas of Concentration)
- ?? exposure to new concepts, controversy, social relevance, changing technology
- ?? development of initiative, responsibility, and capacity for self-education.

The Flexible Program is **unique**; CWRU is the only medical school that has the Flexible Program.

There are 164 **Type A electives**; the largest number of them are clinical (clerkship preparatory) with approximately 15% being basic science. The Medical Apprenticeship Program (MAP) is the most popular elective. It pairs a student with a community physician in a one-on-one relationship for one 2-hour afternoon session a week for six weeks. This activity is one venue for alumni not on campus to participate in medical education. It allows the student ample time to ask questions of the physician about every aspect of the process. Dr. Tucker also mentioned the keen interest today's students take in alternative medicine electives. Dr. Tucker described a few Type A electives thereby indicating the wide variety of the program:

- ?? Medical Spanish, which can culminate in "Medicine at the Border," a hands-on experience taking place in California and Mexico
- ?? Medical ethics dealing with end-of-life issues, such as defining death
- ?? HIV counseling at the Free Clinic

?? “Brain Attack,” where Year I students are paged to come to the Emergency Room when a helicopter brings in a stroke patient and are there from the onset of treatment

?? Summer research opportunities following Year I offered at the Biomedical Research Building and the University Research Institute

?? Graduate courses—among the timely listings, Genetics is enjoying popularity.

Dr. Tucker listed the “Top Ten” electives based on numbers and briefly described each.

Dr. Tucker next mentioned that there are 39 **Areas of Concentration** (AoCs).

Requirements for earning an AoC include completion of 4-6 Type A electives, 1-2 one-month Type B elective(s), and independent scholarship. The AoC offers the only pathway to “Distinction” (honors) in the pre-clinical curriculum, which appears on the graduation program. Neither of the notations “Distinction” or “Area of Concentration” currently appears on the transcript. Dr. Tucker encourages students to do an Area of Concentration in a field other than that in which the student is specializing. However, many students choose to do an Area of Concentration in their specialty with the intent of developing a mentorship.

The **dual degree** program makes obtaining an M.D. with another joint degree possible. Available M.D./joint degrees include the following:

?? M.B.A.

?? M.S. in Applied Anatomy (the most popular masters dual degree)

?? J.D.

?? M.P.H.

?? M.A. in BioEthics

?? Certificate in Health Management (offered through Weatherhead).

Dr. Tucker acknowledged the efforts of the **Flexible Program Committee** consisting of Drs. Charles Malemud, Brian Victoroff, Sheryl Kingsberg, Kent Smith, Eric Pearlman, Julie Belkin, and Mr. Joe Corrao (Registrar). She recognized Dr. Victoroff for his idea that students evaluate the elective teaching faculty at every step along the way.

Dr. Tucker spoke about both the **1) elective evaluation of students by faculty, and 2) the elective evaluation of faculty by students**. Currently, students need only show up for 5 of the 6 Type A elective sessions and complete either an online or hard copy evaluation form. In actuality, only about 10% of the students complete the form.

Dr. Tucker projected the *proposed* Type A elective form to be **completed by the students**:

?? indicating if educational objectives were met

?? rating the faculty sponsor on a scale of 1 to 5 (5 denoting excellence)

?? inquiring whether the student would recommend this elective to others, and whether the location/logistics were conducive to learning

?? requesting both specific changes to improve the elective, and also the educational value to each particular student.

The *proposed* Type A elective form to be **completed by faculty** on the student inquires whether the student met the educational objectives, attended and participated actively, merited “Distinction,” and if so why.

Dr. Tucker showed a sample of a **faculty “Thumbprint” Web site**—her own, complete with photo and indicating the electives that she has taught during the last five years. Included would be the elective’s objectives and whether they were met (i.e., data from the students’ evaluation of the faculty sponsor). Electives sponsored would be listed by academic year and contain both the number of students attending and the number of excellent (5) and very good (4) ratings received by the faculty sponsor (data from the students’ evaluation of the faculty sponsor). Teaching in the Core Academic Program and the Core Clinical Clerkships could also be included on the Web site. Dr. Tucker intended the faculty Web site to be 1) a secure site (accessible only

by that particular faculty member), and 2) a tool useful in a) promotion and tenure, and b) refining one's own teaching abilities.

Dr. Tucker next listed both the **advantages and disadvantages of a quantifiable evaluation system**. On the *positive* side, the system is useful in promotion and tenure, quantifies teaching skills for yearly review by the Flexible Program Committee, and offers secure and consistent feedback for teachers. On the *negative* side, is the possible loss of the “flexibility” portion of the Flexible Program by quantifying teaching performance, controversy over sharing Web site ratings with faculty superiors, and making the Web site mandatory.

Dr. Malemud continued the presentation by mentioning the need for an unofficial audit of the electives program, perhaps departmentally. There are **308 unlisted electives, mostly Type B**. They are generally taken in the fourth year at any LCME-approved medical school. We have no descriptions of these electives. Basic science electives comprise 15% of the total Type A electives listed in the catalog. Dr. Malemud encouraged writing basic science electives enriching vertical themes such as sexual health and gender development concentrating on molecular determination as a possible Type A elective. Dr. Malemud would like to increase the representation of basic scientists on the Flexible Program Committee.

Breakout Sessions

Write-up of *only one session in its entirety*

Flexible Program

Tarvez Tucker, M.D., Coordinator of the Flexible Program

Charles J. Malemud, Ph.D., Co-Coordinator of the Flexible Program

Dr. Tucker began the discussion by referring to the figurative teaching faculty Web site. Currently, the information goes nowhere. Dr. Joseph LaManna urged expanding the Web site idea to the entire faculty not just the elective sponsors. Dr. Tucker wondered if all three components—Core Academic Program, Patient-Based Program, and Flexible Program—could be funneled to the faculty. Dr. LaManna felt that Dr. Nosek could design such a program. Dr. Tucker mentioned the push for a reduction in the number of teachers by weeding out the cameo appearances. Dr. LaManna stated that teaching in the Flexible Program has “zero impact” without documentation.

Dr. Amasa (Buzz) Ford felt there is a **lag** in the Registrar's office. There is **no system for evaluation forms completed by the students on his elective to be returned to him in a timely fashion**.

Dr. Malemud felt, that due to the multiple sites and venues of the electives program, there is a need to assess **effectiveness of teaching across the various sites**. It is hard to judge the effectiveness and **consistency of teaching**. The fourth year is designed for independent research and “away” electives. A site at an LCME-accredited medical school is the only criteria for taking an “**away**” elective. There are 64 Type B electives at the Cleveland Clinic. There are 56 Type B electives at Henry Ford. Type B electives consist of clinical rotations and research (reading) electives.

Dr. Tucker reiterated a recurrent CWRU theme: the students are their own educators.

Dr. Kingman Strohl saw the **objectives and time commitments** as the criteria for “away” electives. He provides a one-page write-up of his elective and suggested **standardizing** this format for all electives. Dr. Malemud replied that every Type A elective offered here at CWRU is listed in the green catalog (the current Type A elective catalog).

Dr. Ford inquired how we evaluate non-CWRU students taking electives here. Both Drs. Tucker and Malemud answered that faculty sponsors fill out the visiting student's school's

standardized elective form. Faculty sponsors also receive our CWRU form to complete and return to the home school, although this is not mandatory. Currently, there is feedback at the end of the elective, but there is nothing at the beginning or in the middle. Dr. Tucker suggested expanding the evaluation program for “away” electives to include evaluation of faculty as well as the student.

Dr. Les Nash felt that every potential CWRU student should know **up front**—as early as during the **Admissions** interview—that he/she 1) will be evaluated and 2) will also be an active participant in the evaluation process. Students will be **required to complete evaluation forms in order to receive elective credit**. Dr. Tucker considered allotting more time to making this top priority expectation known **during Year I orientation**.

Year II student Mr. Kimathi Blackwood remarked that he knew there is a required evaluation form at the end of the elective but inquired as to its purpose. Dr. Tucker replied that the evaluation is of value to subsequent students as 1) an indicator of both quality of the elective and quality of the teaching, and as 2) a motivator to make the student think by assessing the elective’s value to him/her.

Dr. Malemud emphasized that we are NOT talking about monitoring what is taught in the elective.

Dr. Tucker mentioned the controversy over making the elective’s evaluation mandatory. Not all students want to have this. Under the current system of voluntary feedback luncheons, for example, a self-selected group—the “loved”-it/“hated”-it groups are vocal. This is not a true representation of the total student population.

Dr. Ford mentioned that he redesigns his elective each year based on student feedback.

Dr. LaManna mentioned that the Committee on Medical Education (CME) has as its major goal this year evaluating and redesigning the Flexible Program. The curriculum revision in the first two years and in the third year has already been accomplished. Dr. Tucker recognized the role that **CME oversight** will play in the Flexible Program renovation.

Dr. LaManna described the Flexible Program as providing **individual enrichment** opportunities, many of which are designed by students seeking out specific faculty for their mentorship/expertise. The Flexible Program is **not an optional program**. While students may create their own elective, it **needs to be evaluated for quality control**.

Dr. Malemud mentioned that, according to the Registrar, there are electives to which no one subscribes. However, we do not know the reason(s) why. Dr. LaManna stated that if no one takes a **university** course for a long time, they pull the course. Dr. Tucker mentioned that that rarely happens with the Flexible Program. Dr. Tucker referred to these as the **“orphan” electives**.

Dr. LaManna asked: What is the incentive for faculty to offer a good Type A elective program? Students participate in the chosen elective, because they are always interested in the topic, but they are less interested in completing the evaluation component. Year II student Ms. Ifeoma (“Iffy”) Igboeli mentioned the negative impact of cameo appearances on completing evaluations. Dr. Tucker brought up the example of a faculty member who may make cameo appearances but does this for ten years. That faculty member still has a teaching portfolio and needs to be evaluated.

Dr. Mark Cheren mentioned that he had worked for a nontraditional college prior to coming here. The students designed the four-year curriculum. If we create an evaluation process, we have to consider what we are going to do with it. If our goal is fewer teachers doing a better job, we need follow-through. Dr. Tucker summarized this topic as asking: **How do we use the evaluation process?** Dr. Cheren suggested an audit review on a rolling basis.

There was discussion focusing on to whom the student evaluations of faculty should go. The consensus seemed to be **opposed to** directing them to the department chairs or the Vice Dean for Education. Dr. Julie Belkin felt that faculty should receive all their own evaluations. Dr. Malemud described the current evaluation system as “strange,” in that we cannot identify who is responsible.

Dr. Tom Chelimsky felt we should **preserve** both the faculty- and student-initiated **flexible** nature of our electives program. He recommended having **faculty evaluate their own elective**. How did I use last year's evaluations, and how did I change the course based on that? Keep this independent. He delineated the minimum requirements of the Flexible Program evaluation system for faculty sponsors:

?? Faculty are being evaluated by students.

?? Faculty must look at that feedback.

?? Faculty are evaluating the students participating in their elective.

Dr. Malemud inquired whether there was a consensus on approving this system (the three aforementioned points) instead of endorsing monitoring of evaluations as is done with paper work.

Dr. LaManna mentioned that any faculty member can make an elective course—all he/she needs is an interested student. Dr. LaManna felt that discussion pertained more to Type A electives. Type B electives last a solid month. Dr. Malemud and Dr. Tucker approximated that there are between 175-200 local Type B electives. We have descriptions of all *listed* Type A electives and Type B electives at Metro, University Hospitals/VA, Henry Ford Health Systems, and the Cleveland Clinic Foundation in our catalogs. Students fill out a description on the "*unlisted* elective form" for unlisted electives, away electives, two-week electives, and reading/research electives.

Dr. Belkin recommended having a Web site of each course. Drs. Tucker and LaManna explained that this information is already on the electronic curriculum.

When Dr. LaManna asked the two second year students present how they choose a Type A elective, logistics turned out to be the deciding factor. Ms. Igbeoli looks at the times the electives that she's interested in are offered. Mr. Blackwood reminded that students are bound by their Physical Diagnosis schedule. Dr. Tucker emphasized that afternoons are not "free" time.

Dr. Harvey Dworken stressed the importance of spending time teaching.

Dr. Malemud mentioned that in Year II there are more teachers and more cameo appearances because the make-up of the curriculum leads to mostly disconnected teaching. Our faculty cannot offer more time than they currently do.

Playing "devil's advocate," Dr. LaManna raised the pragmatic question: "What's in it" for the faculty member and the department? Dr. Tucker responded with references to promotion and tenure. Dr. LaManna remarked that teaching in the core program has more impact—although very little impact—on promotion. Teaching in the Flexible Program has "zero" impact on promotion. Documentation on teaching that is easily interpretable to the Committee on Promotion and Tenure has to be there. Currently, documentation indicating the number of electives taught exists. However, **documentation indicating whether or not the elective was well-received** is not present. Dr. Malemud felt that continuous review of teaching performance would add more weight to its role in the promotion and tenure process.

Dr. Nash described **evaluation as evidence-based learning**. It shows you what your process is. If you create, are you measuring it? Dr. Nash advocated being open about what we are doing in grappling with the role of evaluation in the Flexible Program. Evaluation should never be pejorative; it should be educational. The main recurring problem is that there is little or no outside reward for being educators, other than the personal one. There is no money. It is of questionable academic value. We do not have the pedagogical expertise of a T. Hale Ham with us today. However, Drs. Tucker and Strohl pointed to the **UCITE (University Center for Teaching and Education)** resources we have right here on campus.

Dr. Strohl had the following to say about elective course evaluations:

?? Faculty should **receive** them **in a timely fashion**.

?? They are **useful to students in planning their career and making educational choices**

?? They are **useful to the educator (the “co-learner,” mentor, sponsor) in altering the elective.**

Dr. Malemud felt that UCITE content is a completely different component.

Dr. Cheren mentioned that all the candidates for Vice Dean have asked him how to beef up faculty development with respect to teaching, facilitating, and mentoring. Who will administer this component? How will it be implemented? We need to address the issue of **accountability: a) from the student perspective, b) from the educator’s perspective, and c) to the Committee.** The Flexible Program Committee will have to make some judgments. Dr. Cheren opposed **involving the department chairs**, which, in his opinion, would only result in an added layer of bureaucracy. Dr. Malemud added that we would not have the integration of the academic chairs in the education process but rather their emissaries. Dr. Cheren mentioned that some departments have Vice Chairs for Education.

Dr. Tucker pointed out a noticeable progression from more structured to less structured in the Flexible Program. There is a definite distribution pattern mandated for the 13 Type A electives. The Area of Concentration affords more flexibility. During the fourth year, the student is free to choose just about anything. Students can earn “Distinction” at the end of the fourth year if they participated in an Area of Concentration, which includes the pre-clinical Type A electives. However, participation in an Area of Concentration does not in and of itself guarantee “Distinction.” “Distinction in the Flexible Program” appears only on the graduation program, not on the transcript.

Dr. Chelimsky brought up the issue of faculty development. He has been here for ten years and has attended UCITE seminars and Continuing Medical Education courses. However, learning is slow. He would like to see **a mentorship program across the faculty for junior faculty.** He supported making mentorship a credit for promotion. We need some sort of financial support and credit as promotion for that activity. A mentor can cover expertise that an educational program cannot.

Dr. LaManna would like to go beyond the Flexible Program. He would like to run a **faculty workshop every year on Flexible electives Type A and Type B for the faculty.** Dr. Tucker mentioned that we already have an established *Area of Concentration* Fair for students. Dr. Malemud added that we have a monitoring system for the Areas of Concentration. Dr. Tucker suggested offering a faculty workshop at lunchtime in the Biomedical Research Building. Dr. LaManna suggested holding a **Type A elective registration “fair”** before the electives catalog comes out. We could have a sign-up form right there. There would be opportunities for a dialogue between the student and the faculty sponsor of the elective. Dr. Tucker did not believe that a Web site for the elective would be very effective in attracting students. Dr. Susan Wentz suggested offering **CME (Continuing Medical Education) credits for taking the electives workshop.**

Dr. Malemud questioned to what extent the Flexible Program fosters scholarship, self-study, and life-long learning. Mr. Blackwood replied that depends on what the student puts into it. The Flexible Program offers a chance to explore. Mr. Blackwood agrees with Dr. Cheren that a realistic evaluation is needed. Mr. Blackwood feels that the current mandatory online Core Academic Program evaluations may not be getting to the right people.

Dr. Tucker felt that deciding how to use these evaluations was the next step. Dr. Tucker suggested that Dr. Malemud, the Vice Dean, the Flexible Program Committee, and she receive these evaluations. Dr. Tucker felt there exists uncertainty as to: **What one person is accountable?**

?? **Who do people go to for advice?**

?? **the Flexible Program Committee Chair,**

?? **the Flexible Program Co-Coordinator, or**

?? **the Associate Dean?**

Dr. Cheren noticed a marked trend in our school to exercise more oversight as embodied by the roles of the Curriculum Leadership Council (CLC), the Committee on Medical Education (CME), the Clinical Rotation Development Council (CRDC), and the Vice Dean for Education. **Continuing Medical Education (another “CME”) could design some of the programs on how to teach so that both the faculty and the students could get more out of their courses.**

Dr. LaManna mentioned that it has taken six years to create the Vice Dean accountability position.

Both Dr. Harvey Dworken (Professor Emeritus of Medicine) and Dr. Scott Inkley (Professor Emeritus of Medicine) wanted to see the support of department chairs. Dr. Inkley remembers the era of the 1950’s innovative curriculum, where every department chair attended the Gates Mills Meetings. There was an acceptance of the commitment to education. The part-time clinicians were the substance of the new curriculum of the 1950’s. In that era, the interrelationship between the medical school and the hospital was exceptional. Dr. Inkley noticed the absence of hospital executives attending today’s retreat. He felt that the Dean should talk to the department chairs.

Dr. Nash mentioned that department chairs are academic chairs. With that comes an academic appointment in the medical school and the resulting responsibility.

Dr. Malemud questioned whether any academic chair at University Hospital is in charge of his department’s educational program.

Dr. Inkley felt that the “revolution starts here” at the medical school. Dr. Nash felt that it starts from the top down. It has to be stipulated that having an academic appointment carries the responsibility of supporting the medical school’s educational mission.

Dr. Ford pointed to the MAP (Medical Apprenticeship Program). Part-time community practitioners are sought out by the students themselves. Dr. Ford recalled the evaluation system book where students wrote out their impressions of their particular MAP elective experience. The MAP is our outreach to the medical community.

Dr. Malemud mentioned that there may be variation in each department. We need buy-in. Dr. Tucker added that we are trying to make the evaluation process easier.

Dr. Belkin felt that many faculty committed to teaching are not at today’s retreat. She suggested having a representative from each department update its members on issues discussed at the retreat. Perhaps there could be circulated summaries.

Dr. LaManna mentioned that dual degree programs are part of enrichment. They already have a built-in evaluation program, due to their graduate course status. The M.D./Ph.D. students (M.S.T.P.=Medical Scientist Training Program) are already part of the dual degree program. The Committee on Medical Education’s goal is to have 50% of medical students participate in the dual degree program. Currently, 20% of medical students are dual degree students. Distinction in the Area of Concentration is not listed in the Dean’s Letter. The Dean’s Letter is written prior to the awarding of “Distinction in the Flexible Program.” We can best utilize the dual degree program, Areas of Concentration, certificates, and general electives to set high standards for the Flexible Program.

Lunch-time Address
Information Technology in Support of the Medical Curriculum
Thomas M. Nosek, Ph.D.
Associate Dean for Biomedical Information Technologies

Dr. Nosek provided an overview of the electronic curriculum and of the staff that supports it. He began by describing the **mission**: 1) to provide state-of-the art information systems, 2) to facilitate effective use of these information systems by the faculty, students, and

staff, and 3) to coordinate research on the application of technology in the medical student environment.

Dr. Nosek familiarized faculty with whom they would be dealing by projecting **photographs of all his staff members**. He presented the **five divisions of the Biomedical Information Technologies (BIT) Office**, each with its own manager and assistants. His goal was to inform faculty of the resources available, how to access them, and of the technologies being developed.

Ms. Tanya Long heads up the **Syllabus Office**, which converts all materials to the electronic curriculum. The cost of the black and white print syllabus is \$60,000 per year. Dr. Nosek explained that many enhancements are lost converting the electronic syllabus to the print copy. However, students are adamant in their desire for a print copy. Dr. Nosek showed a sample Web site link found in the electronic curriculum. He told the faculty, "If you can dream it, we can do it." Dr. Nosek listed enhancements made possible by the electronic curriculum such as commercial Web sites, original materials produced by faculty, PowerPoint presentations, slide collections, animations and video, 3-D reconstructions, and sound. A "hit" system enables counting every time someone comes into the electronic curriculum so that Dr. Nosek has figures on use of Web sites by the students. New additions to the electronic curriculum include the Student Calendar System, a Class Roster with color photos of each student in the class, and online scheduling for third year core clerkships and electives. There is a link to the PubMed resource popular with students. Old practice exams can also be accessed online. For a complete listing of topics, log onto the School of Medicine e-Curriculum page.

Application Development is headed by **Irene Medvedev, Ph.D.**, who creates and maintains *all* programs, many of which are administrative. Dr. Nosek mentioned that the Admissions process is going paperless over the next two years. This year the electronic exam system was implemented for the Year I class. It is a secure (password required) system to which the subject committee chairs have access. It provides an evaluation of scores by analyzing data. Faculty can start with the previous year's exam and modify it themselves. Dr. Nosek mentioned the upcoming Year I exam December 3, where students will take the exam at their desks on computer, and afterward, receive immediate feedback (the mean score), and be provided with links to question sites.

Classroom Support is headed by **Mr. Tracey Liston**. We have put over \$300,000 into adapting the lecture halls E301 and E401 with the latest presentation technology. This year, we will provide the students with wireless access to the Internet. Faculty can record (video or audio) their lecture and have it streamed live over the Internet. There are also videoconferencing capabilities.

Network Operations is headed by **Mr. David Pilasky**. He is responsible overall for the medical school's NT server system and for design and maintenance of Web sites. **Webmaster Ms. Aisha Bhatti** is the person credited with providing "the look" of the Web sites. She is also the contact person for faculty interested in obtaining access to the electronic curriculum. Faculty need to have Internet Explorer to access the electronic curriculum. Faculty members need to submit a hard copy form containing their case-sensitive password to Ms. Bhatti.

Ms. Deepa Sastry heads up **Computer Support**, the office responsible for making sure the technology works. Dr. Nosek mentioned the computer classroom E324, which contains 24 student workstations connected to the Internet and a faculty workstation.

Dr. Nosek reflected on CWRU's long tradition of innovation in medical education. In 1993, we became the first medical school, perhaps in the world, to give students computers. In the fall of 2001, we developed all components of the integrated electronic curriculum. Dr. Nosek listed current **initiatives** such as:

- ?? Further development of the electronic curriculum in all four years
- ?? Further development of the electronic testing system—for example, the computer grading of *essay* questions

- ?? Facilitating the use of computers in large classrooms and small group rooms
- ?? Facilitating the use of PDAs (Personal Digital Assistants) in the clinical years—perhaps switching to the pocket PC
- ?? Development of one comprehensive online calendar of student activities
- ?? Date warehousing of all student, administrative, and faculty information to facilitate data management.

Dr. Nosek concluded his presentation by inviting faculty to reach him by getting in touch with his assistant, **Ms. Teresa Goldfarb**.

BREAKOUT SESSION REPORTS **Core Academic Program – Dr. William Merrick**

Dr. Merrick's breakout group categorized CAP (Core Academic Program) issues as either "strengths" or "weaknesses." Under **strengths**, Dr. Merrick listed

1. Absence of Saturday classes, which allows time for individualized study and special study sections
2. Anatomy is almost entirely completed during Year I, with Head and Neck carrying over to Year II.
3. Small group format, which allows for
 - ?? integration of material across lectures, and
 - ?? an improved level of understanding, longer retention that lasts past the exam.
4. Sequencing of normal in Year I, pathophysiology in Year II
5. Use of e-Information (individual faculty materials supplementing what was printed text)—students prefer particular targeted information to generic sites.

Under **weaknesses**, Dr. Merrick listed the following areas that need more work:

1. During Year II, do students remember what was normal? Under the old curriculum, there was more integration of normal and pathophysiology. With the current second year curriculum, we are finding a need to review more, to re-orient the student and improve retention.
2. The *post*-exam review process is no longer routine. Students do not have the opportunity to learn from their mistakes.
3. Directly related to the number of teaching faculty in the subject committee, **integration with respect to content and material** reveals both
 - ?? duplication (due to lack of communication)
 - ?? gaps (based on assumptions).The CLC wanted fewer teachers and the best teachers. Having that pared-down group increase their teaching hours would have done much to eliminate duplication and gaps. It would have resulted in better integration across the committee and improved the quality of delivery. The goal was to minimize the different styles by having fewer teachers.
4. The CLC has yet to incorporate the Master Teacher concept. This is something that perhaps the Vice Dean can explore.
5. Generating committees to look into student performance with respect to clinical skills and student performance during the clerkship year

Drs. Wile, Echols, and Brandt, the chief residents as well as the preclinical Patient-Based Programs could help set evaluative forms to assess how students are doing in the clerkships.

Dr. Wile mentioned that 2004 is the projected date for implementation of the USMLE Clinical Skills examination for the Class of 2005. We need more feedback

on personal interaction, clinical skills, the impact of Year I Physical Diagnosis on clerkship performance. We need other outcome measures in addition to the multiple-choice-question format. The small group format has been well received by the students.

Dr. Merrick would like a *quantitative* assessment on clinical skills rather than “satisfactory”/“unsatisfactory.” He would like to find out the correlation between what we test and the USMLE Step 1. We also need more information on borderline students.

With respect to the normal and pathophysiology issue and the integration within committees that still results in duplications and gaps, Dr. Altose felt that such matters fall under the purview of the subject committee chairs.

Dr. Merrick mentioned that all subject chairs sit in on all the lectures, thereby enabling them to relate to specific points that were mentioned “yesterday.” However, we cannot demand that of all clinical faculty.

Dr. Altose suggested utilizing the electronic curriculum to communicate what faculty members are doing and let the subject committee chair make the final decision.

Dr. Malemud mentioned that the topics themselves throughout the curriculum can be redundant. What is covered in one area may be covered in other committees.

Dr. Merrick felt that we are ready to develop better integration going from committee to committee.

Core Clerkships, Patient-Based Program

Dr. Jay Wish

Dr. Christopher Brandt

The following **strengths** were noted:

1. We have dedicated people evidenced by our clerkship directors and administrators who offer protected time for teaching.
2. Our content now incorporates orphan topics and professionalization [largely a result of the Macy grant and CLICS (Contemporary Learning in Clinical Settings) groups]. The doctor/patient relationship, communication skills, functioning of the health care team, the student as an accountable physician, and lifelong self-directed learning are concrete concepts well delivered and reinforced in the curriculum.

The following **challenges** were delineated:

1. Assessing the success of professionalization
2. Fragmentation of the clerkships
The third year consists of core clerkships, the Macy communication skills, orphan topics, and CLICS groups. Unlike during Physical Diagnosis training, the attending on the wards never sits in for an entire Physical and Examination in the third year.
3. Immersion of clerkships—the need to get students and faculty at the same place at the same time
4. Desire to have a faculty mentor during each clerkship
5. Desire to establish a continuity clinic similar to the successful Henry Ford Primary Care Track model
6. Desire to establish a year-end OSCE (Objective Structured Clinical Exam) such as that found in the Primary Care Track
7. Assessment and rewards for teaching faculty achieving content goals and serving as a model for social goals
There would be Web-based grades for the faculty by each student. This idea ties in with Dr. Tucker’s teaching portfolio.

8. Scheduling of third year clerkships—minimize fragmentation
There has been a backlash against the interdisciplinary approach. While common content areas such as the grouping of Family Medicine, Medicine, and Pediatrics has been very successful, the interaction between Neurology and Psychiatry and between OB/GYN and Pediatrics has progressed as far as it can.
9. Students are not currently getting exposure to career paths in the smaller, less visible residencies, such as ENT, Anesthesiology, and Radiology, in the main third year courses.
10. Need for reinforcement and reassessment of the basic science knowledge that the student brings from the first two years
Breakthroughs in medicine will be on the molecular basic science level. Students need more of an incentive to keep updated. Perhaps the electronic curriculum can help to achieve this.

Dr. Dan Wolpaw referred to education portfolios and the Master Teacher Program that the University of Kentucky has. This rewards energetic younger faculty. Dr. Wolpaw would like to see formal recognition of teaching.

Dr. Smith replied that this has been discussed in a number of forums. He referred to the University of California at San Francisco that has distinguished itself in this field. We hope to accomplish something in this area.

Flexible Program – Dr. Tarvez Tucker

Dr. Tucker summarized the issues raised at the Flexible Program breakout session:

1. Uncertainty of the role of the department chairs
?? Their absence was noted at today's medical education retreat. By contrast, in 1953, there was integral involvement of the chairs in the curriculum.
2. Revamping of the Flexible Program and the electives evaluation data
?? How advantageous are the evaluation data to the faculty member's teaching portfolio?
?? Accountability—to whom are the students and faculty accountable?
3. Hold a workshop every year for the faculty on creating Type A electives to strengthen the ever-evolving pool of new elective opportunities.
4. In actuality, students choose electives based on timing. Students have other requirements in the afternoon, such as Physical Diagnosis, which limit the choice of electives
5. Evaluations are evidence-based learning. When we have the database, what do we do with it? Do we keep these faculty evaluations? Do we share them with the department chairs?
6. Should we bring minutes of major events such as this retreat to departmental meetings as a means of disseminating information?
7. We do not want to lose the spontaneity and student-initiative in making the Flexible Program more stringent.

Medical Students – Dr. Robert Haynie

Dr. Haynie remarked that in response to a prior criticism of the Admissions process's vesting too much control in one person made by the LCME visiting committee, *all* applicants chosen for interview are now presented to an *Admissions Committee*.

There has been a decline in the number of applicants. However, we are doing better than the national trend, and we are still attracting good quality students.

The pool of minority applicants is also declining. We are low in financial aid. We rank 12 out of 13 in the 13-school consortium in providing scholarships. It is estimated that \$50,000 is the cost of living expenses/tuition for one year of medical school here. Top minority candidates are offered extremely attractive packages at many prestigious schools.

This year we sent out an all-time high of 360 offers for 145 slots.

Since the CWRU School of Medicine is a recipient of the Ohio subsidy, 60% of our entering class must be from Ohio. We receive a \$4 million reimbursement for education, and Family Medicine/Geriatrics receives \$1½ million.

Dr. Haynie proudly announced that we are finally fixing up the Student Lounge—long a request of the student body.

Dr. Haynie listed issues for consideration:

1. Provide a place to obtain food after hours, similar to the Weatherhead Café
2. Provide more student parking close to the medical school and with safety in mind

Dr. Haynie recognized Dr. Echols for her outstanding work in both personal counseling and remediation.

Dr. Haynie referred to the elimination of the former one-person position and subsequent redistribution of duties that has occurred since the last LCME visit. This has resulted in the division of duties between the person who writes the Dean's Letter (Dr. Aach) and the person that provides academic counseling (Dr. Haynie). In Dr. Haynie's opinion, this has been a wise step in that students are no longer fearful that the person aware of their problems will also be writing the Dean's Letter. The first year class has been divided into thirds, whereby Drs. Smith, Aach, and Haynie provide a mentoring system of sorts.

This year Dr. Aach has sent out a survey on the class of 2000 to assess how our students are doing in residency. Many program directors have awarded our students the top ratings 4 and 5 in relation to preparedness and clinical skills.

Dr. Haynie referred to the Match. Primary Care is definitely experiencing a decline, while the subspecialties are on the rise. This year we have 9 students interested in anesthesiology.

Dr. Haynie concluded by mentioning that facilities remain our main challenge.

Basic Science Departments: Brief Report
Lynn T. Landmesser, Ph.D.
Chair of Council of Basic Science Chairs

Dr. Landmesser's report focused on 1) assessing the health of the basic science departments, and 2) problem areas. The self-study report preparing for LCME accreditation cited these as the **strengths** of our basic science departments:

1. They provide a major focus for cutting edge basic biomedical research and a bridge to clinical research and translational applications.
2. They play a critical role in the education of medical students in Years I and II and in the core curriculum.

Dr. Landmesser urged re-engaging the basic science chairs. The role of the subject committee chairs has reduced the involvement of the department chairs.

3. They play an essential role in the Ph.D. training of both M.S.T.P. and B.S.T.P. students and in the training of Masters candidates.

They play a vital role in research training. Dr. Landmesser listed 11 basic science departments in the medical school, including the department of Biomedical Engineering, which is shared by the Schools of Engineering and Medicine.

Dr. Landmesser pointed out that in today's world many departments do not come under the umbrella of traditional disciplines. There is also much inter-disciplinary, inter-departmental interaction. We have hired a new chair in Molecular Biology and Microbiology.

Since the last CME accreditation, most basic science departments have grown in size, national stature, research productivity, and NIH funding. **We have a healthy research environment here.** A number of our departments rank in the top 10-15% of NIH funding nationally. We have 265 faculty, the majority of whom have active research programs and are involved in medical education. We have 300 Ph.D. students, 55 of whom are M.S.T.P. students.

Dr. Landmesser codified our educational philosophy: "to teach independent thinking and to provide students with basic concepts and with the skills to acquire new information and techniques as they become available." She stressed that with the information explosion, students need the tools to access information. We must teach how to use those tools to remain competitive.

Dr. Landmesser next listed the **challenges** confronting the basic science departments:

1. The need to fill the open chairs
While we have recently filled the Molecular Biology and Microbiology slot, Pathology, Genetics, and Anatomy remain open.
2. The need to increase the number of graduate and postdoctoral students
We must recruit double our number. Our training programs are good quality.
3. The need to improve research and educational infrastructure and core *facilities*.

Clinical Science Departments: Brief Report

Murray D. Altose, M.D.

Associate Dean for Louis Stokes Veterans Affairs Medical Center

Dr. Altose presented data contained in the prepared self-study on the clinical departments. He first spoke about the **faculty**. There are approximately 1300 full-time faculty and 2000 part-time faculty. There has been a growth of 7% in the past two years. The ratio of full-time faculty to part-time faculty has remained steady. Thirty percent of full-time faculty are women. Since 1994, the number of full-time faculty has increased by 20%. Departments vary in size: Medicine is a very large department, while ENT, and Neurosurgery are very small. In describing the distribution of our faculty, Dr. Altose mentioned that 18% are professors and 19% are associate professors. Our faculty members are distinguished. They have been elected to national office. They enjoy high academic standing as evidenced by their participation on journals, study sections, examination panels, ACGME residency review committee.

Dr. Altose next mentioned the **organization** of the clinical science departments. Our faculty are based at affiliated hospitals. This provides some degree of autonomy. Individual chairs at affiliated hospitals are responsible for clinical and administrative matters and educational and research programs. This is a relatively new change.

Dr. Altose spoke of **finances**. Sources of support include practice revenue, hospital salaries, the university or the medical school, endowments, and research and training grants. Research and training grants are an important element in many clinical departments.

Dr. Altose described **facilities** as largely modern clinical facilities with renovation completed or underway to provide additional office and lab space to handle growth. New research facilities are under construction. We have good, modern inpatient care facilities.

When describing **professional activities**, Dr. Altose mentioned **teaching, research, and patient care**. He stressed **our faculty's strong commitment to teaching**. **According to U.S. News & World Report the CWRU School of Medicine ranks 17th among research-oriented schools and 14th among Primary Care programs.**

With respect to **research**, Dr. Altose stated that we have 500 active research projects headed by 250 investigators. Twenty percent of full-time faculty are principal investigators or have externally funded grants. \$100 million of research funding is in clinical departments. Four of our departments made the NIH top ten: Dermatology, Orthopaedics, Medicine, and Dr. Altose could not recall the fourth.

In describing **patient care**, Dr. Altose mentioned that it is under the control of the affiliated hospitals, covers the complete spectrum of clinical services, is recognized as among the best in the nation, places a major load on the clinical faculty, and presents us with a challenge to maintain a **balance** of patient care, teaching, and research.

Dr. Altose concluded that we have a large, dedicated, distinguished faculty in the clinical departments that enjoy a national and international reputation and are strongly committed to the teaching enterprise.

Dr. Strohl inquired about the training of graduate students in the basic science departments through clinical departments and translational research. Can we build on that? Can there be more basic science training in collaboration with clinical research and vice versa? Dr. Altose replied that with respect to the collaborative research enterprises, the best approach would be on the department level or on the individual faculty level.

Dr. Landmesser added that residents have come to her Neurosciences department and much is going on. The best results are driven by the interaction of faculty. She would encourage basic science chairs to interact more with their clinical counterparts.

Dr. Henri Brunengraber mentioned Dr. Richard Hansen's outstanding work on metabolism. Directors of training grants could encourage more interaction.

**An addition to the original agenda:
OSCE (Objective Structured Clinical Exam) Workshop
Jason Chao, M.D.
(in response to the proposed USMLE Step 2½)**

Prepared by Lois Kaye
Secretary to the Committee on Medical Education