

## January 26, 2006 CME Minutes

### 1. **Basic Science Update/*Curriculum Renewal***

**Dr. Amy Wilson-Delfosse**, Basic Science Curriculum Council Chair, mentioned the excellent turnout and reception for the three three-hour **case-writing workshops** led by **Dr. Alan Neville** of McMaster University on January 23 and 24. As an expert from outside the university, Dr. Neville responded to questions from faculty designing the first six blocks of the new curriculum with a student-centered small group format in mind. Dr. Neville responded to philosophical concerns as well as practical matters. It is anticipated that Dr. Neville's expertise will be sought again at a future time to "fine tune" the cases. **Cases are key in that they drive identification of the learning objectives that students will need to master. Dr. Neville advised faculty to write each case so that students cannot move forward until they define that particular need.** Dr. Wilson-Delfosse announced that the Foundations of Medicine and Health blocks will identify all block content and complete a weekly template hour-by-hour, indicating what is taught and in what format, for presentation at the March 3 education retreat.

Dr. Altose, who also attended what he considered "a useful and productive session," appreciated Dr. Neville's remarks distinguishing *context* in which learning objectives are presented. Dr. Neville gave examples of what kinds of learning objectives should be included in a case and what kinds of learning objectives are better suited to a different format, such as a large-group lecture. *Lecture* lends itself well to framing—how everything fits together, and to *vocabulary*.

Dr. Wilson-Delfosse commented on the *timing* of when to give the learning objectives. Starting with a broad overarching learning objective gets the students "in the ballpark" and focuses them. Students need the opportunity to identify what they know and what they do *not* know. They need the time to dig and to discover their own learning needs. Giving the students the intended learning objectives at the end of the case is likely to reduce students' anxiety about whether or not they learned what was hoped.

### 2. **Basic Science Update/*Basic Science Curriculum Council***

Dr. Wilson-Delfosse, now in possession of test results, returned to a discussion of the recent **Mastery Exam**, as the CME had requested a mid-year review of the new process. January 6 marks the first time that the Mastery Exam has been given. It serves as a remediation program for the Classes of 2008 and 2009. Students who took the Mastery Exam reached this consensus:

- The exam was fair.
- Their increased self-confidence will enable them to move forward and not feel that they are behind or that they will have to make up for "gaps" when studying for the USMLE Step 1. They learned what they did not learn before.
- They took the exam seriously and studied hard.

The Mastery Exam was scheduled so that students could devote their two-week break to study. Future scheduling will guarantee from one-to-two weeks when class is not

scheduled as a study period. Dr. Wilson-Delfosse deemed the exam a success and noted student appreciation for the work of the society deans and subject committee chairs. While the Mastery Exam is a transitional strategy, Dr. Wilson-Delfosse hopes that the *philosophy* behind the exam—student responsibility for their learning—will continue into the new curriculum.

### 3. **Flexible Program Council Update**

**Dr. Kent Smith**, Flexible Program Coordinator, mentioned that Case students are focused on meeting the 72-week minimum of clinical courses required for graduation. In response to a discussant's question regarding the number of first year students (Class of 2009) participating in the now voluntary Type A elective program, Dr. Smith was happy to report that 35 first year students had signed up for Type A electives for the first period. A large number of fourth year students have done reading electives to prepare for the USMLE Step 2.

Apart from the Flexible Program, Dr. Smith mentioned later in the meeting that the Early Match finished today, and he reviewed the results, which will be posted later.

### 4. **CCLCM Curriculum Steering Council Update**

**Dr. Andrew Fishleder**, Cleveland Clinic Lerner College of Medicine Curriculum Steering Council Chair, highlighted the **Foundations of Clinical Medicine Year I Course Review** as presented to the Curriculum Steering Council by course leadership: J. Harry Isaacson, M.D., Anita Misra-Hebert, M.D., and David Rolston, M.D. Components of the course included:

- Longitudinal Clinic Sessions (every other week)
- Pediatric Clinic experience
- Physical Diagnosis/Communication Skills
- Science of Clinical Practice (Tuesday morning large- and small-group sessions) in collaboration with the University Program
- Geriatric Clinical Skills Sessions
- Pediatric Clinical Skills Sessions
- Neurology Clinical Skills Sessions
- Sub-Acute Medicine experience (step-down unit using outpatients)

Overall, student feedback was very positive, with the Longitudinal Clinic Sessions, Pediatric Clinic experience, and Physical Diagnosis/Communication Skills small group discussions receiving the highest ratings. Student confidence in the patient encounter increased, as each student was observed and received feedback on his/her performance of 1) a complete history and physical, 2) oral and written presentations, and 3) a medical interview using a patient-centered approach. All patients seen by students in the Longitudinal Clinic were outpatients. Students saw four patients per day and used the patient log system, an electronic journal of patients, to enter data on each of their patient encounters. Faculty are able to access each entry and input their comments after observing a particular student/patient encounter. The patient log becomes part of the student's ePortfolio. The students benefited by receiving an excellent first year clinical experience. In response to student feedback and direct faculty observation of the Year I Foundations of Clinical Medicine course, minor changes were recommended and

approved. Continued faculty development will be encouraged to promote consistency among preceptors.

Appointed to the Vice Dean's Committee on **Integrative Complementary and Alternative Medicine (ICAM)**, Dr. Brunengraber inquired about the Clinic's approach to inclusion of ICAM in the curriculum, since the Clinic has a Center for Integrative Medicine. Dr. Fishleder indicated that the College Program is working to integrate selected alternative medicine topics into the curriculum. In the patient log, where students write about certain topics, these topics may include Complementary and Alternative Medicine as well as pharmaceuticals. Dr. Brunengraber mentioned that the Case ICAM Committee has been discussing the role of CAM in electives and in the curriculum. One current point of discussion is whether Case should adopt the philosophy recently presented by Dr. Barrie Cassileth, Director of the Division of Integrative Medicine at Sloane Kettering (who was recently invited by Dean Horwitz to deliver a special lecture at the School of Medicine). This philosophy can be summarized as "Complementary Medicine, Yes; Alternative Medicine, No." In agreement with Dr. Cassileth, Dr. Brunengraber favors informing medical students about both Complementary and Alternative Medicine, since many patients use them. However, we should not promote Alternative Medicine. Dr. Brunengraber inquired about the position of the Clinic on this matter. Dr. Fishleder offered the perspective that students need to be informed for their own understanding and to be aware of the impacts of ICAM treatments. For some CAM modalities, there is scientific evidence. There may be some situations where the CAM treatment becomes the primary therapy.

Dr. Altose stressed the necessity for *balance* when both conventional medicine and complementary and alternative medicine are entertained in the context of a real case.

Dr. Fishleder added that students need to be informed about a broad range of CAM therapies. The public uses them and they can have impact on primary therapies.

Dr. Altose noted that the health care system and the College do not necessarily have to be in agreement.

Dr. Frank felt it counterproductive to try to distinguish between Complementary and Alternative Medicine or to become embroiled in definitions. He added that a successful Complementary and Alternative treatment, such as hypnosis or acupuncture, can become integrated as a primary treatment. He cautioned about creating debate that impedes informing students.

Dr. Montgomery stressed that our students need to be critical thinkers who can engage with their patients.

Dr. Fishleder next presented the **Year II** summer **Clinical Research Block Course Review** as presented to the Curriculum Steering Council by course leader Michael Lauer, M.D. Overall, the five-component course was well-received, with the **Introduction to Clinical Epidemiology Seminars** and the **Journal Club** highly rated. Starting next year,

only one textbook will be used for the Epidemiology seminar course. The **Biostatistics seminar series, entitled Statistical Science for Medical Research**, will be re-examined and re-organized for the coming year. The highly rated **Biostatistics Problem Solving Sessions** will be incorporated into the Biostatistics Seminar class time to increase time available for research projects. Overall, the **Clinical Research Experience** received positive feedback, although course work limited time available for research. Based on course evaluations and suggestions from student focus groups, some minor changes are planned for next year, which include re-ordering and streamlining of seminars to free up afternoons for clinical research. Additionally, the course director will assess the amount of work assigned to prevent compromising clinical research time.

#### 5. **Overview of the Year I Patient-Based Program**

**Dr. Dan Wolpaw**, Clinical Curriculum Council Chair, highlighted patient-based programs in Year I. **RAMP**, short for **Rotating Apprenticeships in Medical Practice**, began this fall. While evaluation results are still being analyzed, general feedback has been very positive. Students have recorded their experiences and these records can also be used for program evaluation.

The **longitudinal preceptorship**, led by Dr. Mimi Singh and assisted by Ms. Denise Carter-O’Gorman, is currently getting underway. There has been a very good faculty response, and the program is nearing the number of clinical opportunities needed to accommodate the entire Year I class. (There is still a need if any faculty are available.). Additional Primary Care Track preceptors will become available in the summer, and some students may choose to delay beginning the preceptorship until then. As a rule, however, the preceptorship runs from February 6 through December with a break in the summer. Every student will be matched with a preceptor and actively participate in patient care at the same clinical site once a week for a three-to-four hour period. The goals are to 1) practice/implement the clinical skills learned in Physical Diagnosis and Communications skills training, 2) participate in a patient-centered experience, and 3) develop a continuing relationship (continuity-of-care) with patients. A very effective online tutorial developed for the Primary Care Track will be incorporated into the preceptorship curriculum. Dr. Wolpaw described the preceptorship as an exciting new venture that increases the intensity of student exposure to patients as compared to its Family Clinic predecessor. Student experience will be recorded and reflected on in an electronic patient log.

Dr. Susan Padrino provides the leadership for **Physical Diagnosis**. The second part of Year I Physical Diagnosis offers students opportunities to work with specialty clinics. Student will do a series of four regional exams on real patients under the guidance of a specialist in that area.

#### 6. **New Curriculum Update**

**Dr. Terry Wolpaw**, Associate Dean for Curricular Affairs, provided an update on **Student Assessment in the New Curriculum**. She distributed for input a draft of the **student assessment principles** formulated by the work group to be consistent with the **curriculum principles** that promote 1) student responsibility for learning and self-

assessment, 2) use of educational methods to stimulate active interchange between students and faculty, 3) development of students into physician scholars, and 4) achievement of the goals of the School of Medicine (critical thinking and inquiry, scholarship, life-long learning, and obligations to society). Student assessment principles apply to the University Program only.

**The CME accepted by consensus the following Principles for Student Assessment—which incorporate suggestions made by members at the meeting—as the official record:**

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**PRINCIPLES FOR STUDENT ASSESSMENT  
UNIVERSITY PROGRAM  
CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE**

The University Program at Case School of Medicine supports the development of the Physician Scholar by emphasizing critical thinking and inquiry, scholarship, clinical mastery, life-long learning, and obligations to society. It promotes the student’s responsibility for learning and self-assessment and uses educational methods that stimulate an active interchange of ideas between students and faculty. The assessment process will support and promote our overall educational principles to help students develop into physician scholars and achieve the goals of the School of Medicine.

**PRINCIPLES FOR STUDENT ASSESSMENT**

1. The assessment process is competency-based and ensures that students have mastered the major areas of learning and scholarship of the University Program.
2. The process facilitates continuous rather than episodic learning, and includes early and frequent formative assessment and feedback.
3. Assessment forms an integral part of the learning process by fostering opportunities for reflection and self-directed learning.
4. Assessment methods chart progress across the curriculum in both basic science and clinical studies through measurements based on performance standards and competencies.
5. The assessment process fosters a supportive and collaborative relationship among students as they help each other in the process of mastery.
6. Periodic judgments (summative evaluation) of the students’ progress in the curriculum are based on the evaluation of multiple qualitative and quantitative measures.
7. Students have a continuity relationship with an adviser that guides the student’s progress throughout the curriculum and meets frequently with them to provide formative assessment and feedback.

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Dr. Wolpaw mentioned that the next step is to define the core competencies for the University Program and to decide on operational definitions and benchmarks for each. The 6 ACGME (Accreditation Council for Graduate Medical Education) competencies will be among the core competencies. All four curricular pillars (civic professionalism, leadership, research and scholarship, and clinical mastery) will be included in the competencies.

Discussion focused on terminology and priorities. Dr. Smith wanted to be sure the term “**physician scholar**” would be understood to include being an excellent physician

(clinical mastery) as well as being a scholarly physician with an understanding of the sciences of medicine. Dr. Wilson-Delfosse felt that the term “physician scholar” encompasses more than research. The physician scholar thinks about “cutting edge” medicine. We want our graduates to demonstrate more than competency as physicians. Several discussants felt that the term “physician scholar” connotes research and therefore becomes a marketing issue that will affect the applicant pool. Dr. Fishleder suggested asking a student focus group what the term physician scholar means to them. Dr. Terry Wolpaw described the driving force behind the “physician scholar” as approaching one’s life as a physician consistent with the criteria for scholarship, whether as a physician in practice, as a researcher, or as a teacher. The Physician Scholar follows Glassick’s Six Criteria of Scholarship in whatever he/she does: 1) clear goals, 2) adequate preparation, 3) appropriate methods, 4) significant results/outcomes, 5) effective presentation, and 6) reflective critique. Dr. Montgomery felt there is a distinction between the “scholarly physician” and the “physician scholar.” For a physician scholar, all six of Glassick’s criteria must occur. When asked what “physician scholar” means to him, first year representative, Mr. Brandon Maughan, thinks of the medical scientist researcher in the M.S.T.P. (Medical Scientist Training Program).

Dr. Altose introduced the topic of **oversight of the new curriculum** by mentioning that the Dean established the **Curriculum Monitoring Council (CMC)** to serve in conjunction with the CME. Dr. Terry Wolpaw mentioned that while the **CME** oversees curricular **policy**, the **Curriculum Monitoring Council**, under the auspices of the Vice Dean, has **operational** oversight for the **University** Program. The Curriculum Monitoring Council, a broad overview committee of 18 members, was established to meet LCME accreditation standards for curriculum management at an LCME-accredited school of medicine. There is a need for continuous quality improvement (CQI) to improve programs on an ongoing basis rather than wait for formal program evaluation results that could take up to ten years. The CMC meets every other week. At its second meeting, which took place this week, the CMC entertained presentations from Blocks 1 and 2 of the new curriculum. Every block will report to the CMC prior to implementation of the new curriculum and again when the curriculum is in effect. Dr. Altose added that the CMC will in turn report regularly to the CME. The CMC ensures that the curriculum is sound operationally and serves as a venue for making improvements.

Questions from discussants were then addressed. When asked about adding more student representation to the CMC, Dr. Wolpaw explained the intent to get broad student feedback is already a priority. When asked about operations being consistent with policy, Dr. Altose replied that the Curriculum Monitoring Council will be similar to the Cleveland Clinic Lerner College of Medicine Curriculum Steering Council, where each program does its own evaluation and presents to the Steering Council. When a suggestion was made to add block leaders to the Curriculum Monitoring Council, it was pointed out that the block leaders are the ones presenting to the Council. In the interest of promoting continuity and avoiding redundancy, there will be sufficient communication to relay one block leader’s findings to the other blocks. Dr. Wolpaw mentioned that the Basic Science Curriculum Council will continue to have a critical role as a safe forum to share both “best practices” and problems. Dr. Altose recalled that during his first year as

chair, the CME entertained reports from individual subject committees on accomplishments, areas needing improvement, and the action plan for the coming year. The CMC is asking for a more rigorous analysis. There will be more quantity and quality of assessment and evaluation through the CMC.