PRESENT:  Dr. Keith Armitage, Chair; Drs. Wanda Cruz-Knight, Barbara Freeman, Abdulla Gori, Martin Snider, Amy Wilson-Delfosse, Daniel Wolpaw, James B. Young
Drs. Daniel Ornt, Klara Papp, Terry Wolpaw; Ms. Lois Kaye (secretary)

VOTING MEMBERS ABSENT:  Drs. Jalal Abu-Shaweesh, Robert Bonomo, James Bruzik, Paul Ernsberger, J. Harry (Bud) Isaacson, George Kikano, Mimi Singh

Comments from the Chair
Dr. Dan Wolpaw opened the meeting for Dr. Keith Armitage, CME chair, who arrived later.

Comments from the Vice Dean
Dr. Dan Ornt, Vice Dean for Education and Academic Affairs, mentioned that the official LCME report will be written by the site visit team and sent to us around October. We will receive a preliminary report in August or September to review for factual material over a two-to-three week period.

We are currently welcoming a full contingent of new students. The target class size for those entering July 2009 is between 165 and 167 students. These numbers include 11 M.S.T.P. students and 155 or 156 students (a combination of University track students and 32 College track students).

Foundations in Medicine and Health Update
Dr. Amy Wilson-Delfosse, Basic Science Curriculum Council Chair, recognized Dr. Dan Wolpaw for organizing the well attended Clinical Immersion retreat held in June for block leaders and Clinical Immersion leaders. The Clinical Immersion occurs in Blocks 2 through 6. Focus was on revisiting goals and objectives for the Immersions. This perspective yielded a more developmental approach and new opportunities.

Dr. Dan Wolpaw described it as “one of the better retreats,” taking a deeper look at the Clinical Immersion, which is “heavy with opportunities that have not yet been tapped to the fullest. Block 2 ‘sets the stage’ by getting students oriented to the medical environment outside the classroom. At the other end of the spectrum, Block 6 enriches and develops skill sets the students will be needing soon.” Participants presented some very interesting and innovative ideas. The retreat was productive and follow-up is planned. Minutes will be circulated. Block leaders intend to invite Clinical Immersion leaders to their own meetings to focus on further developing the Immersion.
Dr. Wilson-Delfosse added that there was tremendous student representation at the retreat. Dialogue with the students made it easier to come up with the bigger picture and proved quite helpful.

Dr. Dan Wolpaw stressed that student participation was critical.

Dr. Jim Young inquired whether we have stable, strong leadership in each block for the Clinical Immersion.

Dr. Wilson-Delfosse replied that this is an area needing attention. In Block 5, Block Leader Dr. Robert Kalayjian also takes on leadership of the Clinical Immersion. This is too much for one individual. In Block 3, co-block leader, Dr. Colleen Croniger, has other faculty working with her. Block 4 has nine leaders but this works.

Dr. Dan Wolpaw described Block 4 as “the most successful Clinical Immersion.” It has 3 threads: cardiology, pulmonary, renal.

Dr. Wilson-Delfosse added that we are encouraging all faculty from within a discipline to talk to each other: all the cardiology participants from all the sites; all the pulmonary staff from all the sites; all the renal staff from all the sites.

**Reviews/Action Plans for both Blocks 4 and 6** will take place when the CME reconvenes in September.

Dr. Dan Wolpaw provided a brief update on the Tuesday morning seminar series. **Leadership** will be enhanced as a theme. It has always been there but as an underdeveloped theme. Faculty are further developing leadership as a theme in the IQ+ curriculum.

Dr. Ornt would welcome someone from the College track to join in. Dr. Young replied that the College track has already pulled material into the Friday afternoon FCM course at the College.

**JCOG Update**

Dr. Dan Wolpaw, Joint Clinical Oversight Group Co-Chair, highlighted prominent projects:

- Clarifying a reporting format for the new re-organized core clerkships that will be available in six to eight months as an information and monitoring tool for department chairmen and clerkship directors
- Developing a report that focuses on how individual faculty are responding to student requests for feedback
- Examination of how effectively the Clinical Assessment System (CAS) is being utilized for grading and timely feedback. The goal is to continue to move to an entirely electronic system to document and communicate both formative and summative student assessment.

**No Curriculum Monitoring Council (CMC) Report**

**No CCLCM Curriculum Steering Council (CSC) Report**

**Update from the Office of Curricular Affairs**

Dr. Terry Wolpaw, Associate Dean for Curricular Affairs, highlighted current OCA initiatives:

- Recruiting IQ Faculty
• Student portfolios
• **Peer Hand-Off Program** where approximately 25 students will orient the new group of entering students
• Addition of new elements of **histology** to Block 1 via **peer teaching**. On Tuesdays for 5 weeks, Year I students will be in small group with a second year peer leader.
  Dr. Barbara Freeman anticipates a more robust program this year than last. From Day 1, students will be with cadavers, but there will be no cutting until Block 2. Students will get practice using both surface anatomy and terminology. There will be 8 students per peer teacher. Getting this activity up and running requires much preliminary paper work.
  Dr. Ornt expressed concern for space, particularly the size of the rooms.
  Dr. Freeman foresees a ratio of 4 students per cadaver if we use all available spaces.
  Dr. Ornt felt that 6 students per cadaver was a more realistic prediction.
  Dr. Dan Wolpaw would welcome a **peer teaching overview** presentation at the CME, particularly as related to 4 other programs: Peer Handoff, Physical Diagnosis, Dr. Scott Frank’s Public Health elective, and the proposed senior student role in Bridge Week.
  Dr. Wilson-Delfosse suggested that the CME invite a **Scholars Collaboration in Teaching Learning** update on all the exciting projects.

**CAML Update**

**Dr. Klara Papp**, Director for the Center for the Advancement of Medical Learning, announced that the **Fall faculty workshop series** has been finalized. The schedule will be circulated via e-mail. All faculty, residents, and staff are welcome to attend the faculty workshop series.

During recent CME discussion examining the various tools we use to measure the efficacy of the curriculum, a **faculty survey** was suggested. Dr. Papp had explained then that the **CWRU Faculty Perceptions of Western Reserve2 Curriculum** was administered in **2008** and results are prepared. Dr. Papp began by describing the **annual survey** that was developed in two months with input from Drs. Terry and Dan Wolpaw, Dr. Dan Ornt, Ms. Siu Yan Scott, the Society Deans, and the Assessment Committee. Questions pertain to the pre-clerkship curriculum in the University track and the joint clinical clerkship curriculum in the University and College tracks. There are 5 demographic questions (situating faculty’s home base, degree, and faculty rank) and 18 general perceptions, with answers ranging from “Strongly disagree,” “Disagree”, “Agree,” “Strongly agree” to “No opinion.” The actual number of questions the faculty member completes, however, depends on where he/she teaches. Faculty are asked whether they taught prior to 2006 and since July 2006, the beginning of Western Reserve2. There are many opportunities for comments and several open-ended questions. The **verbatim comments** provided by respondents are quite thoughtful. The survey was open for completion from the end of May through early June 2008. There were **208 respondents (11% response rate)**, one-quarter basic scientists, three-quarters affiliated with clinical and medical science departments. The identical survey is being
administered this year, in 2009, and responses have begun to arrive. Dr. Papp will prepare an update including the most recent results in Fall 2009.

Dr. Armitage acknowledged that not a huge percentage of faculty is involved teaching students outside the wards.

Dr. Ornt added that the current curriculum creates more opportunities for faculty/student interaction than previously.

Dr. Armitage asked Dr. Papp for the most noteworthy finding of the survey. She directed those present to the summary of results on the first page of the handout. She urged considering this as a baseline assessment, given that we are repeating the survey.

On the positive side, respondents agreed that:

- The curriculum prepares students for the practice of 21st century medicine.
- They understand the curriculum’s goals.
- They felt adequately prepared for their role in the curriculum.
- They found student feedback useful to their development as a teacher.
- They are familiar with competency expectations for students.
- They feel their department chairs support medical school teaching.

Areas needing attention include:

- Inadequate communication about the curriculum
- Insufficient administrative support for teaching faculty
- Not enough value placed on teaching by the medical school

Dr. Ornt suggested categorizing the verbatim comments using keywords to make the survey more reader-friendly.

Dr. Armitage acknowledged that there always exists a small percentage of persons who are disgruntled or unhappy.

Dr. Jim Young found the narratives fascinating. He inquired why the “No opinion” category was allowed.

Dr. Martin Snider felt that “No opinion” is relevant to some questions. For example, an IQ facilitator should not answer about the end-of-block essay exams.

Dr. Terry Wolpaw felt that the comments reflect much of what has been said and is very helpful.

Dr. Armitage was struck by the perceived weakness in communication and hopes that the CME can do better in the coming year.

Dr. Ornt felt that the LCME visit created the necessity to communicate better. He also noted that the faculty responding to the survey are the committed teachers.

Dr. Terry Wolpaw felt that communication is directly related to faculty participation in the curriculum.

Dr. Ornt noted that only 8% of the survey respondents did not teach.

Dr. Snider commented that he was not surprised. Acronyms such as IQ are used and outsiders do not know what we are talking about. He advocated using “plain English” and dropping the jargon.

Dr. Armitage agreed that those faculty only a little involved and those not much involved are apt to be confused.

Dr. Wilson-Delfosse acknowledged that a large subset of the faculty who deliver only one lecture do not see teaching involvement as their priority.

Dr. Armitage feels that faculty should have some interest in teaching.
Dr. Papp mentioned that CAML does a workshop for residents. Perhaps we should add one for new faculty and put it online so that people could link in.

Dr. Terry Wolpaw mentioned faculty development via Grand Rounds.

Dr. Armitage supports the idea that anyone who teaches students, fellows, or residents at University Hospitals be required to take 2 hours per year of Continuing Medical Education, where one hour could be a curricular session.

Dr. Wanda Cruz-Knight noted that one needs to get permission to be able to attend the aforementioned opportunities. She recommended taking advantage of departmental meetings to do faculty development. In general, the clinician in the hospital is far-removed from the School of Medicine.

Dr. Wilson-Delfosse reiterated that for basic scientists, teaching is not their priority.

Dr. Young mentioned that how you review your faculty impacts faculty development and teaching. The Annual Performance Review (APR) and Academic Dashboard are more integrated at the Clinic.

Dr. Armitage mentioned that at University Hospitals, there are mandatory RVUs (relative value units) to measure physician productivity.

Dr. Young recalled communicating via town meetings, which no longer seems in vogue. Town meetings appear to have been replaced by electronic formats as the alternate form of communication.

Dr. Ornt put it succinctly: “You have to have malpractice insurance. You do not have to teach.” Personally, he does not want to drive doctors away by mandating teaching, but he is in favor of encouraging faculty to take advantage of all the educational opportunities offered.

Dr. Terry Wolpaw views the problem as faculty’s lack of discretionary time for things other than clinical or research responsibilities.

Dr. Young admitted that, “we rely on the largesse of faculty to teach. Those that are involved love it. The problem is getting institutional chairs and department chairs to manage it.” He favors having explicit requirements. The Cleveland Clinic can base merit salary increases on the Annual Performance Review score.

Dr. Abdulla Gori felt that currently there is not much priority for chairs to evaluate faculty on anything else than productivity. He cited ACGME’s (Accreditation Council for Graduate Medical Education) concern over lack of faculty development in graduate medical education. He also mentioned that he is a big fan of CAML. In his opinion, everyone can find two hours to take a workshop delivered right at one’s own doorstep—in his case, it was at Metro. He added that Dr. Al Connors is putting together a new faculty development requirement and urged CAML to take advantage of this opportunity.

Dr. Armitage felt that tying medical school teaching into Graduate Medical Education is a good idea.

Dr. Gori added that if these activities are given a value, more people will participate.

Dr. Papp acknowledged that the certificate awarded after attending three CAML workshops has turned out to be quite a motivator.

Dr. Armitage added that at University Hospitals, the monthly fellows’ conference is mandatory, and the session given by Dr. Papp was well received.
Focus returned to the faculty survey presented at this meeting. Dr. Papp intends to compare this year’s faculty survey with last year’s. She will also try to categorize comments by keyword.

For next year, Dr. Armitage would like the CME to do a survey of our recent graduates and their residency program directors.

Dr. Ornt mentioned that Beth Bierer at the Clinic has already put considerable work into a program director’s survey. Do we want to have two surveys out there?

Dr. Armitage has the impression that our current Residency Program Director Survey has two main uses:
1. To get feedback on our Dean’s Letter
2. To measure the efficiency of our curriculum

He feels we could get better results than those yielded by our current survey tool. We have a whole year to prepare this survey.

Dr. Ornt mentioned that the Class of 2010 has had a consistent curriculum for four years, as Western Reserve2 started in 2006.

As a point of clarification with respect to ease in communication, Dr. Armitage mentioned that Case Western Reserve University does not give their graduates permanent e-mail addresses. He concluded the meeting by thanking Dr. Papp for her insightful report and expressed appreciation on behalf of the CME for her many contributions as an expert in assessment.

Respectfully submitted,
Lois Kaye
Secretary to the CME