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2015 June 16 - Medical Student Education Committee Retreat and Annual Meeting Minutes

Medical Student Education Committee, East Tennessee State University

MSEC Approved July 21, 2015

QUILLEN COLLEGE of MEDICINE
EAST TENNESSEE STATE UNIVERSITY

Medical Student Education Committee

Retreat & Annual Minutes: June 16, 2015

The Medical Student Education Committee of the Quillen College of Medicine met on Tuesday, June 16, 2015, at 12:00 pm in the Academic Affairs Conference Room of Stanton-Gerber Hall.

Voting Members Present:
Ramsey McGowen, PhD, Chair
Caroline Abercrombie, MD
Reid Blackwelder, MD
Anna Gilbert, MD
Jennifer Hall, PhD
Howard Herrell, MD
Dave Johnson, PhD
Paul Monaco, PhD
Jerry Mullersman, MD, PhD
Kenneth Olive, MD
Omar McCarty, M1
Rebekah Rollston, M3

***Ex officio* / Non-Voting Members & Others Present:**
Teresa Lura, MD, *ex officio*
Robert Acuff, PhD, co-chair M1/M2 review subcommittee
Robert Schoborg, PhD
Rachel Walden, MLIS
Cindy Lybrand, MEd
Cathy Peeples, MPH
Lorena Burton, CAP

Shading denotes or references MSEC ACTION ITEMS

1. Approval of Minutes
Minutes of the May 19, 2015 meeting were approved as distributed.

2. MSEC Meeting Dates and Times for 2015-2016
The 2015-16 Academic year MSEC meeting dates and times (to include Retreats and Annual Meetings) had circulated prior to the meeting. Dr. McGowen reminded MSEC that our new meeting time is 3:30 pm, on the third Tuesday of each month with the exception of November 2015 and June 2016, when we will meet on the first Tuesday of the month.

3. LCME Element 6.3
Dr. McGowen reviewed the LCME Standard Element 6.3, **Self-directed Learning and Life-Long Learning**, which replaced previous Standard ED-5-A.The new Standard reads as follows:

"The faculty of a medical school ensures that the medical curriculum includes self-directed learning experiences and time for independent study to allow medical students to develop the skills of lifelong learning. Self-directed learning involves medical students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of information sources."

Discussion focused on assessing students' self-directed learning. Four, crucial elements that must be together in one place (not across multiple courses) to demonstrate self-directed learning takes place:

- Identify, analyze and synthesize information
  - "Gap analysis" by student precedes process (self-assessment)

- Assess credibility
- Share information with peers and supervisors
- Receive feedback on information seeking skills

Each of the following LCMC expectations for Standard 6.3 is to be addressed in our narrative:

- Describe learning activities in the first 2 years that include self-directed learning (students are expected to be doing self-directed learning on the clinical rotations so we must prepare and assess the students to ensure they are capable of doing so)
- **Identify time available for self-directed learning in the weekly schedule (protected time)**
- Estimate time used for required in-class preparation that impacts time available for self-directed learning (reading, online modules)
- Describe workload policy for preclinical students
  - required activities only or includes assignments completed outside of class time – clarification needed
- How does MSEC monitor academic workload and assure adequate time for self-directed learning?
- With what frequency does MSEC monitor academic workload and adequacy of time for independent and self-directed study in preclinical years?

To support the narrative we will need to provide supporting documentation to include sample weekly schedules that illustrate the amount of time in the first and second years of the curriculum that medical students spend in scheduled activities – the weekly schedule must show blocks of time available, not scattered short periods-of-time, and must be reasonably available. LCME does not identify a set number of time blocks required in a curriculum for accomplishing this; so MSEC will need to identify formal policies or guidelines that identify the rationale for the number of opportunities provided and that the limiting of scheduled time during a given week does occur in the first 2 years. We need to be able to demonstrate that the skill(s) is/are acquired with the opportunities provided by the school and our assessments should enable us to do so.

Dr. Olive commented that *Case Oriented Learning* lends itself best to self-directed learning and independent study, but the faculty feedback on how well students have done assessing their informational resources needs will need to be improved. Dr. Abercrombie and Dr. Monaco added that the Cadaver presentations could be the final assessment of how well the students have done. Each Cadaver case is different and covers a wide range that requires identification, analyzing, and synthesizing of information to satisfy the student's "gap analysis". MSEC discussed the *Practice of Medicine* course, how it might integrate self-directed learning and independent study with Rachel Walden offering examples of ways the Medical Library may be able to assist with the student's "gap analysis of information".

4. Program Evaluation – 4th Year Review of Curriculum

Dr. McGowen began the discussion by saying MSEC needs to begin focusing their reflection and discussion on the curriculum as a whole and be ready to begin the process of evaluating the whole, each of its segments, and their relationships between each other. Today's Annual Meeting, with pre-clerkship course and clerkship directors will begin preparations for the review of the curriculum as a whole (Program evaluation). We will discuss how to approach the first six (6) of the seven (7) questions contained in the program evaluation section of our policy in breakout work group. The seventh (7th) question will be answered by MSEC after ad hoc working groups address the preceding six (6) questions.

The program evaluation process will be to establish ad hoc work groups to tackle the questions and gather all the data they need to answer the questions. There may be some time constraints, which may mean that some of the work groups will need to work more quickly or have priority over other data gathering efforts with their feedback back to MSEC. When setting up the working groups we need to identify:

- How many working groups are necessary?
- How much time does each working group need?
- Who should be on the working groups?
- Should MSEC members chair the committees?
- Periodic updates from working groups needed to ensure all components of the review are fitting together.

Discussion included whether there is a need to have two (2) main review groups, one for M1M2 curriculum review and one for M3M4 curriculum review or to combine pre-clerkship and clerkship together to allow for more creativity. MSEC felt that this is an opportunity to separate or breakdown the silos of groups and discussion, but there could be breakouts (sub-groups) within the identified work groups to accomplish their work and bring back to MSEC.

MSEC reviewed curriculum recommendations that have been suggested in recent months:

- Allowing Sub-internships in other clerkships besides IM or FM
- Moving Immunology back with Microbiology
- Clerkship lengths
- Fourth year – moving some of the Keystone course to earlier in the year
- Fourth year – some type of Transitions course where skills occur
- Improve/remove block scheduling in the first two years
- More clinical evidence medicine into the first two years
- Basic science review in the 3rd and 4th years
- Redeveloping the Community Medicine clerkship
- More information from other schools about how they integrated curriculum
- National data that looks at integration of curriculum
- Disciplined-based versus System-based curriculum
- Hybrid curriculum systems (disciplined based curriculum with clinical threads)
- Doctoring course with individual courses/topics and a director to maintain oversight
- OSCE use
- Acknowledgement that testing has changed and we must adapt to the nature of exams. Create a committee to include clerkship and pre-clerkship faculty to vet all exam questions. This would create faculty integration across the curriculum.

Dr. McGowen emphasized that throughout the whole review process we must keep the LCME accreditation standards, our Institutional Educational Objectives, and the College of Medicine Mission in mind. There is not a national developed curriculum; we are responsible for developing our curriculum.

Dr. McGowen asked and received MSEC consensus that clerkship directors and department chairs are to be notified now of MSEC's serious consideration for changes to clerkship lengths during the *4th Year Review of Curriculum.*

5. M2 Course Directors Review

Dr. Schoborg gave a report for Dr. Duffourc on update to the M2 Course Directors review of eye disease coverage in the curriculum. Dr. Duffourc has recently met with Dr. Eric Beaumont and Dr. John Schweitzer and identified that Dr. Beaumont will review eye structure and autonomic control. Dr. Schweitzer will cover the high yield topics of diabetes retinopathy, macular degeneration, and glaucoma. Dr. Schweitzer will address retinitis pigmentosa, UV melanoma, and diabetes hypertension in the eye. The M2 group is going to check exactly where in the curriculum, retinoblastoma, is covered. They feel Dr. Earl Brown covers the topic, but this will be confirmed. Drs. Schweitzer, Beaumont, and Duffourc also plan to sit in each other's lectures on these topics to make sure their coverage meshes with the other.

Cindy Lybrand reminded Dr. Schoborg that any new content/pieces added to any of the courses needs to be identified and tagged for upload to the curriculum database.

6. USMLE Performance Trends – Content Area Step 1 and Step 2 CK

MSEC had requested follow up information on Step 1 and Step 2 CK exam results for review (note**:** standard deviations are shown as 1/10 of a deviation and the year shown is when the student took the exam). Graphs of each exam -- from 2009 to 2014 -- were presented. MSEC discussion concluded that there are multiple factors contributing to the overall exam results with a significant trend that we need to address. We do need to look at all the factors that contribute to our student's test scores and be sure that our students are well prepared for passing their exams and being competent physicians.

7. CBSE data and reports of 5/22 and 5/29

MSEC reviewed results of the Comprehensive Basic Science Examination, which was given for the first time this academic year to the M1 and M2 classes. MSEC discussed both the value from a curriculum management point of view and value to students. Some medical schools use the CBSE strictly as formative assessment for the students, as we did. Some use it as a gateway to taking of Step 1.

CBSE Class of 2017

The exam was a self-assessment for the M2 student to determine how well prepared they are for taking Step 1. CBSE has fairly well established predictive scores. The students took the CBSE before they began their intensive study for Step 1, at the very end of their M2 classes. Dr. Olive corresponded with students about how to interpret their scores and what to do if they are one of the students whose score is below the passing threshold. We now have eleven (11) students who have reasonable doubt about moving forward at this time to take Step 1, and are delaying the taking of their Step 1 exam. Most of these students also had one or more "shelf exams" which were low. These students will complete the Transition course, and take Step 1 during the Period 1 period and begin their third year rotations in Period 2. This will mean that during the student's senior year their time will-be-shortened for time off to study and away electives, as they will be completing the clerkship they missed at the beginning of their third (3rd) year. Dr. Olive will now be notifying the course directors and faculty who teach in the first two year's courses and let them have a chance to review and digest the CBSE results.

CBSE Class of 2018

The CBSE offered a practice to the M1 student for this type of examination and question types so that they might become more familiar and comfortable with this type of assessment and maybe how the CBSE relates to performance on courses they had in the first year. MSEC asked to hear from Omar McCarty, MS1, on his thoughts about taking of the CBSE. He stated that the students knew a lot of the material would be foreign to them. Some did not take it seriously because of

vacation/travel plans. Most students approached the exam for what it could be – a view of content and stem writing technique.

MSEC discussed a number of thoughts about what feedback the CBSE could provide to help improve the student's exam scores as well as curriculum development. Questions about how the MCAT scores or GPAs related to CBSE results, how important it is to look at all exams and catch problems early on, and how we need to assist students early on to identify good study habits as well as providing mentors for M1 and M2 students.

8. Grade Policy for Standardized Use of NBME scores

Dr. Olive reviewed reasons for standardized use of NBME subject exam scores within College of Medicine courses and clerkships.

- Importance of standardized measures such as NBME subject exam scores in evaluating our students' performance and our curriculum accomplishments.
- Lack of consistency in how subject exam standard scores are converted for use in calculating course grades.
- Faculty uncertain over statistical properties associated with correct use of standard scores and percent correct scores.
- Time-consuming process associated with converting scores using certain statistical methods.
- Concern about the impact of standard score conversion on course and/or clerkship grades.

The goal of today's discussion is to develop a consensus and be the basis for a uniformly followed policy that will:

- Convert NBME standard scores for use in percent-correct based course grade calculations for pre-clerkship courses and clerkships.
- Utilize NBME exam scores in determining course grades (percentage of grade, use of cutoff for differentiating grade categories, etc.)

Dr. Olive presented a number of examples of how NBME provided scale scores can and are being used, with pros/cons for each application. Discussion followed with MSEC endorsing the need to establish uniformity across all courses and clerkships, but noted that the same standardization may not fit both pre-clerkship years and clerkships. MSEC concurred that the clerkship directors want clarity in how to use NBME exam scores, and want to feel empowered with setting of their own individualized grade scales, but guidance from Academic Affairs may be warranted to ensure uniformity of policy can be maintained throughout the varying clerkship grade structures over the academic year.

A motion by Dr. Herrell to delay action on standardization for utilization of NBME grade scales for pre-clerkship years till the July 2015 MSEC meeting; but, apply a standardization for utilization of NBME grade scales to the clerkships who currently administer an NBME subject exams at the end of their clerkship rotations. The standardization is to follow the mathematical calculations and/or formula introduced by Dr. Mullersman, with individualized tables and administrative guidance for cutoff for differentiating grade categories, given to clerkship directors by Academic Affairs. The standardized NBME grade scale for clerkships will be effective with Period 1 of the 2015-2016 academic year. The motion was seconded by Dr. Monaco, with unanimous approval from MSEC.

9. MSEC Action/Activity Table

Dr. McGowen reviewed the current *2014-2015 Activity Year MSEC Actions Table,* which reflects actions by MSEC that are not yet completed and considered in an *on-going* or *pending status* with finalization to come with upcoming MSEC meetings in 2015-2016. Academic Affairs tracks all MSEC actions to ensure uncompleted actions are completed. There were no comments from MSEC regarding any of the yet-to-be completed actions.

10. AAMC M2 Survey Results

Dr. McGowen presented the AAMC M2 Survey taken by M2 students from 142 LCME accredited medical schools. The results are national results, not school specific. AAMC is considering providing school specific data in the future. The purpose of the survey was to:

- Identify and address issues "crucial to future of medical education"
- Explore issues related to medical student well-being
- Align with other AAMC surveys
- Emphasis on
    - stress
    - wellness
    - adjustment
    - career plans and
    - learning environment

The students responded to questions based on perception of their own schools in areas of curriculum, teachers, classmates, and other aspects of their experiences. Several scales measuring personal attributes were also included.

Twenty-four percent (24%) of the students identified experiencing at least one adverse experience (e.g., being publically embarrassed or humiliated, threatened, subjected to sexual advances, denied opportunities based on gender/sexual orientation, subjected to offensive remarks or lower grades because of gender/race/ethnicity/sexual orientation).

The national data reflected an overall satisfaction by the students of "High". Eighty-five percent (85%) agree or strongly agree - "Overall I am satisfied with the quality of my medical education".

11. Additional End of Year Evaluation

Omar McCarty, MSEC MS1, presented the idea of a retrospective student evaluation of the curriculum as a whole at the end of an academic year. This would be a separate survey, in addition to the total evaluations done for each course at completion of the year. The addition survey would provide an opportunity for students to make additional comments related to prior courses (course content and sequencing) after experiencing more of the curriculum. As presently envisioned the survey/evaluation would be optional, and include a narrative block for each course in the curriculum.

MSEC endorsed the idea of an additional survey and asked for a draft document be developed and brought back for approval.

Adjournment

The meeting adjourned at 3:16 p.m.

Medical Student Education Committee

Retreat & Annual Minutes Continued: June 16, 2015

The Medical Student Education Committee of the Quillen College of Medicine held their second Annual Meeting on Tuesday, June 16, 2015, at 3:30 pm in the Large Auditorium of Stanton-Gerber Hall.

Participants:

Dr. Robert Acuff	Dr. Theodoor Hagg	Dr. Robert Means
Dr. Patricia Amadio	Dr. Jennifer Hall	Omar McCarty
Dr. Caroline Abercrombie	Dr. Russ Hayman	Dr. Tamara McKenzie
Dr. Eric Beaumont	Dr. Howard Herrell	Dr. Ramsey McGowen
Dr. Reid Blackwelder	Dr. Shawn Hollinger	Dr. Merry Miller
Dr. Martha Bird	Dr. Lamis Ibrahim	Dr. Jerry Mullersman
Stefanie Bowen	Dr. Tom Jernigan	Dr. Kenneth Olive
Lorena Burton	Dr. David Johnson	Cathy Peeples
Dr. Earl Brown	Dr. John Kalbfleisch	Dr. Mitch Robinson
Dr. Thomas Ecay	Dr. Tom Kwasigroch	Rebekah Rollston
Dr. Joseph Florence	Dr. Tiffany Lasky	Dr. Robert Schoborg
Dr. Kenneth Ferslew	Cindy Lybrand	Dr. Daniel Wooten
Dr. Jennifer Gibson	Dr. Paul Monaco	
Dr. Anna Gilbert	Dr. Teresa Lura	

1. **Overview of Annual Meeting**

   Dr. McGowen welcomed everyone to MSEC's second Annual Meeting. New course and clerkship directors were introduced: Dr. Shawn Hollinger, Pediatrics 4th year Course Director, Dr. Jennifer Gibson, 3rd year Pediatric Clerkship Director, Dr. Patricia Amadio, M2 Practice of Medicine Co-Director and Dr. Merry Miller, 3rd year Psychiatry Clerkship Director.

   Dr. McGowen reviewed the purpose of the Annual meetings and identified that they are part of the *Policy for Periodic and Comprehensive Review of the Curriculum* and allow for a means to:

   - Provide feedback and assistance among the pre-clinical and clinical directors
   - Provide horizontal and vertical integration of curricular content
   - Address gaps and unplanned redundancies across the curriculum
   - Identify of areas in need of improvement

Last year's meeting was viewed as a positive addition to the curriculum evaluation by providing and obtaining:

- Enhanced communication within and between those in different segments of curriculum with increased opportunities for knowing about each other as faulty and course methodologies/content, etc.
- Identification of technology tools to enhance and track delivery of information and assessments of knowledge – Integrity, Exam Soft
- Increased knowledge of curriculum and facilitated basic science content in clinical education and that more can be done with content integration
- Stimulated generation of ideas to include: "theme directors" for all 4 years of curriculum
- Identification of curriculum strengths and areas for improvement that will take us to the next level and get us where we need to go for review of our curriculum in the four-year review cycle

Dr. McGowen revisited each of the components of the *Policy for Periodic and Comprehensive Review of the Curriculum* and provided a time line for the Year Four Program Evaluation that will need to be followed:

July-August 2015 Identify members and tasks of working groups; organize data to respond to questions.

September-February 2015-2016 Working groups collect and begin analyzing appropriate data and developing reports.

January-March 2016 MSEC reviews working group reports, synthesizes information into a comprehensive report and identifies actions commensurate with final report.

March-April 2016 Development of plan for and implementation of approved actions.

Calendar considerations – changes to M3 calendar must be adopted by October 2015; fall semester M1/M2 changes must be adopted by March 2016.

The remainder of the meeting focused on accomplishing the annual meeting goals through discussion directed at preparing for the Year 4 Program Evaluation. The attendees broke into six working groups for thirty minutes. Each group included a MSEC member, a clerkship director, and a preclinical course director with one program evaluation question assigned to each of the groups.

2. Break-out Sessions

Each group addressed one of six program evaluation questions identified in the *Policy for Periodic and Comprehensive Review* that will guide the review of the curriculum as a whole. The questions are the same type that LCME would ask during the accreditation process. Each group was asked to identify what MSEC needed to do to effectively answer the question they were assigned. The groups were not charged with answering the program evaluation question(s), but instead to help identify how MSEC needs to approach answering the program evaluation question(s) over the course of the Program Evaluation year by

addressing the following three questions about their program evaluation question assignment:

- **What aspects of the program question(s) is/are the highest priority to consider?**
- **What information or data need to be available to answer it effectively?**
- **Who should be involved in addressing the question—from whom do we need input?**
  - **Should certain individuals be invited to serve on the work group addressing?**

After thirty minutes of discussion, each group presented recommendations to the large group.

3. **Large Group Discussion**
   Each group leader stated the program evaluation question(s) assigned and summarized his/her group's discussion and responses.

Question 1: *Group Leader: Howard Herrell*
Does the curriculum include all required content? What evidence supports this conclusion?

- The question was more difficult to decide on highest priority than you might think**.**
- Data or information needed**:** professional societies, groups and books as references. USMLE content (best place as anywhere to start but is not a stopping point). Institutional Objectives, our school's mission statement, and LCMC standards be considered. Define what is our required content (comes back to evaluated data to see if we are teaching to stated content). Identification of gaps and/or redundancies.
- People/individuals who need to be involved: senior students, all years of curriculum faculty, and an Academic Affairs person with access to curriculum database.

Question 2: *Group Leader: Paul Monaco*
To what extent is curriculum logical in its sequencing?
What factors need to be considered regarding sequencing and what modifications should be considered?

- The final product is whether our students enter residency programs – this must be considered before we can decide if the curriculum is logically sequenced. Look at desired outcomes and work backwards. If there are modifications to be made to the sequencing, we need to have a perception of the workload on the students. We need to have foundational information for each step in the curriculum. Are we providing material for student to be effective in delivering patient care and enables them to pass exams (in-house, national, and licensing)?
- Data or information to be gathered from students, faculty, course directors, and a Year-by-year feedback with a live forum/focus group, program directors' input, and potentially Graduation Questionnaire information.

- People/individuals who need to be involved: students, chairpersons of departments, licensing exams performance (data driven, not opinion driven) to see if students are getting and retaining information**.**

Question 3: ***Group Leader: Kenneth Olive***

To what extent is curriculum content organized, coherent and coordinated.

- Foundational to more complex information is priority. Key is asking if we have right info in the first year to progress to the second year. Vertical integration has an effect on sequencing. There is impact on faculty with other responsibilities in addition to teaching (how does it work for them to have small teaching assignment spread out over the year versus having one block of assignments). Faculty resources and deploying them was the question. How important is integration (is there good data to support higher outcomes than without). Systems based reviews are good way to integrate. How do we do a better job of transferring basic knowledge to more systems based knowledge known as Trans Systems knowledge? What are priorities for integration?
- Data/information to review: teaching our students to be more effective with integrating information - involving student in the decision making (a toolbox that we can provide
- People/individuals who need to be involved: course directors, clinicians, MBA educator or someone with organizational skills, academically strong students and preferably junior or senior students who have seen more of the curriculum, resident physicians (even better with COM graduates), people from other schools

Question 4: ***Group Leader: Ramsey McGowen***

In what ways is curricular content integrated within and across academic periods of study (horizontally & vertically integrated)? Is this adequate? Where could additional integration occur?

- Answers to questions number one and two (above) are important preliminary information to have -- to know what our content currently is and what sequencing is in place. It is hard to integrate things, which are distant to each other in time, and things that are presently absent. Content and sequencing are important. Clarification to what integration means (what are we referring to: within years, courses, and models-spiral). Be sure everyone is on the same page about what integration means.
- Data or information to be gathered: foundational material – where do we stand now? Look at existing models (in-use, read literature, look at other schools). What evidence do we need -- content, sequencing, status report, step scores to some extent, Graduation Questionnaire information, AAMC curriculum reports, other colleges, and student perceptions.
- People/individuals who need to be involved: course directors, clerkship directors (someone from each of the three years), students are valuable, consultant from professional organizations or other schools regionally close.

Question 5: *Group Leader: Reid Blackwelder (presented by Caroline Abercrombie)*
In each segment of the curriculum, are the methods of pedagogy appropriate?
Clinically relevant? Student-centered? Effective?
What are the practices in place that accomplish this?
How does the pedagogy in each curriculum segment relate to the adequacy of our curriculum as a whole?

- Priority to keep a student centered learning environment. Remember that every student is going to have a different learning environment -- pedagogy. Keep in mind: Knowledge, skills, and attitudes (KSAs) -- step scores do not highlight this.
- Data or information to be gathered: Breakdown pedagogy, what are we doing or providing in our courses and clerkships? How effective is it? Look at self-studies. How do our students learn? Look at courses, and how they relate to flipped classroom – some courses are not designed for a flipped classroom. Look at attendance in class. A breakdown of instruction methods within a course and across courses would be desirable. Objectives dictate instruction methods. Look at course evaluations and clinical OSCEs – do they match our pedagogy? Are they in the right place? Midterm in M1M2 to pick-up trends for identification of students at risk. There is a lot of information out there that we are not using.
- People/individuals who need to be involved: students, student evaluations (end of year hindsight of curriculum as a whole), preclinical faculty, clinical faculty, IT knowledge (Technology). It is important to share information and provide faculty development.

Question 6: *Group Leader: Jerry Mullersman*
To what extent are evaluations: linked to objectives and competency-based?
Providing adequate formative and summative feedback?
Measuring cognitive and non-cognitive achievement?
Measuring knowledge, attitudes and skills?
What needs to occur to improve evaluations throughout the curriculum?

- Priority is to link evaluations to objectives and competency. Need to have good, robust objectives to reflect what you are trying to teach. A smaller group priority asked us what needs to occur to improve evaluations.
- Data or information to be gathered: self-study reports, curriculum review subcommittee reports, a work group could spend time looking at objectives, assessment instruments, student assessments. There are surveys, the Graduation Questionnaire, program director assessments of graduates, graduate surveys, and course and clerkship director evaluations by students. There is a lot of information available to review.
- People/individuals who need to be involved: students (one or two of them), either M2s or M4s, who have over-arching view, faculty from M1 – M4 courses/clerkships,

Academic Affairs person who can get at information readily, and medical community people who are involved in training students, physician, nurse, etc.

Question 7: MSEC Question – Summation to all of the questions: *Dr. McGowen*
To What extent are we achieving our education objectives and accomplishing our mission?

Question number seven (7) is contingent on information from answers for questions one through six. Discussion from the group participants asked: Are our students matched. Do they receive residency slots they want and do they stay? Students we select for the committees need to come from both ends of the bar so it is representative of all students. We need a clear understanding as a group – what is our objectives/metrics/scorecard that we are trying to achieve/meet? Dr. McGowen reminded the group that we do have Institutional Benchmarks for each of our curriculum objectives. Consensus from the group identified that we need to put these in front of course and clerkship directors annually and communicate them to our faculty. Our Mission has to be infused within all the questions and our curriculum.

4. Comments and Closing

Dr. Means thanked MSEC and the entire teaching faculty for their continued support. The College of Medicine has several missions, but none of them is more central to our identity than the education of our students. The education of our students is the underlying theme for all of our missions – to train students who will practice primary care and practice in our underserved rural communities and improve care for our all of our region. All of the activities link to the education of our medical students. It is appreciated what MSEC is doing and it is essential that we examine what we do and what our roles are with the training of our students. What we teach, how the students do on the exams, where our students place in residency, are all metrics of what we need to focus on. Residency position availability is becoming sparser and our goal is to produce the best physician, enhance health care in the community, and to be able to have our students selected for a residency position. Thank you for everything.

Dr. Olive added a word of thanks to all the course directors, clerkship directors and coordinators that participated in the discussion today.

Adjournment

The meeting adjourned at 5:30 p.m.

Upcoming MSEC Meetings

Tuesday, July 21, 2015 – 3:30-6:00 PM

Tuesday, August 18, 2015 – 3:30-6:00 PM

Tuesday, September 15, 2015 – 3:30-6:00 PM

Tuesday, October 20, 2015 – MSEC Retreat – 11:30 am to 5:00 pm

Tuesday, November 3, 2015 – 3:30-6:00 PM