10-20-2020

2020 October 20 - Medical Student Education Committee Minutes

Medical Student Education Committee, East Tennessee State University

The Medical Student Education Committee (MSEC) of the Quillen College of Medicine met on Tuesday, October 20, 2020, via Zoom meeting.

Attendance (remove any not present)

Faculty Members	Ex Officio Non-Voting Member
Ivy Click, EdD, Chair	Ken Olive, MD, EAD
Caroline Abercrombie, MD	
Martha Bird, MD	Academic Affairs Staff
Thomas Ecay, PhD	Mariela McCandless, MPH
Russell Hayman, PhD	Skylar Moore, HCMC, BSPH
Jon Jones, MD	Dakotah Phillips, BSPH
Paul Monaco, PhD	Aneida Skeens, BSIS, CAP-OM
Jason Moore, MD	
Jessica Murphy, MD	Subcommittee Chairs
Mitch Robinson, PhD	Robert Acuff, PhD
Antonio Rusinol, PhD	John B. Schweitzer, MD
Robert Schoborg, PhD	
	Guests
Student Members	Patricia Amadio
Sarah Allen Ray, M3	Lorena Burton, CAP
R J Black, M2	Leon Dumas, MMED
	Theo Hagg, MD, PhD
Ex Officio Voting Members	Jerald Mullersman, MD
Joe Florence, MD	Cathy Peeples, MPH
Tom Kwasigroch, PhD	Trevy Ramos, MD
Rachel Walden, MLIS	Tory Street, AD
	David Taylor, M4

Meeting Minutes

1. Approve: Minutes from September 15, 2020 Meeting.

Dr. Click opened the meeting at 12:30 p.m. and asked for comments/updates to the September 15, 2020 meeting minutes, which were distributed with the MSEC meeting reminder.

Dr. Moore made a motion to accept the September 15, 2020 minutes as presented. Dr. Abercrombie seconded the motion. MSEC approved the motion.

The MSEC minutes for September 15, 2020 were shared with MSEC Members via Microsoft Teams document storage.

Announcements:

- Faculty Development - On October 28 at 3:30 p.m., Dr. Robert Schoborg will be presenting "Active Learning and Online Environment." A Zoom invitation will be forthcoming.
- The Curriculum Transformation Steering Committee will be having a second Town Hall meeting in the near future once an acceptable date is found.

2. **Discussion/Approve:** Elective (Dumas hand surgery)

   Dr. Leon Dumas presented a proposal for a two-week hand surgery elective for M4 students that would be offered during all periods. The course would be taught 100% online and is intended as an adjunct to orthopedic and plastic surgery electives. The goal of this course is to revisit applied anatomy, applicable pharmacology, nerve blocks and evidence-based procedures relevant to hand surgery. Students will be able to identify anatomy of the hand and forearm, anatomical landmarks, common fractures of the hand and wrist, tendon injuries, and equipment and pharmacology for regional and neuraxial nerve blocks of the upper limb. The students would be expected to be involved in this rotation for approximately 35 hours per week. Dr. Dumas noted hand injuries were common in this area as it is a rural environment where many people make their living using their hands, and this elective could be especially relevant for students going into Family Medicine in this area.

   The course consists of three sessions. The first section of the class is anatomy material. The second section incorporates the different nerve blocks. The third section involves soft tissue injuries including the management of different fractures of the hand, hand infections, fingertip injuries, tendon injuries, etc. A large amount of the anatomy component comes from the ETSU Department of Anatomy. Slides, videos, and three-dimensional anatomy will also be incorporated and the lab will be available as well if face-to-face demonstrations are allowed. There would also be discussion of when it was appropriate for a primary care physician to treat and when a higher level of care was needed. The course would focus on common injuries that physicians were likely to see on a daily basis such as fingertip injuries and common fractures.

Dr. Moore made a motion to accept the Hand Surgery Elective as presented. Dr. Abercrombie seconded the motion. MSEC discussed and approved the motion.

The presented Hand Surgery Elective document is shared with MSEC Members via Microsoft Teams document storage.

3. **Discussion:** Clinical examples - Percent ambulatory in the clerkships (Clinical phase as a whole – ratio of inpatient)

Dakotah Phillips presented a PowerPoint pertaining to LCME Element 6.4, which states that the faculty of the medical school will ensure that the medical curriculum includes clinical experiences in both an outpatient and an inpatient setting. It was noted that future self-studies will include questions to capture this information. The clerkships reported the percentage of time that students spent in each of the ambulatory and inpatient settings were as follows:

	% Ambulatory	% Inpatient
Family Medicine	50	50
Internal Medicine	0	100
OB-GYN	40	60
Pediatrics	42	58
Psychiatry	13	87
Rural	95	5
Surgery	15	85
Community Medicine	50	50
Total	38	62

These calculations were made including Rural Track. Without Rural Track the percentage of ambulatory time would be 30% and the percentage of inpatient time would be 70%. The longer length of surgery and internal medicine clerkships were not taken into account for these calculations.

During the clerkship year, students spent roughly one-third of their time in an ambulatory setting and MSEC needs to determine if that seemed like an appropriate proportion of the time and does that time seem appropriate to meet the learning objectives for the clerkships. A discussion ensued regarding Internal Medicine showing 0% for ambulatory, which occurred because ambulatory clinical experience was not required for that clerkship. However, some of the electives for the clerkship were ambulatory, so students who chose those electives got ambulatory clinical experiences in Internal Medicine. Concern was expressed whether the 0% for Internal Medicine met the mission of the College because if primary care is the focus of our mission, then having Internal Medicine be all inpatient setting was probably not lending itself to that mission. Dr. Olive stated that MSEC could express this concern to the Internal Medicine clerkship director and request a proposed plan from the clerkship director that would include some ambulatory exposure as a requirement as part of the clerkship.

Dr. Jones made a motion that MSEC require the Internal Medicine Clerkship Director to develop a plan to increase the percentage of ambulatory experience for all students be greater than zero effective the 2021-2021 academic year for MSEC approval. Dr. Abercrombie seconded the motion. MSEC discussed and approved the motion.

The presented Ambulatory vs. Inpatient document is shared with MSEC Members via Microsoft Teams document storage.

4. **Discussion:** LCME survey results

Dr. Click presented the results from the September survey of the students that was done in preparation for the LCME response due in December. She noted that the 2019-2020 academic year had two columns because that class was surveyed in April and again in September. She also noted that participation in September was lower than the participation in April. It was pointed out that the Class of 2024 did not have data for every course because the students have either not had those courses yet or not been in those courses long enough to answer the questions on the survey. The students were asked to rate their satisfaction with the general course organization, the quality of teaching, and the overall course quality for each of the courses and to evaluate the courses.

There has not been a substantial change in the level of dissatisfaction for the Class of 2023 between the survey results from April 2020 and September 2020. However, there has been marked improvement in the level of dissatisfaction expressed by the Class of 2024 for many of the courses when comparing the results with the Class of 2023. Cellular and Molecular Medicine (CMM), Genetics, and Epidemiology and Biostatistics courses have ended for the 2020-2021 academic year and so far, based on evaluation reports, the students seem to be generally happier and more satisfied than their predecessors.

There has not been a substantial change in the level of dissatisfaction for the Class of 2022 between the survey results from April 2020 and September 20202. However, there has been marked improvement in the level of dissatisfaction expressed by the Class of 2023 for many of the courses when comparing the results with the Class of 2022, other than some aspects of Doctoring II. Changes to the course due to COVID-19 could account for some of the dissatisfaction.

The April 2020 data will be used as the primary data for the 2019-2020 academic year for the response to LCME since that survey had a higher response rate. However, the additional data would be provided to show that we are continuing to monitor this.

Satisfaction with the coordination and integration in the first and second years showed improvement, although there are still high levels of dissatisfaction with the integration and coordination of the first and second years. Coordination and integration with the first year improved from 23.9 in April 2020 to 10.0 in September 2020 and the second year improved from 55.0 in April 2020 to 22.6 in September 2020. Although the students are early in the year, we hope this shows some of the work being done by our faculty to align and integrate their courses and that it has been effective.

It was pointed out that the current M4 students were M1 students when the Doctoring course went into effect, so they were the first group to experience some of those changes. Additionally, this was also the year where some of the courses were reordered and integrated testing between biochemistry, physiology and cell and tissue were implemented. For clarification, the M4 students from the survey in April of 2018 are students that graduated two years ago, the M4 students for the survey in April of 2020 were the students who graduated in Spring of 2020 and the M4 students for the survey in September of 2020 are the current M4

students now. There was some discussion about whether increased satisfaction was due to changes in courses and curriculum or differences in the personalities and make-up of the difference class years.

The satisfaction with the College of Medicine's responsiveness to student feedback showed great improvement from where it had in 2018 compared to the April 2020 survey. The September 2020 survey had a little more dissatisfaction in the third year, but overall our satisfaction was still much improved from where it had been previously. It was suggested that the M3 dissatisfaction could be related to COVID-19 and the delays around the start of the year and when the students would be able to go into their clerkships. Satisfaction with academic counseling was also greatly improved from April 2018 to April 2020 and the dissatisfaction remained low in September 2020. Notably, many students chose N/A as they are not using the service, especially M1 students. The dissatisfaction with the availability of academic counseling was a bit higher than the dissatisfaction with the academic counseling but it is still improved from previously. It was decided that students would not be resurveyed again as it was not thought to be beneficial and there was concern over survey fatigue.

No action required.

The presented LCME Survey Results document is shared with MSEC Members via Microsoft Teams document storage.

5. **Discussion: Curriculum Transformation**

Dr. Click presented a review and update for the Curriculum Transformation Steering Committee (CTSC), stating that some of this material had been shown before at the Town Hall, but she wanted to get everyone on the same page. In addition to the presentation, there would also be breakout groups for small group discussion. Information was reviewed regarding the establishment of the CTSC, the committee's charge and its members and MSEC's role to refine and approve the committee's recommendations and work on implementation and management of the curriculum.

Reasons why the curriculum was being changed:

- LCME's determination of unsatisfactory accreditation elements
- Student dissatisfaction with current curriculum integration
- Desire to increase student and faculty engagement
- To be more appealing to potential students, as the current curriculum may be viewed as outdated.

The process timeline was discussed beginning with MSEC's review of the curriculum as a whole in January and the working groups presentation of reports in April that were provided to the CTSC formed in May. Since its formation, the CTSC added a student to the committee, developed guiding principles, prioritized a list of peer institutions to interview about their curriculums, discussed a potential three-year track program for students, established a website, created a best practices document, finalized the guiding principles, and hosted a town hall meeting. Implementation groups are slated to begin work in January 2021 as the Dean has asked the CTSC to shoot for a fall 2022 implementation of a new curricula, which means there needs to be a solid implementation plan by December 2021. There was concern if this potential

implementation date was too soon and whether we might be committing ourselves to that timeframe. There was also concern of needing additional pre-clerkship faculty. It was explained that the schools interviewed generally had a core group of teaching faculty for the first two years during the pre-clerkship phase. This group consists of a couple of primary care physicians and some basic science faculty that work together to do the majority of teaching. Some of the schools did have a larger number of faculty and most did add committed clinical full-time employees to participate in the first two years, but most did not have a wholesale increase in their faculty.

Key themes from the working group reports:

- Increased integration, both horizontal and vertical
    - More clinical experience in the pre-clinical years
    - More basic science in clinical
    - Recommendation for pre-clerkship being organized into thematic or system-based blocks
- Adopt more active learning methods across the curriculum
- Have complete mapping of the curriculum, which would require a new curriculum management system or improvements to our current one
- Additional leadership and staffing in academic affairs and faculty development to support instruction, mapping, and leadership for course/block directors

Curriculum Framework Concepts:

The following are curriculum concepts the CTSC has investigated and recommend for consideration for a new curriculum at Quillen.

Structure

- Increased horizontal integration
    - Options include
        - Foundational basic science block at beginning of M1
        - Organ systems or integrated systems blocks beginning in M1 and continuing into M2
        - "Keystone" course with multisystem focus at end of pre-clerkship phase
- Increased vertical integration
    - Increased early clinical experience
        - It was suggested that students have a goal such as investigating a specific topic or specific physiologic principle that they were going to write up and have reviewed.
        - Case of the week or topic that was incorporated into the students' experience.
        - Longitudinal experience where students have the opportunity to have seen some patients with a disease unfolding over time to better understand the natural history of illness and disease management. These are often ambulatory in a primary care setting and some bring back cases from that setting for discussion in a problem-based learning setting and others have a significant focus on health care systems as part of that.

        - The goal is to give our students more opportunities to correlate the things they are learning in the foundational sciences with the sort of things they are seeing in the clinical setting.
    - Doctoring aligns with systems blocks
    - Half-day clinical experience every other week during pre-clerkship.
        - This would be an increase to the preceptorships our students do now.
    - Longitudinal Journal Club M1-M4
        - Students are assigned to small groups beginning in their pre-clerkship and continue to meet with their small group throughout their third year and into the fourth year and the students in the group present an article for their group a couple of times a year. Sometimes the students chose their own topics and sometimes the topics were chosen for them.
        - This is a way to pull basic science concepts back into the third and fourth years and also a way to increase vertical integration.
        - Ideally, a facilitator would have oversight of the group that would continue with those students as they go up.
        - This could go really well using learning communities as a scaffold for creating the groups.
        - Accommodating this during clerkships would necessitate correlating this when students in community medicine are doing health fair teaching and are back here on campus, with the exception of rural track students. It would work similarly to the Doctoring III courses where students are divided into groups and they have a series of six topics they work through over the year.
    - "Advanced" basic science course in M4 (specialty-focused, journal club-based?)
- Framework must be compatible with 3-year track and rural primary care track
- Implementation of Learning Communities
    - Used for both Student Affairs activities and Curriculum
    - Can work with IPE/Communications groups
    - Course faculty in same LC group to foster relationships
    - Each LC supported by a dedicated librarian

Instruction

- Increased active learning methods (TBL, PBL, Peer Instruction, Simulation, etc)
    - Standardized schedule
    - Assure sufficient out-of-class time to prepare for active learning sessions
        - Students are engaged in the classroom actively and have prepared to come to class by reading or viewing materials or doing some learning on their own and then come to class prepared to participate.
        - Peer instruction is where students answer clicker questions and if a certain percentage of the class is incorrect they meet in a small group with their peers and discuss the question and instruct each other by asking more questions and supplement instruction from the faculty.
        - Team-based learning starts off with a quiz that is low-stakes points and then they have group discussions and short, limited lectures.
- Core teaching faculty with dedicated time for teaching
- Basic science and clinical faculty dyads for pre-clerkship courses/blocks
- Thread directors responsible for tracking basic science and clinical threads

    - Some schools continue to track basic science disciplines and tag exam questions with the disciplines to make sure students are not missing all the questions related to that discipline.
- Longitudinal Journal Club for students
    - Begin in pre-clerkship phase and continue to clinical phase

Assessment

- Philosophy of assessment FOR learning
    - Plan assessment first
    - Emphasis on formative assessment
- Customized NBMEs
- Separate grades for system block (or course) and discipline threads
    - Discipline grades monitored by thread director
- Specific "gates" students must pass to advance to be sure they are prepared for Step 1
- Consideration of placing Step 1 to after the Clerkship Phase
    - At least 22 schools have moved Step 1 to after the Clerkship Phase and many schools do see improved scores and fewer failures, especially for students that are actually the lower performing students.
    - Step 1 is going to pass/fail, which could possibly play into our decision.

Implementation

- Roll out starting with new class in Fall 2022
- M3/M4 Student committee to identify gaps and redundancies in current curriculum
    - These are the students that will be closest to the curriculum to tell us "here's where things are, here's where we think it should go, here's where there is too much, etc."
    - Changes in 3rd and 4th year would be dependent on changes to the pre-clerkship. The majority of schools interviewed had changed to an 18-month pre-clerkship. A new site for community medicine is being investigated to alleviate current issues, but that is the least developed right now. The number one priority obviously is getting the pre-clerkship settled because that will give us more time to work on 3rd and 4th year.
- Faculty groups to plan content of specific blocks
- Flexibility with asynchronous delivery options for overlap of new and legacy curricula

Resources

- New Curriculum Management System
    - The first step would be to have some demonstrations from some different curriculum management systems. There is an ongoing list of what other schools are using and ones that we like, but there is no timeline as of now for getting any system but it is very high on the list of resources and Dr. Block has been very supportive of this.
- Adequate faculty and administrative team to support new curriculum
    - Office of assessment
    - Instructional design support
- Faculty development for assessment writing, active learning methods, etc.
- Academic Support Program for identifying, remediating, and supporting students

At this point, attendees were broken out into small groups and provided with a link to Google Drive that had some documents including the following questions:

- Review the Curriculum Framework Concepts on the document provided, focusing on the structure.
    1. What is appealing about this proposal?
    2. What concerns do you have?
    3. What additional resources would we need?

- If available, should we engage an outside consultant to support the transformation?
    - If so, what support do we need from a consultant?
        - Process
        - Faculty development
        - Sequencing/Content integration

When the groups reconvened, it was decided that it would be more efficient to take the responses from each small group and compile them into a single document for distribution and review then discuss the responses at a later meeting.

Next Steps necessary for the curriculum transformation

- Approval of a broad curricular framework
    - Three phases: Pre-clerkship, clerkship, post-clerkship
    - Pre-clerkship: organ-systems based blocks with foundation blocks at beginning and advanced/multiple systems block at end
    - Incorporating longitudinal journal club, culminating in M4 course, specialty-focused
- Decision on consultant. Discussion from MSEC on this point included:
    - It is good to get expert opinions from outside but the ones knowing the inner workings and all the moving pieces should be heard before decisions are made.
    - There is a list of potential people in medical education that understand how medical education works and are familiar with medical schools to consider.
    - Leaning on peer institutions as consultants is preferred over a commercial consultant as they may not understand the different environments that we work in and have to work with.
    - Concern over extending the timeline.
    - For an external consultant it would be beneficial to get one experienced in whatever model we choose to go with.
    - Get someone that had recently gone through a similar curriculum change.
- Timeframes for each phase
    - Length of each phase
    - Length of each course block and clerkship
- Step 1 placement – after pre-clerkship or after clerkship?
- Content of foundations course(s)
- Sequencing and content of pre-clerkship organ system blocks
- Implementation groups: What groups do we need?
- Identify additional resources

- Name for the curriculum
    - Most of the schools have named their curriculum something for marketing purposes. One suggestion is to do something geography based like Appalachian Trail or something using mountains in the name and tying that to the learning communities
- Decision to adopt accelerated track(s)
    - Residency programs will have to be on board in order to do a three-year track.
    - Need to be sure whatever we decide for four-year curriculum does not rule out the possibility of a three-year track.

No action required.

The presented Curriculum Transformation Proposal Updated document is shared with MSEC Members via Microsoft Teams document storage.

6. **Report/Approve:** CIS updated report: Patient Safety, Quality Improvement & High Value Care – (recommendations from course and clerkship directors)

Dr. Olive shared a thread report that was presented to MSEC in July 2020 from the Curriculum Integration subcommittee on patient safety, quality improvement, and high value care noting 11 topics that were recommended for inclusion in the curriculum. MSEC asked the clerkships to define what they were doing in terms of teaching these topics in high value care, which is doing things that are proven to be beneficial and not doing things that are not proven to beneficial or are harmful. An example of high value care would be giving antibiotics rapidly when someone comes in the hospital with pneumonia. An example that would not be high value care would be getting daily CBCs in somebody who has normal blood counts throughout their hospitalization. A document from an organization called "Choosing Wisely.org" was shared with the clerkship directors. This document included suggestions from multiple professional organizations that they thought represented high value care and practices in which we should be engaging. The CIS thread report was also distributed to the clerkship directors and they were asked to identify the topics they covered. Several of the clerkships identified topics they were covering and from the thread report, the only two topics that are not covered are topic 1 - "What is patient safety?", which is adequately covered in the first two years in the IHI modules and topic 8 - "Engaging with patients and caregivers" - Understand the ways in which patients and caregivers can be involved as partner in health care, both in preventing harm and in healing from an adverse event. So, that appears to be a topic that we do not have covered.

It was asked if we were confident that all of the students get the material and are assessed on it. It was noted that MSEC did not ask about assessment. The request was to ask where this content was taught. It was suggested that if the students were being graded on their clinical participation and experience and these things occurred on the ward during the rotations then the assessment would be that the student completed that part of the objective that was identified as being taught during the clinical experience. It was further suggested that these items could be tied to patient types that are already required as part of the clerkship assessment. Additionally, now that this content has been identified by the clerkship directors

as content they are going to be responsible for, this needs to be put in their objectives so that the content can be mapped for documentation.

Dr. Jones made a motion to require the course directors to map those aspects of quality improvement and high value care to their particular clerkships and the updated comprehensive review provided by Dr. Olive be added to the CIS report on Patient Safety, Quality Improvement & High Value Care. Dr. Monaco seconded the motion. MSEC discussed and approved the motion.

The presented Patient Safety, Quality Improvement and High Value Care Comprehensive Review document is shared with MSEC Members via Microsoft Teams document storage.

7. **Follow up:** Course review and self-study rubric for annual review and discussion of clerkship review process

Dr. Click reminded everyone that the proposed course and clerkship review rubrics came from an item on the MedEd portal that had been used at another school and was used as the starting point for our rubrics with some edits. These rubrics had been brought up at a previous meeting and there had been suggested changes so the rubrics were sent back for revision. The revised documents are presented for review. The majority of the changes were in the narrative section at the end. There were some comments about the appropriateness of the passing percentage of 95% as the expected threshold, which would be easy not to meet with the small classes, so that has been changed to 90% passing as the expected threshold. There was discussion about the 85% satisfaction, which was chosen as the percentage based on the fact that the LCME has highlighted those courses that were above 15% dissatisfaction. The committee could choose to change that and that is one point that will need to be solidified. There were also a lot of questions or concerns about looking at individual faculty at an 85% satisfaction level and the suggested change is that all course instructors receive an overall satisfaction of greater than or equal to 3.0/4.0, which would indicate that the average rating is satisfied or better. This is a bit lower threshold for all the individual faculty than originally proposed and similar to the 3.5/5.0 currently. "Aspects going well" and "Recommendations for improvement" have been changed to "Strengths of the course" and "Weaknesses of the course" with comments for both the students and the course director. 'Recommended changes for course director", "Course CQI plan recommended" and "Issues Requiring MSEC Action" are the last three items on the form. Feedback from the M3-M4 review subcommittee was that the rubric would make it easier for them to do reviews.

Additionally, a couple of questions on the self-study have required changing such as the 5-point scale being changed to a 4-point scale. There has also been a question added about content integration to be able to answer that question on the rubric.

Currently there is no criteria set for what requires a CQI plan but MSEC can set that criteria or leave that up to the M1-M2 and M3-M4 review subcommittees to decide. What was presented was the curriculum review subcommittee template that they will use to provide standardized information. It was suggested that MSEC set objectives that would trigger a CQI plan rather than have the M1-M2 and M3-M4 review subcommittees randomly decide who needed to do a CQI plan and who does not.

Approving the rubric form is a different matter than setting criteria for a CQI plan, and if there is agreement, the form could be approved and recommendations could be made at a later date for when CQI plans need to be done. After much discussion, it was suggested to remove the "Course CQI Plan Recommended" item with the checkbox from the rubric forms. Setting the criteria for a CQI plan can be added to the agenda for the next meeting.

The clerkship review version of the rubric was presented, which was almost identical to the course review rubric with the exception of "course" being replaced with "clerkship" in a few places and there is a question about the mid-clerkship review which is required and a question about resources at their sites.

It is noted for clarification, that these rubrics will be used for the 2020-2021 courses and clerkships.

Dr. Hayman made a motion to accept the course and clerkship review rubrics with the removal of the "Course CQI Plan Recommended" item with the checkbox from the rubric forms. Dr. Bird seconded the motion. MSEC discussed and approved the motion.

The presented Course Review Report Rubric and Clerkship Review Report Rubric documents are shared with MSEC Members via Microsoft Teams document storage.

8. **Report**: M3M4 Review Subcommittee 2019-2020 Reports

- M3 - Jr. CM Clerkship

Dr. Hayman presented the Administrative Review for Community Medicine. The review was completed by Dr. David Wood.

Objectives: The clerkship objectives have been mapped, but the session level mapping has not yet been completed.

Follow up: There was a previous short-term recommendation for creating a written summary of clinical opportunities available within the community medicine rotation to be made available to students prior to the start of the rotation and this document was being prepared and is now available. Previous course reviews have also recommended that due to potential overcrowding at individual preceptor sites and with individual preceptors, that MSEC make every effort to limit class size to no more than 8-10 students per rotation.

Outcomes: The evaluations for the last few years have been consistent and ratings were a bit higher this year going from a 3.17 in 2018-2019 to a 3.55 for 2019-2020.

Strengths: The strengths of the clerkship were that the opportunities were broad and diverse and community-based. The didactic materials are reviewed annually and the spring sessions of didactic material generally reflect more case-based learning in health fair training. Students thought the health fair experience and the ACLS training were good experiences. The Mountain Hope Good Shepherd Clinic provided an excellent clinical experience and had a flexible rotation with respect to scheduling. There was a general student consensus that having an experience

in the community and learning about community-based medicine is an important experience for students in medical school. The clerkship director identified opportunities to explore medicine in a non-academic setting and an opportunity to see underserved patients as a strength.

Weaknesses: Weaknesses identified by the students were that there were not enough preceptors, which led to light clinical experiences and also many preceptors only let students shadow and not see patients with supervision. There was also concern about the organization of the rotation as the students reported they did not get the next week's schedule until the Sunday night before that week, making it difficult to read ahead and be well prepared for the week. Additional weaknesses identified by the clerkship director were that preceptors needed additional faculty/teaching development, the need to recruit more faculty, and lack of student involvement in the development of the curriculum.

Recommendations to the clerkship director:

- Improve recruitment of faculty so there are more sites to precept students
- Develop a plan for faculty development of existing faculty
- Evaluate the educational value received by ETSU medical students at sites that have many other learners, such as PA students or LMU medical students.

Recommendations for MSEC:

- Consider monitoring the number of students at any one time on the community clerkship

It was noted that while MSEC can suggest an optimal number of students on the clerkship, it is Academic Affairs responsibility regarding the actual scheduling of students and if we stipulated a certain number, it may not be possible to always meet that. Part of the issue is the math – the number of students is the class size minus rural track students divided by six. It was pointed out that this year has been even more problematic in terms of clinical sites and clinical scheduling because places we had previously been placing students did not want to take students back due to COVID-19 and some students have had to be scheduled in Johnson City because there were not enough spots in Sevierville. Of note, a meeting has been scheduled with the Chief Medical Officer for Ballad from Greeneville to explore possibilities there, which could help with this situation.

Dr. Moore made a motion to accept the Community Medicine Clerkship Administrative Review as presented. Dr. Monaco seconded the motion. MSEC discussed and approved the motion.

The presented Community Medicine Clerkship Administrative Review document is shared with MSEC Members via Microsoft Teams document storage.

- M3 - Surgery Clerkship

Dr. Hayman presented the Administrative Review for Surgery. This review was completed by Vidiya Sathananthan, M3, and Dr. Leigh Johnson, and was re-reviewed by Dr. David Wood.

Objectives: The course objectives seem appropriate. The objectives are stated and mapped to the Institutional Educational Objectives (IEOs), Entrustable Professional Activities (EPAs), and instructional methods. The clerkship has not yet begun session mapping. The instructional methodology is unified. There are multiple instruction methods delivered at three different venues: Johnson City Medical Center, Holston Valley Medical Center, and Veterans Administration Medical Center. Bristol Regional Medical Center is also a venue but it is uncertain if it was used for the entire year in 2019-2020. Instruction methods include ambulatory and inpatient clinical experience, conference, large and small group discussions, lecture, simulations, problem-based learning, self-directed learning, ward rounds and workshops. Given the main objective of the clerkship is exposure of students to the surgical environment, the total clinical experience for both inpatient and ambulatory exposures seems appropriate. There is a variety of assessment methods and different ways students can acquire grades.

Follow up: There was a short-term recommendation from 2016-2017 that continued into 2017-2018 to consolidate didactic lectures and align content of lectures with quizzes and to specify objectives topics for the quizzes that would allow students to focus their study and test their knowledge in preparation of quizzes and NBME exams. In the self-studies, Dr. Lasky responded and Dr. Browder reiterated that didactic lectures were consolidated as much as schedules allowed and alignment with the quiz content had been done as well. Additionally, quiz content was updated to include content from WISE-MD modules, which the students like.

Outcomes: All students passed the course. There were no failures or incomplete grades. The average numeric grade was 90.39. 42.11% of students scored at or above the national mean of 74.2 and 5.26% fell at or below the 10th percentile scoring level, which is similar to other years for surgery. The clerkship director notes that surgery shelf exams are considered to be more difficult and contain material from other clerkships. This along with the long clinical hours that limit at-home study time may account for the few students who fall at or below the 10th percentile.

Strengths: Strengths identified by the clerkship director are dedicated surgical residents and attending faculty who are able to serve the students at multiple venues, along with other professionals in training. The suture classes are taught by residents and are well received as are the simulation laboratories and skill practice. Students feel the WISE-MD online cases are helpful since they coordinate to the case presentations and quizzes. The clerkship is piloting a new way to reintegrate basic science content into case scenarios and enhancing procedural skill training. Strengths identified by the students are that many attending physicians and residents are enthusiastic about teaching and spend extra time to do effective teaching. There is good exposure to surgical technique and procedural skills and opportunity to practice these skills in the OR and simulations. There are a variety of cases from which to learn. There is some level of independence and autonomy to are for patients during pre-rounds or post-op. There is opportunity to improve oral and written presentation and documentation skills. The team-based approach to patient care was excellent. Student rating of the clerkship improved from a 3.99 in 2018-2019 to a 4.24 for 2019-2020.

Weaknesses: Weaknesses identified by the clerkship director include limited at-home study time for the NBME due to the intensity of clinical hours. Excessive number of students on a

clerkship period is also noted as a weakness as this lessens the one-on-one teaching, patient experiences and surgical experiences for each student on that rotation. Weaknesses identified by the students were that quizzes were unrelated to didactic sessions and occurred too early in the clerkship. Limited surgical experiences if too many students or other students such as PAs on the assigned rotation was also noted as a weakness. Inadequate or limited feedback from the residents due to lack of time and little or no time in the ambulatory clinic at Bristol, JCMC and Holston Valley sites were listed as weaknesses. Students would like to have more time to see consults and practice floorwork rather than only participating in surgeries. Culture of the environment at different sites was also noted as a weakness by the students due to yelling in the OR, derogatory comments about other specialties and some yelling by attendings when students asked questions. Notably, most students noted the surgery clerkship learning environment to be collegial and respectful and Dr. Browder felt these were isolated events, however he has addressed this concern.

Recommendations to the clerkship director:

- Complete clerkship session mapping for input in New Innovations and outline a timeline for this to be successfully completed.
- Dr. Browder will put in writing their policy about behavior in the OR and will encourage the students to report any concerns they have. Any student who does complain about a particular resident or attending, they will allow them to move and the grades from those individuals will be blocked for the student. All complaints will be kept strictly confidential.

Recommendations to MSEC: None.

This review was previously presented and Dr. Wood took it back to re-review the material and investigate comments regarding the culture of the environment at different sites so a more thorough review could be provided. Dr. Browder has addressed the behavioral issue and put into effect a policy regarding behavior in the OR as recommended above. Of note, Dr. Olive performed a detailed review of the surgery student evaluations after this review was first presented and determined there did not seem to be a pervasive student abuse problem as the ratings for the learning environment of this experience ranged from 4.4 – 5.0 on a 5-point scale and 10 of the 14 sub-assignment ratings were a 5.0. The new surgery clerkship director, Dr. Trevy Ramos, was present in the meeting and stated that situations like that do occur but whether it be one student complaint or multiple student complaints, that is something she takes very seriously, and that behavior will not be tolerated.

Dr. Moore made a motion to accept the Surgery Clerkship Administrative Review as presented. Dr. Abercrombie seconded the motion. MSEC discussed and approved the motion.

The presented Surgery Clerkship Administrative Review document is shared with MSEC Members via Microsoft Teams document storage.

9. **Report:** M1M2 Review - Subcommittee 2019-2020 Reports
    - M1 – Medical Physiology

Dr. Acuff presented the Administrative Review for Medical Physiology. This review was completed by Dr. Bob Acuff and Riley Parr, M2.

Objectives: Course objectives are mapped to the Institutional Educational Objectives (IEOs), however, each lecture, laboratory, simulation sessions are not. The old Physiology course as a stand-alone course had been mapped, but since Immunology was split between Microbiology and Physiology, those elements have not reached the session level, so those need to be done.

Follow up: Overall evaluation score for 2019-2020 is 4.38, which is up from 2018-2019 score of 4.06.

Outcomes: There were alterations resulting from COVID-19 including no NBME. Practice quizzes were scored but not counted as part of the final grade. All students passed the course. There were no failures or incompletes. Faculty evaluations ranged from 4.35 – 4.91 / 5.00. The average faculty evaluation was 4.6/5.0. There were no faculty members below the 3.5 threshold.

Strengths: Instruction quality was rated 4.28/5.00 by students. Students said faculty was engaged. They appreciated the quality of instruction as well as the passion displayed for the subject areas. The simulation lab was noted as a great learning experience. Overall organization of the course was also noted as a strength.

Weaknesses: Weaknesses identified by students were organization and detail of the notes were not acceptable and students wanted more "hands-on" experiences, particularly simulation.

Recommendations to the course director: None. Course CQI plan recently submitted and approved in September 2020 addressed concerns.

Recommendations to MSEC: None. Course CQI plan recently submitted and approved in September 2020 addressed concerns.

Dr. Moore made a motion to accept the Medical Physiology Course Administrative Review as presented. Dr. Abercrombie seconded the motion. MSEC discussed and approved the motion.

The presented Medical Physiology Course Administrative Review document is shared with MSEC Members via Microsoft Teams document storage.

10. **Follow up**: Pain Management and Substance Use Thread

Dr. Click presented an update on the Doctoring II Pain Management and Substance Use Disorder Thread previously presented in May and August of 2019 as there were some recommendations made as part of those related to Doctoring II. Under pain management, short-term recommendations were to consider making certain topics under "Acute pain care for chronic pain patients" are specifically addressed and emphasized in the preclinical years' curricula. There was also a recommendation to consider reviewing the current spring delivery of the pain management didactic to include online slide presentations and documents with

considerations for development of a basic introduction to pain management for Doctoring I. Long-term recommendations were to continue delivery of the pain management didactic following the introduction delivered in Year 1 Doctoring I with more advanced discussion on pain management and continue adding pain management cases, encounters, and communications using Standardized Patients (SPs). Under substance use disorder (SUD), it was recommended to make more explicit connections to SUD content in the Practice of Medicine (POM) cases related to intimate partner violence, hepatitis, and pancreatitis.

Dr. Amadio noted updates in the of planning of Doctoring II to include consideration of the pain management thread report and improving coverage of pain management. Specific content included consideration of content in other parts of the curriculum, such as the communication skills section of Doctoring I. Currently, there is a three-hour workshop on pain management in the spring that includes paper cases rather than SPs. The didactic portion of that workshop reviews pain pathways and theories related to that and the concept of managing pain with case discussion, such as determining the difference between someone who is in pain and someone who is exhibiting drug seeking behavior. The focus is a pain management session and not a substance use disorder session. In IPE there is a patient with opioid use disorder that 1/6th of the M2s follow. All of the patients will have this patient covered in an end of year debrief. A sim lab case focused on Sickle Cell crisis has been added in the spring in which opioid pain management figures prominently. Dr. Troxler has ideas for substance use disorder additions to the hepatitis case. There is a pancreatitis case of alcoholic pancreatitis and management of assessment, which is a very important case in terms of preparing students for the oral final, with complicated physiology to discuss. The intimate partner violence case was dropped this year due to similarity with a communications case and strained alignment with basic science content.

Additionally, there was a recommendation from both the pain management and substance use disorder thread reports to consider how these two work together. The substance use disorder objectives and pain management objectives have been correlated and those correlated objectives have been marked with an asterisk in the corresponding reports.

No action Required

The presented Doctoring II Pain Management and Substance Use Disorder Threads Update document is shared with MSEC Members via Microsoft Teams document storage.

The MSEC meeting adjourned at 5:22 p.m.

MSEC Meeting Documents

MSEC Members have access to the meeting documents identified above through the shared Microsoft Teams document storage option made available with their ETSU Email account and login.

If you are unable to access Microsoft Teams MSEC Team please contact: Aneida Skeens at: skeensal@etsu.edu. Telephone contact is: 423-439-6233.

MSEC Meeting Dates 2020-2021:
November 3 – 3:30 – 5:30 pm – Zoom meeting
November 17 – 3:30-6:00 pm - Zoom meeting
December 15 – 3:30-6:00 pm - Zoom meeting
January 19, 2021 **Retreat** – 11:30 am-5:00 pm - TBD
February 16 – 3:30-6:00 pm - TBD
March 16 – 3:30-6:00 pm - TBD
April 20 – 3:30-6:00 pm - TBD
May 18 – 3:30-6:00 pm - TBD
June 15 – **Retreat** 11:30 am-3:00 pm – TBD
June 15 - **Annual Meeting** - 3:30-5:00 pm – TBD