

MEC Retreat Report – Defining our Direction, October 2005

BOSTON UNIVERSITY SCHOOL of MEDICINE

Medical Education Committee, Subcommittees and Working Groups Retreat “Defining Our Direction”

October 14, 2005

NARRATIVE SUMMARY

Dr. McCahan, Associate Dean for Academic Affairs, opened the retreat by welcoming the 64 faculty and students who gathered at the Endicott House in Dedham to consider the direction in which the Medical Education Committee (MEC) should proceed during the next one to five years. He recounted the events that led up to the retreat and described the complexity of the day’s mission. He noted that Dr. Antman’s remarks (below) and the results of the questionnaire (to be reviewed) would serve as catalysts for the discussion. He introduced the facilitators for the day, Michele Gibbons-Carr and Gil Steil, and then introduced Dean Karen Antman .

Dr. Antman spoke about the centrality of the educational program to the mission of the medical school. She noted that the school would be establishing the John McCahan Scholars Program, an endowed program to fund young faculty members with an interest in education and a desire to direct their careers toward medical education. She then turned to the training of tomorrow’s physicians and the challenges associated with the explosion of information, continuing increases in cost, aging of the population, globalization of disease and complexity of care. Attention must be given to the socialization of new physicians and should be accompanied by early exposure to patient care, integration among the basic and clinical sciences, teaching by teams, expanded fourth year experiences that emphasize the sciences in medicine, and additional learning venues such as simulation experiences. She concluded by referring to student feedback that she had received to date which touched on multiple subjects including lecture time, the grading system, academic prerequisites and quality of life at the school.

Dr. Gibbons-Carr cited the results of the questionnaire that had been circulated to the entire faculty and student body. Six areas in need of greater emphasis were identified, 3 relating to the mastery of specific knowledge or skills and 3 describing key institutional activities. ([Click here for list](#)). The complete results from the questionnaire may be viewed at <http://www.bumc.bu.edu/mec/surveyresults/>

Dr. Gibbons-Carr and Mr. Steil described the “open space” process to be used in the retreat. The floor was opened for any faculty member or student to identify a topic about which he/she would like to lead a discussion. Sixteen topics were identified. Remaining students and faculty members joined any discussion group they wished to. Two rounds of discussions were held. The results of all sixteen discussions were briefly reported by each discussion leader to the entire group. The recommendations of the groups were then prioritized by vote of all participants, each participant casting 5 votes.

Originally, each discussion group wrote two sets of recommendations, one to be accomplished in one year and the other to be accomplished in 5 years. The recommendations receiving the most votes have been consolidated into a single list:

1. **Integrate the curriculum**
2. • Integrate horizontally (among concurrent courses) and vertically (among years)
 - Create clear, sequential learning objectives throughout the curriculum
3. **Enhance faculty development**
4. • Encourage and promote effective teaching skills
 - Increase recognition of faculty, residents, fellows and community faculty for exemplary practice

5. **Move to mission based funding**

- Improve transparency in reimbursement mechanisms

6. • Facilitate cross-departmental teaching

7. **Teach to the standard of care**

- Emphasize evidence based development of standards

9. **Promote self directed learning**

- Provide adequate protected time

The remaining sections of this report include the Dean's presentation, the subjects of interest identified in the pre-retreat questionnaire, and the written materials compiled during the retreat. Click on the item below to be taken to that part of the report.

If you would prefer a PDF version of the report, [click here](#)

1. [Listing of retreat attendees](#)
2. [Dean Antman's PowerPoint presentation](#)
3. [Significant issues identified by the questionnaire responses](#)
4. ["Open space" discussion topics and discussion leaders](#)
5. [Collected notes of each discussion group](#)

Attendees

Members of the Medical Education Committee

Members of the Preclinical Curriculum Subcommittee

Members of the Clinical Curriculum Subcommittee

Members of the Mission and Goals Working Group

Members of the Course Objectives Working Group

Members of the MD/PhD Program Working Group

Members of the Admissions Requirements Working Group

Representatives of the Graduate Medical Sciences Curriculum

Members of the Office of Student Affairs

Office of Medical Education Staff

Presentation by Dean Karen Antman

Slide 1

Boston University School of Medicine

MEC Retreat

Slide 2

John McCahan, M.D. Scholars

Slide 3

BUSM Missions

- **Education – raison d'être**
- **Research**
- **Care**

Slide 4

Curriculum Revision

What are the goals?

Training doctors for tomorrow's medicine

Slide 5

Trends in Medicine

- **Diversity and globalization**
- **Rx Cost considerations**
- **Aging population**
- **Quality of life**
- **Knowledge explosion**
- **Integrated health care teams**

Slide 6

Socialization of new physicians

- **Vocabulary**

- **Sleep deprivation**
- **Public presentations**
- **Comfort in a doctor patient relationship**
- **Thinking like a doctor**

Slide 7

Some Thoughts on Curriculum

- **Students are eager for clinical medicine. Why delay?**
- **Easiest to learn from patients & cases, even for first year students.**

Slide 8

Team teaching first & second year students

- **Integrate first year “sciences fundamental to medicine”: anatomy, histology, genetics, imaging, physiology.**

Slide 9

Team Teaching

- **Cardiac gross & microscopic anatomy, imaging, physiology, EKG vectors.**
- **Sports injuries: anatomy, radiology, orthopedics, rheumatology**
- **Renal failure: physiology, medicine, pharmacology,**
- **Colon cancer: public health, genetics, histology, anatomy, pathology, end of life issues.**

Slide 10

Team Teaching

- **Integrated curriculum**
- **Interdisciplinary faculty interactions**
- **Program project grants**

Slide 11

4th year Selectives: Back to the Class Room

- **Pharmacology**
- **Anatomy for aspiring surgeons Advanced ethics**
- **Evaluating medical literature (biostatistics)**
- **International Public Health (e.g. post primary care elective in India !)**

Slide 12

Grand rounds by discipline

Slide 13

Alternatives to Classroom Teaching

- **Web based enrichment**
- **Faculty-student textbooks**
- **Manikin simulation center**
- **NIH or Industry elective**

Slide 14

Student Breakfasts

- **Fewer lectures; more tutorials**
- **Some afternoons off**
- **Zip cars for ICM**
- **3rd year tutorials**
- **Fold extra costs into fees**
- **Marginal passes necessary?**

Slide 15

Student Breakfasts

- **Start August 5th**
- **Other schools can't poach our class**
- **Decompress Orientation: fewer lectures**
- **2 Week "Orientation to the Profession of Medicine"**
- **Boston & class mates: duck tour, museum, pub rounds, red sox game**

Slide 16

Pre Med Requirements?

- **Less organic chemistry, more biochemistry**
- **Less calculus, more biostatistics**

Significant Issues Identified by the Questionnaire Responses

As a measure of their competence, every graduate will:

1. Possess the diagnostic and management skills needed to deliver effective and efficient medical care (objectives 11-18)
2. Understand prevention, progression and scope of medical illnesses and (6) demonstrate knowledge of strategies for promoting health and preventing illness
3. Demonstrate the capacity to find and critically appraise scientific and clinical information – and (10) recognize and utilize the principles of evidence based medicine and their importance in clinical practice

The school will establish a strategy that

1. (62) Provides leadership in developing and applying and evaluating innovative methods of medical education (in developing recommendations consider ways to inspire innovation and/or innovative approaches that facilitate integration, case based and self directed learning)
2. (66) Recognizes and rewards excellence in teaching (68) supports faculty in teaching at the level of standard of care at all times (69) emphasizes and enhances the dedication and participation of faculty in the educational mission of the school (in developing recommendations consider strategies to enhance the status of teaching, provide incentives and support for teaching faculty, determine an equitable way to distribute financial and other resources to support the teaching mission)
3. Structures a systematic curriculum management process that links educational objectives to course/program content and design, teaching methods, measurement of student learning, faculty development and that supports a continual process of review and improvement

“Open space” discussion topics and discussion leaders

Click on a topic to see transcribed notes

Round 1 Topics

1. [How to promote teamwork and leadership skills among students](#) – Cindy Hsu, BUSM M.D./Ph.D.
- 2.
3. [Using mission based budgeting to promote innovation and excellence](#) – Kris Smith, BUSM IV
- 4.
5. [How to integrate clinical topics/teaching into the first year curriculum](#) – Janice Wiesman
- 6.
7. [Barriers to integration and solutions](#) – Wayne LaMorte
- 8.

9. [Reward and recognition for teaching](#) – Peter Shaw
- 10.
11. [Effective pedagogy in medical education](#) – Todd Hoagland
- 12.
13. [Professionalism](#) – Michael Grodin
- 14.
15. [How to promote self-directed learning](#) – Rebecca Grochow, BUSM II
- 16.
17. [Teaching at the standard of care](#) – Jeff Milunsky
- 18.

Round 2 Topics

1. [How can we use areas of concentration to broaden curriculum and decrease knowledge overload for individuals?](#) – Helen Hollingsworth
- 2.
3. [Effect of curriculum revision on other programs at BUSM](#) – Gwyneth Offner
- 4.
5. [Integrated curricula](#) – Sharon Levine, Liz Simons
- 6.
7. [Preparing for the USMLE Step 1 and other National Exams](#) – Wayne Moschetti ,BUSM III
- 8.
9. [Evaluating clinical skills](#) – Lorraine Stanfield
- 10.
11. [Practical approach to implementing change](#) – Nazia Jafri, BUSM III
- 12.
13. [Promoting cultural competency and diversity](#) – Miriam Shiferaw, BUSM III

Transcript of Each Discussion Group's Notes

1. How to promote teamwork & leadership skills among students – Cindy Hsu

Discussion Notes:

Current Problems:

Animosity/ barriers created by various pathways

Community with Teamwork = Leadership

Short Term Recommendations:

Decompress orientation

Hold student retreat/workshops

Randomize the groups (no more ABCs...)

Provide more social activities

Review the pathways

Review the academies – Is the peer advisor system working effectively?

Include issue of school housing in review

Initiate communication between PCS/CCS and a committee comprised of designees from:

Engineering/Medical Integrated Curriculum (ENGMEDIC), Modular Medical Integrated Curriculum (MMEDIC), Early Medical School Selection Program (EMSSP), Graduate Medical Sciences MA in Medical Sciences Program (GMS) and other alternate pathways.

Long Term Recommendations:

Review what departments and sections are doing to promote teamwork/leadership – cultural differences!!

Review what other medical, business, law schools are doing (*i.e.* , management workshops in business schools).

Promote team oriented case presentations!

Focus on development of presentation skills for faculty, students, residents/fellows

Establish an evaluative process to measure the outcome

2. Using Mission Based funding to promote innovation and excellence – Kris Smith

Long Term Recommendations:

Step 1 : Disentangle revenue streams

Create Database

How much teaching now?

What should it be?

Examine education costs

Step 2 : Promote transparency

Develop reimbursement formula

Step 3 : Evaluate teaching

3. How to integrate clinical topics/teaching into the first year curriculum – Janice Wiesman

Discussion Notes:

[Group identified current efforts of integration as follows:]

Anatomy- Clinicians more involved in planning and teaching preclinical curriculum

Histology- Symptom cases

ICM- Some basic science in clinical years.

IP- Involve residents and 4 th years.

Short Term Recommendations:

Have each clinical clerkship identify staff interested in participating in 1 st yr. courses. Provide time & financial support for those clinicians & having those people meet with relevant 1 st yr. course directors

Have 1st yr. course directors identify staff interested in rounding w/ ward teams. Provide time & financial support for those clinicians & having those people meet with relevant 1 st yr. course directors.

Long Term Recommendations:

Continue curriculum vertical integration project.

Involve residents in teaching

4. Barriers to integration & solutions– Wayne LaMorte

Discussion Notes:

[Items listed below were solicited in an initial brainstorming section by the group]

- Multiple Programs (Paths to BUSM)
- - How do you take a part of an integrated curriculum e.g., “Histology” for 7yr GMS or stopping/starting for MD/Ph.D.
- How do we organize an integrated curriculum. (We are a department-based institution).
- - Salary
 - Promotion
 - Common interests and discipline
- Scheduling Meetings (clinicians/basic) for Vertical Integration.
- It's a lot of work and takes time .
- Identifying what models work best (evidence).
- Time for planning plus time for implementation.
- How to organize the clinical “cases” and organizing the basic information linked to the cases
- We are changing what we want to teach
- USMLE! Would scores be worse? Better?
- How do we test/evaluate student progress? (Multiple choice may not be adequate).
- \$\$\$\$\$\$\$\$\$\$
- We need oversight/direction to guide the process because of complexity.
- It's big and complex
- It's not just science (society, culture, ethics)
- How do we measure success?
- Loss of understanding of fundamental principles and concepts.

- We don't know what's being discussed in all the subcommittees (MEC, PCS, CCS, COWG, MGWG).
- What about the rest of the faculty? (not here today –You need buy-in and cooperation esp. among basic and clinical faculty)
- Teaching doesn't generate revenue.
- Who decides who the course managers are?
- Need to teach teachers how to teach in a new way

Long Term Recommendations:

Note: A 5-yr program of integration may be too fast. One doesn't have to exclude lectures & "basic" teaching

Create and support useful organizational structures "Vertical Integration Group" – Body, Mind, Neoplasia

Establish and foster mission-based financing

- foster buy-in and cooperation and provide resources
- re-focus and reward the teachers/recognize good teaching

Redirect of money by Dean

- fight for a tax on clinical income

Maintain tight cost accounting and time accounting

- resources <-> effort

Make a battle plan, task out the pieces.

5. Reward and recognition for teaching – Peter Shaw

Discussion Notes:

- Centralized support for coordinating/administering lex (part is faculty development.)
- " Academy of Educators "
- - Mentoring
 - \$ support
 - Faculty Development
- Clinician Educator Track for Promotion
- Development of online faculty development (modules) – directory of resources for help with course development.
- Transparency in \$ teaching support coupled with evaluation.
- Mission based funding for teachers
- Recognize administrative full time equivalent (This sometimes happens).
- - Teaching
- How do you use funding stream to ensure in teaching clinic release time (in kind enough?) (\$\$\$)
- Teaching excellence

- ◦ Publicized awards
 - Scholar support (Conferences, Stanford, Harvard Medical School)
 - MA in Medical Education (endowment)
- Departmental Award System and BUSM-wide System
- ◦ Increase little awards to:
 - ■ Faculty
 - Attendings
 - Residents
 - Fellows
 - Community Preceptors
- Increase Mentorship Teaching
- Dean's Vision/ Dept. Chairs Vision
- ◦ \$\$\$
 - Product/Skill Set (a mystery)
 - Community Preceptors

Short Term Recommendations:

Increase # teaching awards for:

- faculty
- residents
- fellows
- community faculty

Establish teaching track to promotion

Institute educational funding transparency

- each dept. release time for teaching
- each dept. require teaching of faculty

Have Dean tie educational funding of departments to specific personnel, products (esp. type of graduate).

Long Term Recommendations:

Continue to promote transparency of Dean's funding and department accountability for same.

Establish scholarship programs for educator faculty

Establish a teaching track for promotion fully endorsed by Dean

Adopt a Masters of Medical Education Program for both faculty & students

6. Effective Pedagogy in medical education – Todd Hoagland

Combined Short and Long Term Recommendations:

Decrease ineffective lecture time while increase effective small groups

Include more effective lecturing and less overall contact time

Allow students more time to pursue self directed, life long learning.

Include 4 th year student facilitators

Incorporate clinical advising for basic science classes.

Provide more teaching development.

Evaluate teaching effectiveness via student & faculty oversight.

7. Professionalism – Michael Grodin

Discussion Notes:

- How do you define it?
- How do you define goals & objectives?
- How do you convince/convey to students its importance?
- Where do you teach it?
- How do you teach it?
- How do you measure it?
- How do you give feedback/remediate?

Character Confidentiality EPH

Virtue – Honesty Rules & Regulations EPH

Trustworthiness Professional Responsibilities EPH

Ethics EPH (HIPPA, Malpractice, etc.)

Communication ICM

Collaboration/Teamwork

Responsibilities – Patients & Physicians

Service/Sacrifice

Understanding Systems

Advocacy/Equanimity

Recognition & remediation of conflicts of interest

Boundaries

Appropriate Dress

How (Where) is it currently being taught?

EPH – Didactics

ICM – Clinical/Practical Applications

Clinical Rotations

Role Modeling

Didactics/Cases

Summary:

How could we do it better?

Clinical cases that integrate some of the didactics taught in 1 st 2 years

Specific role modeling

Conclusions:

There is a need for a more formal & integrative curriculum on professionalism across the curriculum.

There is a need for a standard for assessment/feedback/remediation.

There is a need for a cultural shift amongst faculty/residents.

Recommendations:

Need specific 4 yr. curriculum that addresses professionalism.

Faculty and resident training on effective modeling across clerkships.

Need an assessment & feedback tool/mechanism.

Need a more standard/robust plan of remediation.

Short Term Recommendations:

Create and Implement a 4 Year curriculum that addresses professionalism

Establish and provide Faculty and resident teaching on modeling professionalism.

Long Term Recommendations:

Acquire a shift in mindset about importance of professionalism amongst faculty/residents (within the general Medical School environment).

8. How to promote self-directed learning – Rebecca Grochow

Discussion Notes:

Decrease Lecture (Passive Learning)

***Improve EBM education**

Finding Information

Evaluating Information

Formulating Clinical Questions

Required Electives (1 st , 2 nd) 3 rd year

*** Protected time for self-learning**

Longer lunch

Problem sets with clinical vignettes

Eliminate syllabi/add clarify learning objectives

Pass/Fail 2 nd year

- Protected afternoons

Add Biochemistry as a Premed requirement

Decrease amount of Organic Chemistry, Genetics? and Biostatistics?

- Eliminate content

Decrease Biochemistry

Eliminate overlap through integration and coordination

- Teach IP Case w/Papers (Submit search and references),
- EPH Stats w/ Study review

1 hr. follow-up tutorial with case/paper evaluation

- Clinical Setting

Requirement of coming in with primary reference

Encouraging/facilitating questions

Students need to clarify expectations – make okay to ask what do I need to excel in this rotation

3 rd Year Orientation (Use students)

Asking Good questions

Decrease Advance Cardiac Life Support (ACLS)

Clarify hidden curriculum

Encourage students to clarify expectations

How to Promote Self Directed Learning- Rebecca Grochow – continued

Combined Short and Long Term Recommendations:

Establish protected time for self learning

Decrease passive learning (i.e ., lectures)

Eliminate syllabi (course, content) and clarify learning objectives

Improve EBM education

Increase clinical vignettes based problem sets

Facilitate self-directed learning in clinical years

9. Teaching at the Standard of Care – Jeff Milunsky

Discussion Notes:

- Some Insights:
- Introduce concept of standard of care into each clinically relevant subject.
- Pairing clinical/pre-clinical course managers
- Web site for updated standard of care with links to clinical sites (i.e ., ACOG, etc.)
- Vertically integrated with residency teaching.
- 1-Day CME course on current standards of care in multiple diff. specialties for:
 - Faculty
 - Community Faculty
 - 4 th year students
 - Residents
 - Fellows

- Continuing Medical Education Course
 - Provide risk management credits
 - Modeling for students/residents RE: cont. self-learning.
 - Teaching “better” medical care
-
- Conclusions
- Concept of Standard of Care not formally taught or successfully integrated at this time.

Short Term Recommendations:

Develop a CME Standard of Care one-day course

- Include each department/major section (each to present ~ 15 min. – will foster continuing self-learning/modeling)

Introduce concept of standard of care not just as topic but integrate concept of how to use learned material to practice medicine

Create a website with links to already created sites of standard of care

Long Term Recommendations:

Incorporate evidence based standard of care and periodic review at all levels of the formal teaching curriculum.

Continue faculty development/ Foster cultural issue of staying current.

Make tutorials/lectures – i.e. proposed course of CME standard of Care – mandatory (2 years)

10. How can we use areas of concentration to broaden curriculum and decrease knowledge overload for individuals? – Helen Hollingsworth

Discussion Notes:

Insights: “Information overload” is mix of

- (1) too much information
- (2) difficulty coping/managing
- (3) frustration at not “getting it” (poorly presented material)

Need to reduce core of information maybe 20-25%.

Can’t go too far because of standardized tests.

Short Term Recommendations:

Reduce core curriculum by examining objectives of courses

Take time liberated from core to put into selectives (individualized learning)

Develop team & problem based course where individuals would contribute to problem solving by bringing back information from selectives

Long Term Recommendations:

Improve quality of life/decrease stress through decreasing amount of info.

Maintain board scores

Individualize educational goals and (possibly) create selectives to explore special interests – BUT bring knowledge back to team (?IP).

Broaden knowledge base of school/class.

Bring knowledge from selective back to group – learn to present.

11. Effect of Curriculum Revision on other programs at BUSM – Gwyneth Offner

Discussion Notes:

[Items listed below were solicited in a brainstorming section by the group]

- Lack of Representation of GMS/ MMEDIC etc. on Curriculum Committee
- GMS -Preparatory vs. Equivalency
- \$\$\$\$\$
- Who is in charge?
- Dr. Franzblau?
- Who else?
- How to Integrate Input from Different Programs into Changes in Medical School Curriculum
- Pathways incorporated into draft proposal.
- Add representatives to PCS/CCS?
- Carl generate committee (separate) to review MEC proposals.
- All pathways **NOT** just GMS
- Separate vs. Committee?
- Focus on Early Medical School Selection Program (EMSSP)
- Applicants want innovation!
- Problem: Med. Students vs. Pathway students
- Investigate separate programs for GMS students. Students would like this!
- This is being dealt with:

- Pass/Fail
- TAs
- Applicants want innovation!
- Equivalent Courses are Necessary for Different Pathways

- Engineering/Medical Integrated Curriculum(ENGMEDIC), Modular Medical Integrated Curriculum (MMEDIC), Early Medical School Selection Program (EMSSP), Graduate Medical Sciences MA in Medical Sciences Program (GMS) on new committee and 1 member from PCS

- MD/PhD? -Changes on MEC Recommendations
- Restructure IP groups
- All students – 2 yr. Med. School and “block” during Ph.D. yrs.
- Training in clinical research required for MD/PhD.

- Respond to changes in Medical School OR Be part of changes.

Short Term Recommendations:

Initiate communication between PCS/CCS and “alternative pathway” curriculum committee (to be formed).

12. Integrated Curricula – Sharon Levine, Liz Simons

Discussion Notes:

- Clinicians involved in pre-clinical curriculum development and basic science. in clinical curriculum over 4 years
- “Manpower” issues (recognition of teaching)
- Create balance between basic science and clinical medicine
- Vertical integration with a shift toward case-based teaching would better focus basic science teaching and, at the same time, stress its relevance to clinical practice.
- Spectrum
- Problem solving from day 1
 - Basic Science and clinical integrated from get go
- Integration helps focus on what’s important in the curriculum (repetition is the key to success).
- Incremental vs. overhaul
 - Incremental is temporizing with a new (move?) toward full integration in 5 yrs.
 - Task force for incremental change
 - Task force for integration

Conclusions:

- One Year Plan:
- Group to look at clinical integration *Students/clinicians/basic science 1 st 3 semesters
- Draw clinical faculty into current basic science to give clinical relevance

- Look at programs who have accomplished integration
- Clinicians read syllabi of basic science/ preclinical
- Five Year:
- ?Full Basic Science/ Clinical integration (Columbia a non-med. Model)
- Entering class has new curriculum
- Total integration can be accomplished with a 5 year plan involving “examination of other programs with field trips”.
- Task Force formed now with a view towards implementation. in 5 years.
- Need to start basic science. <-> clinical supplement now as incremental change. Task force for this – relationship building
- 2 task forces – Incremental change and overall dramatic change

Insights (Key pieces): Faculty recognition basic science./clinic.

Review syllabi

Clinician input into preclinical curriculum

Get basic science folks into clinical years

2 task forces formed

Commitment from top down

Total faculty buy-in (Student Representatives)

Resources \$\$\$\$\$ and personnel

Integrated Curricula – Sharon Levine, Liz Simons – continued

Short Term Recommendations:

Form two task forces

- Full integration
- Interim integration

Identify other programs who have done curriculum change

Begin working on faculty buy-in

Conversation between basic sciences and clinical sciences – Course syllabi

Involve discussion of incentives for task forces

Long Term Recommendations:

Have established a fully integrated basic science and clinical curriculum w/ clear learning objectives

Establish a task force to continue reviewing process with the existing integrated curriculum

Build in an assessment of this reviewing process

Continue to improve and provide input

13. Preparing for the USMLE Step 1 & other Nat'l Exams – Wayne Moschetti, BUSM III

Short Term Recommendations:

Provide more administrative support to basic science departments to communicate relevant clinical board information that students will encounter

Use Q bank, first aid type resources

Incorporate more "board type" questions into exams not just multiple choice but increase clinical vignettes.

14. Evaluating Clinical Skills – Lorraine Stanfield

Short Term Goals:

Identify (list) essential clinical skills

Assign (list) responsibility for teaching each skill.

Assign (list) responsibility for evaluating each skill.

15. Practical Approach to Implementing Change – Nazia Jafri, BUSM III

Short Term Goals:

Expect participation of faculty in formal faculty development mechanisms already in place (*i.e.* , Gail March)

Tie teaching performance to promotion and contract renewal (incentives for basic scientists) with consequences for poor teaching.

Create 2 Committees that take results from today and advise recommendations in 4 months

- Blue Sky: Radical Change
- Greener Pastures: Incremental Change

Establish continuous quality improvement: with robust, measured goals – (i.e. Nebraska – goal to improve Step 1 scores).

Establish more opportunity for student teaching

Continue with plan for 4 th year – Have students return to teach in preclinical years.

Long Term Goals:

Facilitate and monitor continuous quality improvement w/ robust, measured goals

Continue to establish opportunities for and monitor student teaching

16. Promoting Cultural Competency & Diversity – Miriam Shiferaw, BUSM III

[Items listed below were solicited in a brainstorming section by the group]

- Brought up only twice in first two years.
- Too much stereotyping.
- Student/resident diversity does not reflect/have bearing upon patient diversity
- Office of Minority Affairs
- Academies of Advisors
- Content in lectures/cases
- Role modeling – clinical experience.
- Tolerance/understanding in team based situations.
- Training preceptors; faculty development.
- Committee to study the facts of culture/diversity ethics.
- Culture based lectures in clerkships.

Long Term Recommendations:

Teach faculty about the diversity of the student body

Form committee to build a foundation of facts/data on culture/diversity ethics

Refocus the Office of Minority Affairs for a larger student population

Use IP and ICM to facilitate discussion of cultural topics & interviewing with an interpreter.

Retrun to top of report