GEISEL SCHOOL OF MEDICINE
AT DARTMOUTH

MEDICAL EDUCATION COMMITTEE (MEC) MEETING

TUESDAY, OCTOBER 15, 2013
4:00 – 5:30 PM DHMC
AUDITORIUM G

MINUTES

Voting Members		Voting Members		Non-voting Members		Non-voting Members	
Ahmed, Yashi	X	Johansen, Sarah G.	X	Comi, Richard	--	Lyons, Virginia T.	X
Abdelghany, Mazin T.	--	Madden, Dean R.	X	Cousineau, Laura K.	--	McAllister, Stephen B.	--
Barnes, Jonathan A.	X	Manning, Harold L.	X	Davis, Ann J.	--	Noble, Geoffrey P.	X
Bay, Jessie	X	Nierenberg, David W.	X	Dick.III, John.F.	X	Reid, Brian P.	X
Black, Candice	--	Reed, Virginia A.	X	Eastman, Terri L.	--	Shoop, Glenda H.	X
Boyce, William	X	Rees, Christiaan A.		Fall, Leslie H.	--	Stewart, Cynthia L.	X
Tiffany, Brazile, M	X	Shah, Krina S.	X	Grollman, Diane W.	X	Todd, Frances M.	--
Burchard, Kenneth W.	X	Simons, Richard J. (Chair)	X	Hahn, Cynthia K.	--	Trietley, Kalindi E.	X
Colby, Benjamin S.	X	Supattapone, Surachai	X	Jaeger, Michele W.	--		
Freemantle, Sarah	X	Usherwood, Edward	X	Lahey, Timothy	X		
Hyde, Robert	X	Weinstein, Adam	X				

Guest(s)	
Adrales, Gina	Kidder, Tony M.

Present = X Absent = --

1. **Call to Order -** *Richard Simons, MD*

   Dr. Richard Simons, Chair, called the meeting to order at 4:05 pm.

2. **Approval of August meeting minutes**

   Dr. Surachai Supattapone made a motion to approve the September minutes. The motion was seconded by Dr. Sarah Johansen. The motion passed by a unanimous vote.

3. **Announcements -** *Richard Simons, MD*

   - November 22, 2013 – Joseph C. Kolars, M.D., **Senior Associate Dean for Education and Global Initiatives from the** University of Michigan's School of Medicine will present at Medicine Grand Rounds. He will focus his

presentation on how medical education relates to global health. Presentation begins at 12:15 pm. The room has not been announced.

- Dr. Simons is establishing an Assessment Council. The role of the council is to guide and support decisions regarding the assessment plan for the new curriculum and beyond. The group will be an advisory and strategic group whose work will supplement the work done by the MEC.

4. Essential Clinical Conditions – *John Dick, MD*

Dr. John Dick led the discussion about the school's targets for the essential clinical conditions that students are expected to achieve. Two points were made regarding the current target for the number of times a student experiences a clinical encounter related to an essential clinical condition: (1) the number assigned to each essential clinical condition was made arbitrarily by the CECD and MEC; and (2) the current targets can place the school in a precarious position with the LCME if the targets are not met. The members debated the value of setting targets, even if the targets are set at the level of the clerkship, rather than being set by the MEC, and whether the targets prioritizes the conditions. The level of student responsibility in the clinical condition (observe, assist, etc.) was also discussed. The language for the level of responsibility will be discussed further at another MEC meeting.

Dr. Dick made a request, on behalf of the CECD, to remove the targets for the number of essential clinical conditions.

A motion was made by Dr. Adam Weinstein to approve the CECD request to remove the targets for the number of essential clinical conditions (the required number for each experience), and focus on the essential clinical condition itself. The motion was seconded by Dr. Harold Manning. A vote was taken, and the motion passed by a majority vote. There was one dissenting vote.

5. Surgery Clerkship Review – *John Dick, MD*

Dr. John Dick reported the findings from the surgery clerkship review (refer to Attachment A, p. 5).
Dr. Gina Adrales, surgery clerkship director, presented the action steps that will be taken in response to the findings (refer to Attachment B, p. 14).

Dr. John Dick proposed to revise that acute respiratory failure is co-owned by surgery, medicine, and pediatrics clerkships. Respiratory failure will be listed as an essential clinical condition for the three clerkships. There was a debate among the members if essential clinical conditions should be cross-referenced. Dr. John Dick will follow up on this proposal, and come back to the MEC with a plan.

A motion was made by Dr. Harold Manning to accept all recommendations in the action plan for the surgery clerkship with the exception of the issue regarding acute respiratory failure. The motion was seconded by Dr. Surachai Supattapone. A vote was taken, and the motion passed by a unanimous vote.

6. Overview of Competency Based Education – *Richard Simons, MD*

Dr. Richard Simons gave a presentation on competency-based education. The overview was given to update the MEC members on issues and topics implicated with the new Geisel competencies. In a competency-based education, schools must think about the needs of the health system and patients, and then develop competencies and outcomes for the learners.

What's to be learned with the competency-based movement:

- Standardization of language for competency domains
- AAMC issued a taxonomy of competencies in August 2013

Robert Englander, MD, MPH, Terri Cameron, MA, Adrian J. Ballard, Jessica Dodge, Janet Bull, MA, and Carol A. Aschenbrener, MD, (August, 2013) *Toward a Common Taxonomy of Competency Domains for the Health Professions and Competencies for Physicians*. Academic Medicine, 1088-1094.

- Looking forward, schools are going to be asked to map their competencies to the AAMC's competencies (the national standards).
- Assessment is critical in a competency-based curriculum; the full range of competencies must be assessed
- Outcomes drive curriculum

7. Discussion of Proposed New Geisel Competences - *Richard Simons, MD*

The proposed Geisel competencies, and program objectives written for each competency (Attachment C, p. 18) were discussed, specifically focusing on the following broad issues:

1) An emphasis on population versus personal practice (the new competencies seem to lean heavily on population-based practice);

2) Competencies and program objectives unique to the physician (are the new competencies and program objectives different from those of a nurse practitioner and physician assistant); and,

3) How the new Geisel competencies and program objectives relate to the new competencies and program objectives released by the AAMC.

The competencies of medical knowledge and clinical care are where the greatest distinction can be made to show the uniqueness of a physician education.

Going from six competency domains (the Dartmouth competencies) to eight competency domains (the new Geisel competencies) is reasonable as we look forward to a new curriculum, and align our competencies with the AAMC. A suggestion is to make the Geisel competencies as close as possible to the AAMC competencies.

There was general agreement that the competency named Population Health should remain as a stand-alone competency. This is distinctive to Geisel, and should be called out as something distinguishing. Geisel's Population Health program objectives are most likely included in the AAMC's competencies.

A decision was made by the MEC members to send the MEC feedback to the Curriculum Redesign Leadership Team (CRLT) subgroup for further review and revisions. The revised document will be sent out to the MEC before the next meeting if the subgroup can convene in time. Mapping the Geisel competencies and program objectives to the AAMC's should be done to show any major gaps.

8. Proposed Curriculum Design Timeline - *Tim Lahey, MD*

Dr. Tim Lahey discussed the timeline for course proposal reviews by the MEC.

- The course design teams are currently working on the course learning objectives. They will then move into assessment, and follow with the syllabus.
- The directors will prepare the course proposal for presentation to the MEC.
- All courses in Phase I will need MEC approval.
- MEC must review the course objectives separately.
- Course objectives will be completed in November.
- The course objectives will come before the MEC in December and January.
- April is targeted to begin the formal course proposal review (sessions, faculty names, and session dates will not be on the proposal) – Foundations of Medicine will be first. This formal review of all the courses will extend into AY 15-16.
- Course directors were encouraged to take the objectives to the relevant departments for departmental input before the MEC review.

The curriculum framework was approved by the MEC. One issue that was raised is the likelihood that the MEC will endorse the entire curriculum package if Phase 1 begins before all the courses are approved by the MEC.

The course proposal form has been created for the review process. Dr. Lahey will distribute the proposal to the MEC members.

The full faculty vote for the new curriculum was deferred. This vote will not be done in time for April when the Admission's office needs information on the curriculum. A suggestion was made to use the curriculum template that was approved by the MEC.

9. Student Representative Comments

None reported

10. Other Business

None reported

Adjournment

Dr. Simons adjourned the meeting at 6:06 pm.

To Do

- Convene a CRLT subgroup meeting and revise the new Geisel competencies (Glenda Shoop)
- Distribute the course proposal form to the MEC members (Tim Lahey)

Future Meeting Dates (Third Tuesday of each month, 4:00-5:30 pm)

- December 17, 2013
- January 21, 2014
- February 18, 2014
- March 18, 2014

Prepared by: Glenda H. Shoop
Date: November 8, 2013

Appendix A

Surgery Clerkship Review

MEC subcommittee: 8/29/13

Geisel Competencies -> Course Learning Objectives -> Assessment of Learning -> Learning Activities

Course Description:

8-week block with 7 weeks of clinical time. The student rotates on two separate services for 3.5 weeks each, including one required rotation on a general surgical service, and a second rotation on either a surgical subspecialty service (thoracic, urology, orthopedic, otolaryngology, and cardiac surgery) or on another general surgical service of the student's choosing. Four sites used including DH, Concord, VA and Mt. Ascutney.

Course Objectives

Course Objective	Geisel Competency	How Assessed	Learning Activity
Apply appropriate knowledge developed from critically relevant, consensus based literature to the delivery of surgical care.	1a, 5a, 5b	NBME shelf exam, Ward Evaluation	Patient Care; OR involvement; Weekly sessions
Apply current clinical and translational sciences, outcomes and quality measures in the diagnosis and treatment questions in the delivery of surgical care of the patient.	1c, 1d, 5c, 5d	Ward Evaluation, Oral Exam	Patient Care; Weekly sessions
Recognize and define knowledge of surgical diseases that demand risk factor modifications, end of life decisions, palliative care, pain management, medical legal issues and substance abuse.	1e	NBME shelf exam, Ward Evaluation	Patient Care; Weekly Sessions
Communicate effectively with patients and families of different social, economic and cultural backgrounds, or when special needs or barriers to communication exist, particularly in the areas of individual health, or factors that may impact health and informed consent.	1f, 3c, 6j	Ward Evaluation, Oral Exam, Patient Simulation	Patient Care, Patient Simulation
Perform professional responsibilities by establishing respectful relationships; e.g. student-patient,	2a,3a,3b,4a,4b,4e	Ward Evaluation, Oral Exam, Patient	Patient Care

student-family, colleagues, and all members of the health care team. Professionalism also includes respect for diverse patient concerns, opinions and cultural perspectives, with respect to the basis for the doctor-patient relationship.		Simulation	
Interview patients skillfully, perform a complete physical exam with attention to infection control, patient comfort and privacy in order define and prioritize the patient's problems and organize a differential diagnosis.	2b,2c,2d,2e	Ward Evaluation, Oral Exam, Patient Simulation	Patient Care; patient simulation
Identify, define and perform the indications, complications and limitations of simple clinical procedures; e.g., suturing, foley placement, etc., and assist in common surgical interventions; e.g., laparoscopy, chest tube placement, abdominal exploration, etc.	2f,2g,2i	Ward Evaluation, Passport	Patient Care, Knot tying session; Simulated foley, NGT
Interpret without assistance common abnormalities and urgent findings on common diagnostic tests and studies; e.g., chest x-ray, abdominal series, CT scan, ECG, etc.	2h	Ward Evaluation, Passport	Patient Care, CORE cases; Weekly Sessions
Demonstrate the ability to assist patients in understanding their treatment options and motivating them to make healthy behavioral and treatment choices.	3d	Oral Exam, Patient Simulation	Patient Care, Patient Simulation
Communicate effectively and collegially with physician colleagues and other members of the health-care team verbally, in writing and in the electronic medical record.	3e,3f,3g	Ward Evaluation, Oral Exam	Patient Care, Write Ups
Demonstrate responsibility for his or her own medical education, develop the habits of mindfulness, reflection, and continuous learning by adhering to high ethical and moral standards, accepting responsibility for personal actions, incorporating constructive criticism and respecting patient confidentiality.	4d,4f,4g,4h,4j	Ward Evaluation, Self Assessment	Patient Care; Weekly Sessions

Identify and utilize appropriate resources to support patient care and collaborate with all members of the inter-professional team.	6a,6b,6d	Ward Evaluation	Patient Care, OR
Removed last Objective			

Essential Skills/Conditions

Year 3: SURGERY CLERKSHIP				
10 ESSENTIAL CLINICAL CONDITIONS	LEVEL OF STUDENT RESPONSIBILITY	CLINICAL SETTING	% students meeting at least 1	Alternative learnrning experience
Shock or SIRS	Assist	Inpatient	98	
Fever, post-op	Manage	Inpatient	97	
Pain management	Manage	Inpatient	100	
Surgical evaluation of cancer patient	Assist	Inpatient	98	
Post-operative care	Manage	Inpatient	100	
Abdominal pain	Manage	Inpatient	100	
Abdominal trauma	Assist	Inpatient	92	
Peritonitis or intra-abdominal abscess	Assist	Inpatient	100	
Bowel obstruction, large or small bowel	Assist	Inpatient	98	
Acute respiratory failure	Assist	Inpatient	94	
16 ESSENTIAL CLINICAL SKILLS				
Interpret CT scan of the abdomen/pelvis or chest	Perform	Inpatient	100	
Interpret Ultrasound of the abdomen	Perform	Inpatient	99	
Interpret X-ray (KUB) of the abdomen	Perform	Inpatient	100	
OR/intra-abdominal surgical procedure	Assist	Inpatient	100	
Trauma resuscitation in the ER	Assist	Inpatient	98	
Insert a foley catheter	Perform	Inpatient	100	
Inject a local anesthetic	Perform	Inpatient	99	
Place an NG tube	Perform	Inpatient	98	
Suturing (simple, skin)	Perform	Inpatient	100	
Remove sutures or staples	Perform	Inpatient	98	
HPI relevant to this clerkship	Perform	Inpatient	100	
Abdominal exam	Perform	Inpatient	100	
Trauma exam and evaluation	Assist	Inpatient	100	
Wound evaluation	Perform	Inpatient	100	
Orally present a patient admitted to hospital	Perform	Inpatient	98	
Write an admission note	Perform	Inpatient	98	

Learning Assessment Tools:

1) DMEDS – Assess progress on meeting essential skills and conditions
2) Essential Skills Competency Form – Students assessed as meeting level of skill expected of 3rd year
3) Clinical Performance Evaluation Form – Competency based assessment, completed by faculty learning leader
4) NBME subject matter exam
5) Rotation specific quiz
6) Oral Exam
7) Case Presentation with feedback from students/faculty
8) Mid-clerkship feedback form
9) Mid-rotation feedback (Write up feedback?)

Feedback:

The student's receive mid-rotation feedback at weeks 2 and 6 with their designated attending faculty member, mid-clerkship feedback with a clerkship co-director at week 4, and final evaluation at the end of the clerkship.

Grading:

- 20% NBME Shelf
- 40% Ward Performance – From faculty learning leaders based on conversations with residents/attendings
- 30% Oral Exam – 3 parts (present own case, demonstrate informed consent, respond to case)
- 10% Professionalism / Assignment completion – CORE cases, presentations, DMEDS recording, self-assessment, time card
- 0-5 % additional given for performance on rotation based exams (2)

Learning Environments / Activities

- **Orientation**
  - Knot Tying skills
- **Ward and OR based experience on Surgical Teams**
  - 3.5 weeks per team; "General" and subspecialty/general
- **Weekly Sessions:**
  - Students have one 3 hour academic session per week over 6 weeks. These are run by the clerkship directors and invited faculty. 3-8 case studies per week are used to engage students and prompt discussion.
- **Online CORE cases:**
  - 4 online radiology cases taking about 30 min each.
- **Student presentation:**
  - 10 minute case presentation given during the clerkship and reviewed by faculty and students
- **Outpatient clinic / ED:**
  - 4 hours per week expected - passport

- **Night Call:**
  - 4 calls per block.
- **Write Ups:**
  - 1 -2 per week handed in to learning leader
- **Self Study**
  - Textbook provided
  - Case based review

Session Objectives

On Blackboard:

Session Name	Session Objectives: At completion of this session/experience, a student will be able to:
Abdominal Pain Small Group / Case Studies	Define the different characteristics of visceral and parietal pain.
	Describe the neurologic pathways for this pain.
	Interpret the implications of pain in an acute abdomen for surgical decisions.
	Describe location of pain and how that would inform your differential diagnosis.
	Define referred pain.
	Outline pain management strategies.
	Demonstrate independent learning initiative to prepare for group / case studies.
Oliguria Small Group / Case Studies	Describe the clinical features of oliguria.
	Explain the etiologies of oliguria.
	List the testing that would differentiate the etiologies of oliguria.
	Describe the most efficient and cost effective modalities in making a diagnosis.
	Implement a treatment plan for the treatment of oliguria.
	Demonstrate independent learning initiative to prepare for group / case studies.
Fluid and Electrolyte Small Group / Case Studies	Describe the electrolyte composition of various body fluids as compared to serum.
	List pathology or interventions that would uniquely disrupt various fluid compartments.
	Define the common available intravenous solutions.
	Implement an appropriate IV therapy for common electrolyte disturbances.
	Explain the difference between crystalloid and colloid fluids.
	Demonstrate independent learning initiative to prepare for group / case studies.
	Explain the difference between resuscitative and maintenance fluids.
Fever Small Group / Case Studies	Describe the post-op fever work-up.
	Describe the physiologic basis for fever.
	Develop a differential diagnosis based on case scenarios.
	Interpret how surgical intervention or patient disease may modify fever response.
	Demonstrate independent learning initiative to prepare for group / case studies.
	Identify unique surgically modified infections.
Wound Healing Small Group / Case Studies	Identify factors that influence wound healing.
	Describe interventions that can modify wound healing.
	Describe the wound classifications for closure.
	Demonstrate independent learning initiative to prepare for group / case studies.
	Describe at a physiologic level the wound healing process.
Surgical Metabolism	Define the various forms of malnutrition.
	Describe the basic nutritional elements required for replacement.

and Nutrition Small Group / Case Studies	Demonstrate independent learning initiative to prepare for group / case studies.
	Describe the pros and cons of enteral or parenteral approach in nutritional replacement.
Human Response to Injury/infection TBL / Case Studies	Describe the inflammatory cascade.
	Define specific organ response to inflammation.
	Describe the pathophysiology of systemic inflammation.
	Identify organ specific therapies for injuries and inflammation.
	Define imaging modalities to identify inflammation.
	Demonstrate independent learning initiative to prepare for group / case studies.
	Recognize laboratory markers for inflammation.
Suture Skills Workshop	Demonstrate suturing techniques.
	Identify wound care issues, and approach to wound closure, e.g. anesthesia, cleansing, and forms of closure.
	Execute knot tying.
Oral Skills / Peer Review Seminars	Communicate case information clearly, concisely, efficiently.
	Demonstrate effective communication with physician colleagues.
	Demonstrate an ability to communicate with colleagues collegially in a peer review process.
	Interpret non-verbal communication skill strengths and weaknesses.
Patient Care Experience	Recognize the different focus for patient care within the inpatient, ambulatory, emergent, and operating room environments.
	Demonstrate efficient interviewing and physical exam skills.
	Organize an appropriate differential diagnosis.
	Give a concise oral presentation of findings and evaluation.
	Describe the informed consent process.
	Participate as a member of a health care team, working with staff and patients.
	Exhibit professional conduct and communication with patients during interviews, counseling and care planning.
	Identify gaps in knowledge and skills utilizing DMEDS entries, self-assessment, and feedback.
	Document patient care thoroughly, accurately and concisely.
	Recognize the ambulatory setting as an active learning and self-assessment opportunity.

Ilios also contains:

Ambulatory experience; inpatient experience, night call, or experience, grand rounds, m and m, online cases, tumor board, path conferences

Course Planning

- **Educational Team Structure**
  - Two clerkship co-directors
  - Clerkship Advisory Board – chair, rotation advisors
  - One Clerkship Coordinator
- **Self –Review/ Planning Methods**
- **Method and Frequency of Coordination with Non-DH sites**
  - **Annual – in person**
  - **Clerkship Advisory**
- **Faculty Preparation**
  - **Annual teaching session**

- **Annual clerkship guide**
- **Faculty learning leader retreat 2 x per year**

- **Resident Preparation**
  - Two interactive and documented didactic sessions are held annually to inform residents of the clerkship objectives and to foster a culture of learning.

Duty Hours

Violations by Quarter:

Q1: 15*

Q2: 6*

Q3: 9

Q4: 1

Time card carried by student

*Many of these reports were due to a misunderstanding of the Geisel Policy on the part of the students as evidenced by their comments.

Clerkship Outcomes

NBME Shelf Scores

Avg NBME Raw Score		
2010-11	**2011-12**	**2012-13**
Geisel: 78.3 Nat: 74.7	Geisel: 78.5 Nat: 75	Geisel: 79

AAMC GS 2013 Questionnaire

Surgery

Surgery: I received clear learning objectives for the clerkship

Dartmouth-Geisel	2009	8.2	8.2	14.3	36.7	32.7	3.8	49
Dartmouth-Geisel	2010	0.0	9.6	12.3	38.4	39.7	4.1	73
Dartmouth-Geisel	2011	5.2	10.3	6.9	55.2	22.4	3.8	58
Dartmouth-Geisel	2012	4.7	9.4	6.3	48.4	31.3	3.9	64
Dartmouth-Geisel	2013	5.7	5.7	18.2	38.6	31.8	3.9	88
All Schools	2013	1.5	4.4	8.5	42.7	42.9	4.2	14,001

* Note: Respondents had the option to select "Not Applicable"; these responses are not included in the report calculations and counts.

2013 Medical School Graduation Questionna

AAMC

8. Indicate whether you agree or disagree with the statements about the following clerkships at your medical school: (Scale: 1=Strongly Disagree to 5=Strongly Agree) (Continued)

		Ratings*						
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	Count
Surgery: My performance was assessed against the learning objectives								
Dartmouth-Geisel	2009	12.2	22.4	20.4	20.4	24.5	3.2	49
Dartmouth-Geisel	2010	4.1	19.2	17.8	32.9	26.0	3.6	73
Dartmouth-Geisel	2011	6.9	17.2	17.2	41.4	17.2	3.4	58
Dartmouth-Geisel	2012	9.4	15.6	14.1	29.1	21.9	3.5	64
Dartmouth-Geisel	2013	18.2	17.0	20.5	27.3	17.0	3.1	88
All Schools	2013	3.6	8.6	13.9	38.1	35.8	3.9	13,977
Surgery: I had an opportunity to follow a variety of different patients (with different surgical conditions) on the clerkship								
Dartmouth-Geisel	2009	6.1	2.0	16.3	46.9	28.6	3.9	49
Dartmouth-Geisel	2010	0.0	6.9	9.7	55.6	27.8	4.0	72
Dartmouth-Geisel	2011	5.2	25.9	13.8	27.6	27.6	3.5	58
Dartmouth-Geisel	2012	6.3	17.2	12.5	31.3	32.8	3.7	64
Dartmouth-Geisel	2013	3.4	20.5	13.6	30.7	31.8	3.7	88
All Schools	2013	1.2	3.6	7.2	38.8	49.2	4.3	13,957
Surgery: A faculty member personally observed me taking a patient history during the clerkship								
Dartmouth-Geisel	2009	20.4	42.9	12.2	18.4	6.1	2.5	49
Dartmouth-Geisel	2010	11.0	35.6	19.2	16.4	17.8	2.9	73
Dartmouth-Geisel	2011	25.9	27.6	12.1	17.2	17.2	2.7	58
Dartmouth-Geisel	2012	15.6	29.7	15.6	14.1	25.0	3.0	64
Dartmouth-Geisel	2013	14.8	30.7	14.8	25.0	14.8	2.9	88
All Schools	2013	8.7	24.4	13.3	26.2	27.4	3.4	13,873
Surgery: A faculty member personally observed me performing physical examinations during the clerkship								
Dartmouth-Geisel	2009	18.4	40.8	12.2	18.4	10.2	2.6	49
Dartmouth-Geisel	2010	11.0	31.5	20.5	17.8	19.2	3.0	73
Dartmouth-Geisel	2011	25.9	20.7	8.6	25.9	19.0	2.9	58
Dartmouth-Geisel	2012	15.6	29.7	10.9	18.8	25.0	3.1	64
Dartmouth-Geisel	2013	13.8	32.2	11.5	25.3	17.2	3.0	87
All Schools	2013	8.2	21.2	12.2	29.5	28.9	3.5	13,875

Surgery: Faculty members provided me with sufficient feedback on my performance

Dartmouth-Geisel	2009	18.4	14.3	24.5	20.4	22.4	3.1	49
Dartmouth-Geisel	2010	12.3	19.2	16.4	24.7	27.4	3.4	73
Dartmouth-Geisel	2011	10.3	17.2	15.5	34.5	22.4	3.4	58
Dartmouth-Geisel	2012	12.5	17.2	17.2	26.6	26.6	3.4	64
Dartmouth-Geisel	2013	17.0	20.5	23.9	25.0	13.6	3.0	88
All Schools	2013	6.0	12.9	15.1	33.9	32.2	3.7	13,963

Surgery: Residents and fellows provided effective teaching during the clerkship

Dartmouth-Geisel	2009	8.2	4.1	10.2	36.7	40.8	4.0	49
Dartmouth-Geisel	2010	2.8	5.6	6.9	33.3	51.4	4.3	72
Dartmouth-Geisel	2011	5.2	3.4	8.6	41.4	41.4	4.1	58
Dartmouth-Geisel	2012	7.8	4.7	10.9	35.9	40.6	4.0	64
Dartmouth-Geisel	2013	4.5	9.1	12.5	31.8	42.0	4.0	88
All Schools	2013	4.3	6.5	11.8	34.9	42.5	4.0	13,436

Student Feedback – See Attached Report

Recent Clerkship Concerns and Changes

- Adopted standardized mid-clerkship feedback form
- Adopted standardized competency based clinical performance evaluation form
- Enhanced resident teaching education
- New leadership
- Addressed work hours by altering schedule

Recommendations for Ongoing Improvement

See attachment

Appendix B

MEC Subcommittee Review of Surgery Clerkship and Action Plan

Recommendations for improvement:

1. Learning Objectives
    a. Change "complete" exam to "focused" exam
    b. Remove last objective completely

    Surgery Clerkship Action Plan

    1. Will revise learning objectives as recommended

2. Essential Skills/Conditions
    a. Change Abdominal Trauma to Trauma
    b. Remove Trauma Resuscitation
    c. Remove Acute Respiratory Distress from conditions
    d. Remove Suture/Staple Removal from Skills
    e. Provide clear alternative means to accomplish if not seen on wards
        i. Simulation Center Use
        ii. On-line case
        iii. Referral to next clerkship
    f. Revise Clinical Performance evaluation form to better align with Geisel competencies

    Surgery Clerkship Action Plan

    1. Will implement the above changes in essential skills and conditions

    2. Have implemented a simulation session to provide an additional education opportunity for skills practice but also to address any individual deficiencies

    3. Will examine the possibility of incorporating WISE cases

    4. Will plan to refer to the next clerkship as needed and will do so through the CECD and the Office of Clinical Education

3. Assessment
    a. Clarify who provides assessment and emphasize the assessment given by those who interact most closely with the students – chief residents/residents

    Surgery Clerkship Action Plan

    1. Will continue to outline Clerkship evaluation process clearly at orientation and post this information on Blackboard

    2. Will re-examine the individual service sites on Blackboard for clarity regarding assessment and revise as needed

    3. Each service will continue to submit an evaluation for each student compiled from the evaluations by the faculty and residents who worked with the student and this will be highlighted at orientation

    4. Each Rotation Director and senior resident (if applicable) will meet with the student at the start of the

rotation to outline expectations

b. Make clear to students how clinical evaluations will be derived and from whom

<u>Surgery Clerkship Action Plan</u>
1. Will continue to outline Clerkship expectations and evaluation process clearly at orientation and post this information on Blackboard
2. Will re-examine the individual service sites on Blackboard for clarity regarding assessment
3. Will ask Rotation Directors to outline at initial meeting how the ward evaluation is completed with expectation that input is sought from each resident and faculty with whom the student worked.

c. Revise Clinical Performance evaluation form to better align with Geisel competencies
<u>Surgery Clerkship Action Plan</u>
1. Have revised Clinical Performance Assessment to align with Geisel objectives and have provided descriptors to the evaluators to facilitate uniformity in grading criteria

d. Revise rotation quiz questions to make them more clear and representative of rotation material
<u>Surgery Clerkship Action Plan</u>
1. Have revised the rotation quiz to address this prior criticism. Will review the service-specific quiz with each service to ensure its applicability to the clinical experience. Will review again the core questions and compare to didactic sessions to ensure the questions are reflective and that the didactic sessions adequately cover the question topics and meet our Clerkship Objectives.

e. Change name of "Learning Leader" to "Rotation Director" to better clarify role of this individual
<u>Surgery Clerkship Action Plan</u>
Will change the name of the Faculty Learning Leader as suggested

f. Change mid-term feedback process to have specific feedback reviewed/given by Rotation Director/Chief Resident of Service with general check in with surgery clerkship director.
<u>Surgery Clerkship Action Plan</u>
1. Will meet individually with each Rotation Director annually to review role, expectations, and effective feedback
2. Will continue to hold Clerkship Advisory Board meetings comprised of the Co-directors, Rotation Directors, and Surgery Chair. Generally held monthly.
3. Mid-rotation formal feedback will be given by Rotation Director and/or senior resident (if applicable)
4. Mid-Clerkship formal feedback will be given by the Rotation Director.
5. An additional brief interview with one of the Clerkship Co-Directors will be given to provide feedback on performance in didactics, student case presentation, and quiz.

g. Provide more feedback on written notes
<u>Surgery Clerkship Action Plan</u>
1.Will address the quality and frequency of feedback on written notes through various measures
-clarify expectations for Rotation Directors and students (provide feedback on at least 1-2 notes per week)

-educational forum on teaching and providing feedback using modeling and perhaps video format based on the excellent teaching provided by highly evaluated surgery faculty and residents

h. Provide more comments and feedback on the final grade narrative that gets sent to the Registrar and is used by the Assistant Dean to write the MSPE

<u>Surgery Clerkship Action Plan</u>

1. Encourage more comments to be provided on ward evaluations. Comments on the final narrative are taken directly from these.

2. Use Geisel Final Grade Narrative Template. Revised Clinical Performance Evaluation Form with anchors will also help us include appropriate comments for the competency-based assessment.

4. Learning Sessions/Activities
    a. Condense or change last three sessions as they seem redundant
    b. Allow more opportunity to meaningfully interact with patients seen in clinic; less shadowing
    c. Provide more formal session on informed consent as this is part of the assessment (oral exam) and an important objective
    d. Provide more formal discussion of how patient diversity affects care and utilization as this is an objective that may not be fully met on clinical experiences
    e. More rotation specific expectations needed – chief resident sit down on first day would be very helpful
    f. Provide examples of different service notes to guide students on expectations
    g. More teaching in the OR

<u>Surgery Clerkship Action Plan</u>

1. Edited cases for weekly didactic sessions 2013-2014

2. Revised last three sessions 2013-2014. Combined and revised the last three sessions to one team-based learning session which covers the topic of inflammatory response and shock but also incorporates formal teaching on informed consent, utilization, socioeconomic factors, high-value care, end-of-life discussion.

3. Included in 2012-2013, informal discussion about informed consent during didactics to add to observation of this process in the inpatient and outpatient settings. Instituted 2013-14 an invited faculty session to discuss informed consent. Handout on principles of informed consent provided to students

4. Last didactic session is skills-based session utilizing the simulation center and also standardized patients session in palliative care and delivering bad news.

5. See action items above regarding expectations. Advisement to Rotation Directors to meet with students at beginning of rotation to outline expectations including notes. The most senior resident on the service should also meet with the student to outline expectations for daily work.

6.Encourage more active learning in clinic and also teaching in the operating room. Co-Directors will meet with the Rotation Directors where clinic student participation is a consistently more passive to see if this can be changed or if the student should not attend the clinic of that faculty.

7. Continue Department of Surgery, "Teach the Teacher to Teach Better" series of annual educational forums for faculty and resident development.

8. **(from above)** ***educational forum on teaching and providing feedback using modeling and perhaps video format based on the excellent teaching provided by highly evaluated surgery faculty and resident.***

While the operating room role of the faculty must be focused on the patient, increased teaching may be improved by "thinking out loud."

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Appendix C

Geisel Competencies: MEC Feedback

I listed the general overarching comments that members thought were well worth discussing at the October 15th MEC meeting. (Feedback on specific program objectives under each competency are highlighted in "red", beginning on page 3.)

1. There is an obvious shift away from an emphasis on personal practice to population analysis.
    a. Should a program objective be added to Clinical Care – "Analyze one's own practice to improve quality care".

2. Does the collection of these competencies and related program objectives describe the unique role of the physician in healthcare that is distinct and different from the role of a nurse practitioner and a physician assistant?

3. Is the sum total of the competencies showing the unique role of the physician or can the competencies be used to describe the role of a nurse practitioner and a physician assistant?
    a. Medical Science: Make this one more sharply distinct – "Use the scientific method to synthesize the primary literature, and inform the discovery and refinement of medical knowledge".
    b. Clinical Care: Add a program objective that states the ultimate responsibility for the outcome is unique to a physician. (See Personal Integrity #8, which might cover this.)
    c. Population Health: In #6, the role of the physician is unclear.
    d. Communication: No program objective is unique to the physician. Might consider, "Translate complex biomedical concepts and advances into useful information for patient decision making".
    e. Personal Development: No program objective is unique to the physician. Might consider adding a program objective that says, "Use an awareness of the expectations of society of a physician in order to improve community health".

4. Roll the "Population Health" competency into the "Medical Science" competency. Write a program objective for population health, and turn the current population health program objectives into core course objectives.

5. Combine the "Collaboration and Teamwork" and "Communication" competencies. Some of the program objectives might be better placed as core course objectives.

6. Add a program objective that specifically addresses the student's ability to "Describe how the various functional systems of the body interact with each other in health and disease".

7. Perhaps we should consider using "sub-domains" in a few competencies. For example, "Professional Integrity" could be broken into Subdomain #1 – Placing the patient's interests first (Obj 1, 4, 5, 6, 7) and Subdomain #2 – Ethics (Obj 2, 3, 8, 9).

8. There's overlap in two areas:
    a. The "Communication Skills" and "Collaboration and Teamwork" competencies.
    b. The "Evaluation and Improvement in Medicine" and "Population Health" competencies.

9. Competency names
    a. Change “Personal, Professional, and Leadership Development” to “Personal and Leadership Development”.
    b. Change “Professional Integrity” to “Professionalism” or Ehtics, Professionalism, and Integrity”.

Prepared by: Glenda H. Shoop
Date: October 4, 2013

Medical Science ***This competency focuses on students' understanding the scientific basis of medicine, and applying this understanding to the practice of medicine.***	
1	Describe the scientific method and how it informs the discovery and refinement of medical knowledge. **Rewrite: Demonstrate how the scientific method is used in the discovery and refinement of medical knowledge. **Rewrite: Use the scientific method to synthesize the primary literature, and inform the discovery and refinement of medical knowledge.
2	Demonstrate core biomedical and social science knowledge necessary to understand the structure, function, and management of human health and disease. **The "…structure and function of human health and disease…" is unclear. **Rewrite: "Demonstrate the basic knowledge necessary to understand disease". **Should this objective be broken out – one for biomedical and one for social science knowledge?
3	Practice self-directed inquiry through framing a discrete question, *searching for the evidence,* synthesizing the relevant literature, and applying the knowledge gained to the care of an individual patient, teaching, research, or the improvement of population health. ** Searching for the evidence is an important step in evidence-based medicine and should be included.
4	Use the skills of critical thinking – observation, evaluation, inference, interpretation, and judgment – to analyze problems. **Rewrite: Analyze problems through observation, evaluation, inference,

	interpretation, and judgment.
5	Demonstrate sound clinical reasoning through the integration of medical science knowledge and critical thinking skills. **Integrate medical science knowledge in clinical reasoning.
6	Recognize, tolerate, and manage uncertainty in medicine. **Remove or merge with #7.
7	Describe the complexity of human disease, the variability in treatment responsiveness, and the potential for unexpected outcomes from the molecular to the population level. **This objective is too complex???
8	Contribute to scholarship through the discovery or synthesis of medical knowledge and its communication to peers or the larger community.

Clinical Care ***This competency includes patient- and family-centered principles and components of clinical care.***	
1	Establish mutually respectful student-patient-family relationships based on trust.
2	Elicit a medical history appropriate to the patient's concerns and clinical context.
3	Perform a physical exam appropriate to the patient's presentation and clinical context.
4	Identify *and interpret* common abnormalities and urgent findings on frequently ordered laboratory and diagnostic studies.
5	Use clinical reasoning to synthesize relevant key patient findings into a concise and accurate assessment, including differential diagnosis. **Rewrite: Synthesize relevant key patient findings into a concise and accurate assessment, including differential diagnosis.
6	Formulate a management plan guided by evidence-based medicine, critical thinking, and a prioritized problem list.
7	Deliver oral presentations appropriate to the patient's presentation and clinical context.
8	Record clinical notes that are accurate, organized, well-reasoned, and timely.
9	Demonstrate the ability to recognize and appropriately respond to commonly occurring ethical issues in clinical care. **Does this belong in Professional Integrity?

10	Demonstrate proficiency in performing select clinical and operative procedures under appropriate supervision.
11	Use information technology effectively while respecting patient privacy and confidentiality. **Two different foci (1 – EHR systems and 2 – respect for patient privacy covered in Professional Integrity #5).
12	Engage patients in **shared decision-*making*,** incorporating values and preferences in discussions of management options and their expected benefits and harms.
13	Recognize and address diverse goals of clinical care, including prevention, diagnosis, cure, chronic disease management, palliation, and end-of-life care. **What does it mean to address a goal? This is vague.
14	Describe how the development, experience, and management of disease can be influenced by family and community context.
	***ADD: Describe how the various functional systems of the body interact with each other in health and disease. [Perhaps Medical Science?]

Population Health ***This competency includes an understanding of the multiple factors that contribute to population health, including the role of health care delivery systems.***	
1	Explain the measures by which health and disease are evaluated at the individual and population level, including their inherent strengths, limitations, and biases.
2	Describe how the patterns, causes, and effects of health and disease are studied in populations.
3	Assess and explain the impact of social, environmental, behavioral, economic, cultural, and personal factors on the health of individuals, and the incidence and burden of disease in populations.
4	Describe the relationships between the medical system and other societal systems and entities that impact population health.
5	Demonstrate the ability to collaborate with community partners to improve the health and well-being of a community. **This may overlap with objectives in the "Collaboration and Teamwork" competency.
6	Explain and exemplify the role of a physician in working to improve the health, well-being, and safety of a community; promote social justice; and advocate for the public good.

Communication Skills *This competency applies at all levels including patients, families, colleagues, and teams.*	
1	Build rapport by listening actively, compassionately, and respectfully.
2	Demonstrate empathy for individuals' concerns, and be respectful of others' perspectives and personal, cultural, and religious values.
3	Address challenges to effective communication, including language barriers, cultural differences, health literacy, and authority gradients.
4	Apply effective motivational interviewing skills as a tool for promoting positive behavioral change. **Rewrite: Promote positive behavioral change through motivational interviewing.
5	Apply effective communication skills to make a connection during difficult conversations. **See notes below
6	Communicate accurately, succinctly, and in a timely manner.
7	Apply effective skills and strategies for managing conflict. **Rewrite: Manage conflict effectively.
	***ADD: Translate complex biomedical concepts and advances into useful information for patient decision making

Notes

#5 ??Do we need communication skills in this program objective?? Using the term being explained in the explanation in not helpful.

#5 ??Not sure what "to make a connection" means.

#5 ??Confusing, try "Apply effective communication skills to elicit and convey information about sensitive and difficult

topics".
#5 Try, "Make connections during difficult conversations".

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Personal, Professional, and Leadership Development ***This competency focuses on taking responsibility for self-improvement and well-being.***	
1	Demonstrate critical and accurate self-assessment, reflection, and effective learning strategies to engage in lifelong learning to improve one's performance. **Rewrite: Improve one's performance with critical and accurate self-assessment, reflection, and effective lifelong learning strategies to engage in lifelong learning.
2	Demonstrate resilience skills by taking responsibility for one's own physical, emotional, mental, and social health and well-being, accessing appropriate assistance as needed. **Delete "social health" Not sure what it means.
3	Elicit, learn from, and offer constructive feedback.
4	Take responsibility for consequences of one's words and actions. **Can this objective be assessed, and is it overlapping with Professional Integrity #8?
5	Engage in active discussion and debate, taking advantage of different perspectives to advance knowledge and understanding, and improve decision-making.
6	Design, implement, and sustain a personal, professional, and leadership development plan aligned with one's values and sense of purpose, with appropriate mentorship.

7	Identify and demonstrate the qualities, knowledge, and skills to lead effectively at the level of one's self, one's team, one's organization, and one's community. **Rewrite: -Identify and demonstrate knowledge, skills, and other qualities needed to to lead effectively….. or -Identify and demonstrate the qualities, knowledge, and skills to lead effectively. or -Identify and demonstrate the qualities, knowledge, and skills to lead effectively at the level of one's self, team, organization, and community. **How realistic is this program objective; it implies that every student will have the ability to lead an organization and a community.

Evaluation and Improvement in Medicine ***This competency relates to the evaluation and improvement in health care, medical education, and research.***	
1	Explain how expected benefits and harms of any health care intervention are evaluated, and how to incorporate that balance into decision-making for individual patients and populations.
2	Demonstrate the ability to effectively use individual, clinic, hospital, and community resources to provide high quality care while minimizing waste. **Rewrite: Use individual, clinic, hospital, and community resources to provide high quality care while minimizing waste.
3	Analyze the structure and processes in a health care system to evaluate and improve the delivery of care.
4	Analyze, describe, and address system vulnerabilities that contribute to medical error, poor quality, inefficiencies, and unwarranted variation.
5	Explain the context – financial, political, legal, historical, and cultural – in which medicine is practiced.
6	Compare and contrast health care across delivery systems, regions, and countries.
7	Explain the role of physicians in leading discovery, evaluation, translation, improvement, and innovation in medicine and public health.

Note:

There's no objective that addresses learning about new medical procedures, treatments, or diagnostic technologies.

- Stronger objective for clinical and translational research (an expectation for critical clinical observations made by astute physicians, basic scientist discoveries, proof-of-principle studies in animal models and humans, large-scale clinical trials, and population-based practice-optimization studies.
- Does this competency relate to "medical education" (see description)?

Professional Integrity ***This competency includes ethical behavior, professionalism, and personal integrity.***	
1	Place the patient's interests first.
2	Behave respectfully, responsibly, and ethically towards patients, families, colleagues, members of the healthcare team, and the community.
3	Describe the ethical, legal, and statutory responsibilities of physicians, and how they apply to the care of an individual patient.
4	Elicit and show respect for patients' values.
5	Respect and honor confidentiality.
6	Minimize health care disparities while respecting patients' values and priorities, regardless of gender, race, religion, socioeconomic status, disability, sexual orientation, or ability to pay.
7	Demonstrate awareness and manage the influence of one's personal values and biases.
8	Demonstrate accountability for all professional responsibilities and commitments, and take responsibility for one's actions. **Rewrite: Take responsibility for all one's professional responsibilities, commitments, and actions.
9	Demonstrate the ability to recognize and help resolve ethical conflicts created by competing values. **Rewrite: Recognize and help resolve ethical conflicts created by competing values.

Collaboration and Teamwork ***This competency emphasizes that medicine is a collaborative and collegial, interprofessional team-based discipline involving leadership, sharing, and delegation of responsibility.***	
1	Develop and maintain a climate of collaboration, mutual respect, and understanding to facilitate optimal team performance.
2	Demonstrate the ability to effectively share or allocate responsibilities among team members, with particular attention to clinical handoffs and other care transitions. **Rewrite: Share or allocate responsibilities among team members, with particular attention to clinical handoffs and other care transitions.
3	Recognize and take advantage of different roles and strengths of interprofessional and other team members to develop and address shared goals. **Rewrite: ….roles and strengths of interprofessional and intraprofessional team members to develop and address shared goals.
4	Develop organizational and time management skills to facilitate serving as an efficient and productive team member.
5	Apply communication skills to the work of a team. DELETE – covered in the Communication Skills competency.