GEISEL SCHOOL OF MEDICINE
AT DARTMOUTH

MEDICAL EDUCATION COMMITTEE MEETING

TUESDAY, DECEMBER 18, 2012
4:00 – 5:30 PM
DHMC – AUDITORIUM A
MINUTES

PRESENT:
VOTING MEMBERS: Jessie Bay, Benjamin Colby, Matthew Crowson, Scottie Eliassen, Aniko Fejes-Toth, Harold Manning, David Nierenberg, Todd Poret, Virginia Reed, Christiaan Rees
NON-VOTING MEMBERS: Laura Cousineau, Ann Davis, John Dick, Leslie Fall, Diane Grollman, Michele Jaeger, Virginia Lyons, Brian Reid, Glenda Shoop, Cynthia Stewart
GUESTS: Denise Aaron

1. **Call to Order** - ***Rich Simons, MD, MACP***

   The meeting was called to order at 4:00 PM

2. **Approval of the October meeting minutes**

   The membership unanimously approved the minutes of the October meeting as written.

3. **Announcements** - ***Rich Simons, MD, MACP***

   LCME Mock Site Visit is scheduled for January 28th and 29th. Participant attendance is critical; Dr. Souba will be sending a letter to all participants very soon. This is an opportunity to learn from mock site team about processes that should be in place. It is important for MEC members to relay to LCME that this is a faculty owned committee and is operated under the Faculty Council.

   Medical Education Program Review was held on Friday, December 14th. The purpose of this session was to review the curriculum as a whole. The review was well attended with 50 – 60 participants. The last hour of the review was reserved for discussion. The results of the review will be tabulated and then distributed for consideration within the new curriculum. Physician wellbeing was a strong topic and one that will be addressed. Dr. Fall reported a lot of positive feedback regarding the program review from faculty.

4. **SBM Dermatology Course Review** – ***Virginia Lyons, PhD***

   Dr. Lyons presented the Dermatology Course Review. The details of her presentation can be found within the attached PowerPoint slides.

   Dr. Denise Aaron presented her action plan. The details of Dr. Aaron's action plan can be found within the attached document (following Dr. Lyons' PowerPoint slides).

   A motion to accept the action plan as presented by Denise Aaron, MD was made, seconded and passed unanimously.

5. **Approval of modified Competency and Educational Objectives for the MD Curriculum** – ***Rich Simons, MD, MACP***

   Dr. Simons distributed hard copies of both versions of the competencies brochure. Dr. Swenson reviewed the relatively few modifications with the committee. Dr. Simons reminded the committee that these competencies are the drivers for the whole curriculum and the LCME places a lot of weight on this document and how course directors view the competencies.

A motion to approve the modified Competency and Educational Objectives as presented was made, seconded and approved unanimously.

The website will be updated with the modified version

6. **Student Feedback –** ***Student Representatives***

Year 1 – As an update from the October meeting, where concern was raised about the respiratory and cardiovascular physiology classes, a plan has since been developed to improve student feedback, as the result of a meeting. Students have been asked to bring up content that they find difficult to understand in hopes to make improvements. Drs. Simons and Lyons also met with the course directors as a result of student feedback and both felt that the feedback was well received by course directors. A suggestion was made to enlist some faculty members whose lectures were highly rated as well as to bring this course back for review at a future MEC meeting.

Year 3 – Students have returned and are just starting ICE course. It was noted that overall the change from 6 and 8 weeks has gone well; more student feedback will be solicited over the next couple of days. Dr. Simons reported on his most recent student lunch where he heard positive feedback about surgery. When Dr. Simons asked for the representatives feedback, they raised concerns regarding the letter grade. This has since been addressed with course directors, with some changes having been made, but it is unclear if it has been resolved. The committee clarified that the purpose of this clerkship narrative evaluation is not to provide all positive remarks. Students clarified that some felt that the feedback they received was unfair. Dr. Simons suggested that students discuss these concerns with the clerkship directors, whose responsibility it now is to go over these evaluations with the student and explain how feedback was derived. Evaluations from faculty often include information that comes in later than the feedback session. Dr. Nierenberg noted that after talking to some of last year's students regarding surgery they reported that a lot of things are better, but one complaint was that negative comments showed up that had never been brought to their attention during the 8 weeks of the course and that these negative comments often came from someone they worked with on a short term basis. The students gave an example of negative feedback given to another student who was criticized for the amount of time spent on a patient note, with no mention of the quality of the patient notes. Dr. Dick plans on discussing the approval of the clerkship narrative evaluation with the clerkship directors. Dr. Davis noted that in her interactions with students she found that they seemed calmed by knowing that this letter does not get cut and pasted into dean's letter. Mikki noted after reviewing an evaluation, that the category being referred to is called "recommendations for improvement" and although it is seen as negative feedback, it is meant to be helpful. Another concern that remains is the burden imposed on students by the cost of travel. Dr. Davis gave an update on this and noted that it remains a topic of discussion.
Year 4 –students are at various stages of the interview process. While there are no major issues to report at this time, it was noted that during interviews students are occasionally asked to demonstrate (or explain their experience with) some manual dexterity and that the general perception is that Dartmouth students are relatively hands-off in comparison to other students. It was questioned whether or not students should be developing some manual dexterity in the 4th year. Dr. Simons wondered if there should be a 4th year elective held after the surgery clerkship for the individual who is considering surgery as a career.

7. **Other Business -** None

The Meeting was adjourned at 5:00 PM

UPCOMING SCHEDULED MEETINGS:

Jan. 15	Feb. 19	Mar. 19 Need to reschdule	Apr. 16	May 21	June 18	July 16
Aud. A	Aud. A	Aud. A	Aud. A	Aud. A	Aud. A	Aud. A

SBM Dermatology [Year 2]

- Course Director: Denise Aaron, MD
- Hours: 24.5
- Pedagogy
  - traditional lecture 21 hrs. (86%)
  - physical diagnosis session 2.5 hrs. (10%)
  - large group interactive review 1 hr. (4%)

Recommendation: reduce number of traditional lectures and incorporate more active pedagogies

Course Objectives

- 18 course objectives mapped to the following categories:
  - medical knowledge – 12
  - clinical skills – 2
  - communication/interpersonal skills – 2
  - professionalism – 2
  - personal improvement – 0
  - health care systems – 0

Recommendation: explore options for incorporating objectives from the 5th and 6th competencies

Course Objectives

- Session objectives were not uniformly distributed to students
- Content was appropriate when compared to national standards (NBME Step I brochure; American Academy of Dermatology Medical Student Core Curriculum)

Recommendation: ensure that course and session objectives are clearly stated on materials provided to the students

Assessment

- Course grade is based exclusively on the final exam (as is common for SBM courses)
- Final exam had 109 multiple choice questions for 2011-2012; 40% of questions were image identification
- Only 10% of the questions were clinical case scenarios that required application of knowledge

Recommendation: increase the number of questions that require students to apply their knowledge

Course Outcomes – Step I

- Over the past 3 years, Geisel students have averaged scores of 0.63 SD above the national mean in the musculoskeletal/skin/connective tissue category on Step I
- This category was the highest ranking category for Geisel students, out of the 11 system-based categories reported by the NBME

Course Outcomes – Student Data

- Overall satisfaction was 3.37 / 5
  (good – very good; 99% participation on survey)
- Strengths
  good introduction to the field; excellent clinical relevance of course material; physical diagnosis day; useful self-assessment resources
- Suggestions
  reduce time and detail of the course; improve labeling on PowerPoint slides; improve some lectures; improve correlation between what is taught and what is assessed

Conclusions

- National measures of performance indicate that Geisel students are successfully learning content regarding the musculoskeletal system, skin and connective tissue

- Students likely gave the dermatology course a relatively low rating for two reasons:

1. the material assessed on the final exam did not correlated well with the material covered in class
2. Several lectures were extremely poor, thus creating a negative "halo effect" of the entire course

Conclusions

- The subcommittee is confident that new leadership in the course will have a positive impact. We appreciate Dr. Aaron's initiative in course planning and her commitment to addressing deficiencies in the course.

Medical Education Committee (MEC) SBM Dermatology Review
December 18, 2012
Course Director: Denise M. Aaron, MD

Item #1:

- **Recommendation: reduce number of traditional lectures and incorporate more active pedagogies**

Action Plan: For 2012-2013 SBM Derm Course active learning pedagogies have been increased:

- Traditional lecture: 16.75 hours (68%) [decreased from 86%]
- Physical Diagnosis: 2.5 hours (10%)
- Large Group Interactive: 2.75 hours (11%)
- Case Conference: 1 hour (4%)
- Connecting Hearts and Minds Rounds: 1.5 hours (6%)

Item #2:

- **Recommendation: explore options for incorporating objectives from 5th and 6th competencies**

Action Plan:

- Will add course objective mapping to competency 5e (Note: needs to be approved by MEC).
- Proposed new course objective: "Demonstrate mastery of material by regularly utilizing the self-assessements tools provided by the course director"

Item #3:

- **Recommendation: ensure that course and session objectives are clearly stated on materials provided to the students**

Action Plan:

- Course objectives will be included in the student handout and posted to blackboard
- Session objectives will be included in either the session syllabus, power points slides, or both.

Item #4:

- **Recommendation: increase the number of questions that require students to apply their knowledge**

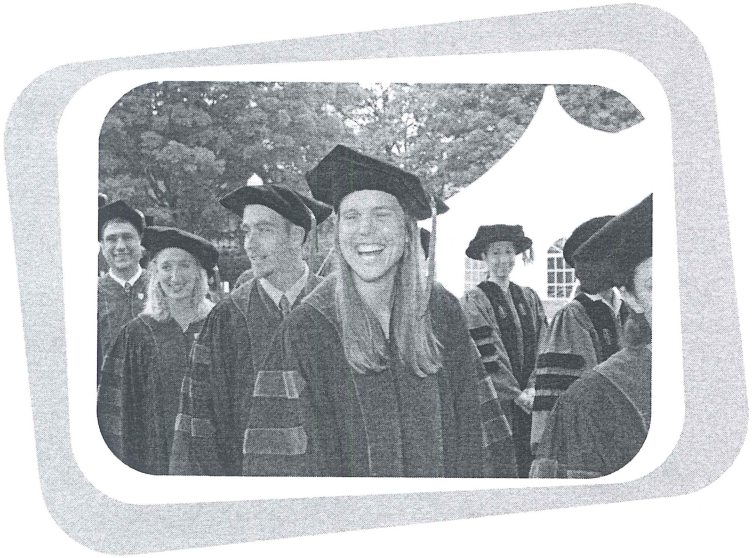
Action Plan:

- Will modify questions as appropriate to include more clinical stems and increase the number of questions that require applied knowledge vs. restating of facts.

- While not a specific recommendation, based on student feedback: Course director will attend as many lectures as possible this academic year to help improve correlation between lecture content and exam content.

COMPETENCIES

The Geisel School of Medicine at Dartmouth



For Geisel School of Medicine
Students Today and for
Geisel School of Medicine
Physician Graduates of Tomorrow

2012

Introduction

What are the learning objectives of the educational program at Geisel School Medicine? What knowledge, skills, attitudes and behaviors – what competencies must all students acquire with an appropriate level of mastery in order to be ready for an internsh or residency position? How will the faculty assess each student's progress in learning the important competencies, and make sure that each student is ready for the next step of medic education?

In 2003, when the Medical Education Committee voted that the curriculum preparing students f the MD degree should be based on six broad areas of competency, it was with the intent addressing the three important questions outlined above. We chose as our six core competen domains the same six that had been selected five years earlier by the ACGME (American Coun of Graduate Medical Education), with a few changes to make them more appropriate for medic students, and adjusted to a different level of mastery.

In 2005, the Liaison Committee on Medical Education (LCME) required that all medical schools develop their own competency-based medical curricula. Geisel (then DMS) was held to this standard during our LCME site visit and review held that year. By 2009, LCME requirements in this area had become even more detailed and rigorous. They included all of the following features (abstracted from LCME Standards, July 2009:

- The medical school faculty must define the objectives of its educational program. The specific competencies must be those that the profession and the public expect of a w trained physician.
- These objectives of the educational program must be stated in outcome-based terms tl allow assessment of each student's progress.
- The central curriculum committee (in our case, the Medical Education Committee) mu develop these competencies through its central oversight role, and these fundamen competency goals must be formally adopted by the medical school's faculty.
- These objectives of our educational program (our competencies) must be made known to medical students and to all faculty, residents, and others with direct responsibilities f medical student education.
- The central curriculum committee must make sure that each course or clerkship not or teaches the appropriate competency items, but also develops a system to assure that ea student has indeed achieved a level of mastery appropriate for that stage of training.
- The medical faculty must design a curriculum, with specific learning objectives, tl provides a general professional education for each student, and that prepares each student f entry into graduate medical education.

In response to these new and more rigorous standards, the Medical Education Committee spe much of its 2009-10 academic year soliciting input from many sources, and developing a new s of more specific and more detailed required core competencies. Useful suggestions we contributed by many faculty and students; course directors, clerkship directors, and departme chairs; the LCME through its requirements; the AAMC through its MSOP reports; and t Carnegie Foundation through its draft white paper on improving medical education. On developed, these DMS (now Geisel) Competencies were then approved by the Dean's Academ Board, and eventually by vote of the General Faculty in March, 2010.

The Medical Education Committee hopes that this pamphlet will help each Geisel applicant a medical student, resident, faculty member, course or clerkship director, and the public at lar understand what the broad objectives are of a rigorous medical education at Geisel. These are t competencies that our Faculty promises to teach, that we expect our students to learn, and that will evaluate in each student to make certain that every student has attained an appropriate level mastery prior to graduation, and prior to moving on to assuming increased responsibility for dire patient care in a residency training program.

One

Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences, and the application of this knowledge to patient care.

By graduation, each Geisel medical student must have consistently demonstrated the ability to:

a. *IDENTIFY, EXPLAIN and APPLY useful knowledge of current "core basic sciences"* regarding normal structure and function, health, and the pathophysiology of disease, particularly as it impacts human health and disease and patient care. Subjects must include anatomy/histology/ embryology, microbiology/immunology, physiology, biochemistry/genetics, metabolism/nutrition, pathology, pharmacology, and pathophysiology.

b. *IDENTIFY, EXPLAIN and APPLY useful knowledge regarding the discovery and validation of new biomedical information*. Subjects and experiences must include biostatistics, epidemiology, basic science research, clinical research, translational research, hands-on or simulated laboratory experiments, and the critical analysis of data from experiments or from the literature.

c. *IDENTIFY, EXPLAIN and APPLY useful knowledge of the current "core clinical sciences,"* in both inpatient and outpatient settings as appropriate, with sufficient and appropriate exposure to primary care experiences. Required rotations in medicine, geriatrics, surgery and its related disciplines, pediatrics, obstetrics and gynecology, psychiatry, family medicine, and neurology should serve as the foundation for the clinical training of the undifferentiated, generalist physician.

d. *IDENTIFY, EXPLAIN and APPLY useful knowledge of some newer "bridge disciplines" or "themes" that have become necessary to deliver excellent patient care*. These subjects include (but are not limited to) clinical pharmacology, imaging, nutrition, clinical genetics, molecular diagnostics, neoplasia, medical informatics, health care delivery science, evidence-based practice, public health, and the global burden of disease.

e. *IDENTIFY, EXPLAIN and APPLY knowledge in several additional areas that have become important in delivering excellent healthcare to patients*, including disease prevention, risk factor modification, end-of-life and palliative care, substance abuse, pain management, medical ethics, and medical-legal issues.

f. *IDENTIFY, EXPLAIN and APPLY knowledge in the disciplines that describe the impact of social, economic, cultural, and personal factors upon the health of the individual*, the manner in which people perceive health and illness, and the health of groups of individuals. It is essential that each student demonstrate cultural competency – the ability to engage effectively with patients from different cultures, when cultural background informs the patient's view of health, disease, and treatment options.

Two

Provide patient- and family-centered care that is compassionate, appropriate, and effective for the treatment of medical problems and the promotion of health, with specific attention to the important clinical skills that are necessary in order to deliver excellent patient care.

By graduation, each Geisel medical student must have consistently demonstrated the ability to:

a. *ESTABLISH comfortable and mutually respectful student-patient relationships*, paying particular attention to cultural, socioeconomic, and other factors that make each patient and each family different.

b. *INTERVIEW patients skillfully*, utilizing a comprehensive or focused history as indicated.

c. *EXAMINE patients skillfully and respectfully*, with appropriate attention to student cleanliness, infection control, and patient comfort and privacy.

d. *DEFINE and PRIORITIZE the patient's problems* (developing an accurate and complete problem list).

e. *GENERATE AN APPROPRIATE DIFFERENTIAL DIAGNOSIS*, based on logical clinical assessment and guided by appropriate statistical reasoning.

f. *APPLY an appropriate level of knowledge about the indications, complications, limitations, and performance of common and simple clinical procedures* (e.g. venipuncture, placing an IV catheter, insertion of urinary catheter, simple suturing, etc.). UNDER APPROPRIATE SUPERVISION, PERFORM these clinical procedures without assistance, and with attention to the patient's comfort and privacy.

g. *DESCRIBE ACCURATELY the indications, contraindications, potential complications and performance of complex clinical procedures* (e.g., lumbar puncture, endoscopy, liver biopsy, cardioversion). When possible, observe such procedures when performed by a skilled physician, and assist that physician when appropriate.

h. *CORRECTLY IDENTIFY WITHOUT ASSISTANCE COMMON ABNORMALITIES AND URGENT FINDINGS on frequently ordered diagnostic studies* (e.g., gram stain, ECG, urinalysis, arterial blood gases, chest radiograph, abdominal CT scan, etc).

i. *PARTICIPATE AT AN APPROPRIATE LEVEL, always under appropriate supervision, in the performance of common operative procedures* (e.g. appendectomy, laparotomy, pelvic surgery, complicated labor and delivery, etc.). Learn the indications, contraindications, potential complications, and postoperative management of such operative procedures, and how thoughtful physicians elicit both patient preferences for treatment, and patient informed consent.

Three

Interpersonal and communication skills that result in clear, appropriate and effective information exchange with patients, their families, and health professionals.

By graduation, each Geisel medical student must have consistently demonstrated the ability to:

a. *BUILD A STRONG RAPPORT with patients and their families, establishing a respectful basis for the doctor-patient relationship.*

b. *LISTEN EFFECTIVELY TO PATIENTS AND FAMILIES,* in order to obtain essential and often sensitive information from the patient and the patient's family as well.

c. *COMMUNICATE EFFECTIVELY WITH PATIENTS AND FAMILIES,* especially when special barriers to communication exist (e.g., patients who require an interpreter, who have cognitive deficits, who have different levels of understanding, or who have different cultural backgrounds that affect their understanding of disease and its treatment).

d. *ASSIST PATIENTS APPROPRIATELY IN UNDERSTANDING THEIR TREATMENT OPTIONS for their own care,* especially in situations where multiple treatment options are available. Develop interview skills to motivate patients when behavioral change, promotion of a healthy lifestyle, or close adherence to treatments are necessary.

e. *DEVELOP MOTIVATIONAL INTERVIEWING SKILLS* when behavioral change, promotion of a healthy lifestyle or close adherence to treatment is necessary.

f. *COMMUNICATE EFFECTIVELY WITH PHYSICIAN COLLEAGUES* both verbally (e.g. short and complete oral case presentations, sign-outs, handoffs, etc.), and in writing (e.g., brief SOAP notes, longer admission notes, daily progress notes, consultation notes, essays, term papers, case reports, and other scholarly written formats, etc.).

g. *COMMUNICATE WITH ALL MEMBERS of the health-care team in a manner that facilitates patient care* through succinct and accurate communication and cooperation between team members from different disciplines.

h. *COMMUNICATE AND INTERACT WITH COLLEAGUES COLLEGIALLY,* including teaching and helping to evaluate peers.

i. *COMMUNICATE EFFECTIVELY WITHIN AN ELECTRONIC MEDICAL RECORD,* observing proper protocols for protecting patient confidentiality, clearly identifying the author of each note, avoiding promulgation of misinformation, and maintaining the professional content of this important repository of patient information.

Four

Formation of a mature, responsible, and ethical professional identity, as manifested through a commitment to carrying out all professional responsibilities in a timely manner, adherence to ethical principles, and understanding the social contract between society and the profession of medicine.

By graduation, each Geisel medical student must have consistently demonstrated the ability to:

a. *BEHAVE RESPECTFULLY AND RESPONSIBLY* towards patients, families, colleagues, and all members of the health-care team at all times.

b. *MEET PROFESSIONAL RESPONSIBILITIES FULLY,* including being punctual, present, and engaged in appointments, meetings and other activities, and being reliable in commitments to tasks.

c. *SUBORDINATE one's own self-interest appropriately, in order to consistently place the patient's interests first.* Avoid real and perceived conflicts of interest. Recognize how one's own personal opinions and biases can interfere with one's ability to deliver quality care to every patient.

d. *ADHERE to high ethical and moral standards,* demonstrating honesty and integrity in all activities.

e. *EMPATHIZE* with patient concerns, and be respectful of each patient's concerns, points of view, and cultural traditions.

f. *ACCEPT RESPONSIBILITY for his/her own actions.* Receive constructive criticism and feedback well. Demonstrate the desire to learn and improve.

g. *RESPECT each patient's confidentiality.*

h. *TAKE RESPONSIBILITY FOR HIS OR HER OWN MEDICAL EDUCATION,* and take the initiative in optimizing his/her personal education plan.

i. *TAKE RESPONSIBILITY FOR HIS/HER OWN MENTAL AND PHYSICAL HEALTH,* and to enhance the provision of excellent patient care

j. *DEVELOP THE HABITS OF MINDFULNESS AND REFLECTION,* and apply them to improving one's own care for patients. Increase awareness of potential conflicts between personal values, patient preferences, and usual practice.

k. *RECOGNIZE AND DESCRIBE HOW ACCESS TO BASIC HEALTH SERVICES IS ESSENTIAL TO MAINTAINING PERSONAL HEALTH* for people everywhere, but especially for those without insurance or financial resources, and those living in medically underserved areas.

l. *HELP COLLEAGUES BY CONTRIBUTING CONSTRUCTIVE SUGGESTIONS DURING PEER REVIEW,* and by reporting impaired colleagues and helping them receiving care and counseling.

Five **Develop the habit of inquiry into and improvement of one's own personal practice,** by reflecting upon and evaluating the student's own direct patient care, and accessing the best information and practices available.

By graduation, each Geisel medical student must have consistently demonstrated the ability to:

a. *SEARCH EFFICIENTLY FOR and OBTAIN* recent, high quality, relevant medical information and scientific literature about important clinical topics and questions.

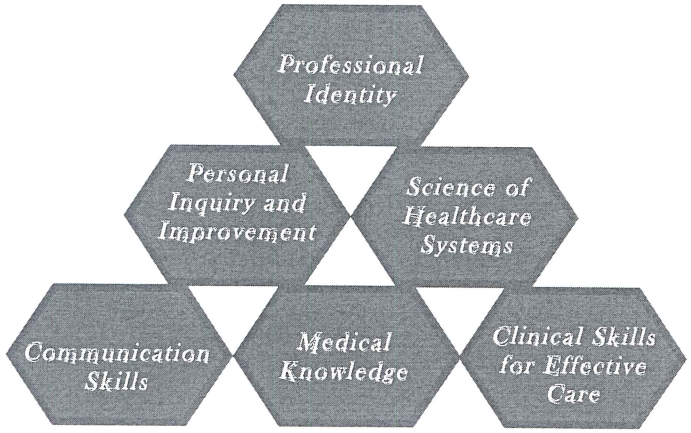
b. *READ CRITICALLY, understand, evaluate, and assess* medical information and scientific literature about important clinical topics and questions.

c. *EVALUATE and ASSESS clinical care processes and outcomes* in the practice environment in which they participate, and understand how this measurement relates to the improvement of care for groups of patients.

d. *EXPLAIN AND BE ABLE TO APPLY* the concepts of improving quality of care, patient safety, and value of care in one's own clinical environment.

e. *DEVELOP THE HABIT OF, AND STRONG COMMITMENT TO, continuous inquiry and lifelong learning,* utilizing both self-reflection and external sources of feedback. Learn and adopt a structured approach to lifelong updating of knowledge and skills.

f. *MAKE ONE'S OWN CLINICAL ENVIRONMENT A LEARNING ENVIRONMENT,* committed to daily improvements in safety, efficiency, and patient satisfaction.



Six **Systems-based practice and the science of healthcare delivery** as manifested by student actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

By graduation, each Geisel medical student must have consistently demonstrated the ability to:

a. *IDENTIFY and UTILIZE appropriate clinical resources* in the hospital, clinic, and the community to support patient care.

b. *COLLABORATE EFFECTIVELY WITH all members of the inter-professional team* (e.g. nurses, pharmacists, health administrators, others) involved in healthcare to assure optimal, comprehensive patient care.

c. *FIND, ANALYZE AND APPLY evidence-based, cost-conscious strategies* in the care of patients and populations.

d. *DESCRIBE how operations and processes* that occur within a complex healthcare organization or system have an impact on cost and quality of care.

e. *DESCRIBE THE LARGER ENVIRONMENT IN WHICH HEALTHCARE OCCURS* (e.g. payment, regulatory, legal, and educational systems), and how physician advocacy can improve each aspect of this environment, and lead to a more just system for delivering health care.

f. *DESCRIBE HOW HEALTHCARE IS CURRENTLY ORGANIZED, FINANCED, AND DELIVERED,* and how various proposals to change the healthcare system would alter the financing, delivery, and fairness of the healthcare system, and potentially benefit vulnerable and underserved populations.

g. *DESCRIBE REGIONAL VARIATIONS IN THE DELIVERY OF HEALTH CARE,* and its implications for quality of care, cost of care, patient health, and evidence-based guidelines.

h. *UTILIZE THE RESULTS OF OUTCOME STUDIES TO IMPROVE PATIENT CARE,* sometimes at lower overall cost.

i. *IDENTIFY THE ROLE OF THE PHYSICIAN* in addressing the medical consequences of common social and public health factors (such as racial, socioeconomic, and cultural factors that affect access to and quality of care) that contribute to the burden of disease (such as malnutrition, obesity, violence, and abuse).

j. *ADVOCATE FOR OPTIMAL CARE FOR EACH PATIENT* (safe, effective, patient-centered, timely, efficient, and consistent with patient preferences), and optimal and cost-effective health care for the population.