Student Curriculum Committee Survey Report
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Introduction

This document presents a synopsis of the results of the Student Curriculum Committee Survey, distributed to all SUNY Downstate medical students in May 2009. The survey was designed to be completed within twenty minutes and contained multiple choice as well as free-answer questions.

From the results the Curriculum Committee distinguished certain themes as being relevant throughout all four years. The main recurrent themes are as follows:

1. The ECM curriculum needs a major overhaul. Currently, there are too many ineffective lectures. Students need more opportunity for hands-on learning experiences. Many students suggested introducing physical examination skills during MS1.
2. CBL is, in theory, an effective way to learn. However, students need to be encouraged or compelled to make a more concerted effort to teach other students, and facilitators need more standardized training.
3. Lectures could be improved by having more organized and standardized notes and slides and by gearing the material towards board exams and clinical practice.
4. Many students found POPS/Gross Path to be an ineffective way to learn. They found the format disorganized and were frustrated by the lack of clear learning objectives.
5. Downstate needs to address the issue of mentoring, which is of particular concern among MS4 students. Students need more one-on-one mentoring from other medical students, MDs, or other staff members.

This report contains an overview of themes that are important across all four years. Included are particularly relevant student comments. These comments were chosen because they expressed opinions voiced over and over again by many students.

The Curriculum Committee's survey elicited strong participation among all four years, and the comments provided by students were valuable and numerous. Due to space constraints, unfortunately not all commentary and raw data could be included in this report. Individuals interested in the curricular reform process are encouraged to read the survey comments in their entirety. The amount of feedback shows that students at Downstate take pride in our school and are interested in improving the learning environment.

Themes For All Four Years

♦*Favorite and least-favorite learning modalities:*

- Positively-rated learning modalities: gross anatomy lab, independent study, patient demonstrations, lecture with podcast and transcripts
- Mixed-rated learning modalities: histology lab, CBL
- Negatively-rated learning modalities: TBL, gross pathology

♦*Ways to improve learning modalities:*

- Uniformity of facilitator training, including standardized grading systems for all professors (CBL/histology)
- Train facilitators to increase student participation and accountability (CBL)
- Importance of an epilogue (CBL)
- Standardization of learning topics (CBL)
- Standardization of slide presentations and access to slide presentations (histology)
- Formalized goals or tasks (gross pathology)
- Supplementary lecture notes (TBL)
- Standardization of lecture notes across all blocks
- More patient demonstrations

**"CBL is absolutely instructor-dependent, and highly variable in how it was taught." (MS3)*
** "CBL needs better supervision." (MS3)*
** "Students should be required to TEACH [during CBL] and not just read." (MS3)*
** "TBL was a disappointment, it lacked a clear structure and did not provide framework for information." (MS3)*
** "CBL should be presented more as minicases are, problems with the students coming up with solutions, and then the answers provided at the end of the session." (MS1)*
** "I appreciate the fact that we were broken up into small groups for histology and gross anatomy, but to be most effective, the many faculty members who facilitate and lead these groups have got to standardize the material they teach (to some extent this could be applied to CBL facilitators as well)." (MS1)*
** "The point-out sections on the [histology] exams are very subjective (on the graders' end) as there are multiple faculty and they don't all grade the same way (some faculty give students a second chance and some do not)." (MS1)*
** "I have thought a lot about why CBL is so ineffective. First of all, having a different facilitator each time means that we never know what to expect. […] Secondly, we all know that our presentations and research will be evaluated, but it's unclear how we are evaluated or where those evaluations end up." (MS1)*
** "I think CBL is a good idea in theory, but it is not an effective teaching tool. Too often learning issues overlap and we end up researching the same thing as other group members. For many of the cases, there are not enough learning issues for each member, so we have to 'make up' issues that we know will not be tested on the exam. While it is always good to know more information, during MS1 is not the time to add on extra work because it is already so busy." (MS1)*
** "I think histology lab sessions would be more useful if it had a uniform PowerPoint presentation given to all carrels and it would also be available for students on Prime."*

(MS1)
** "Occasionally professors held review lectures which were extremely helpful in terms of tying things together and helping us recall lectures from earlier on." (MS1)*
** "Students need to be encouraged to take CBL seriously. This includes the professors." (MS1)*
** "The bedside preceptorship was by far the most effective part of teaching the art of being a physician. It was also the most effective part for teaching the SCIENCE of being a physician. I can still remember all the pathophysiology of the diseases my patients had and I can remember all the drugs they were taking and their mechanisms of action. This is how medical school should be taught." (MS2)*

♦*Ways to improve lectures:*

- Better-coordinated handouts and lecture slides
- More clinicians/less PhDs
- Increasing the "big picture" concept; lessening the focus on minutia
- "Top Ten" summary of each lecture (refer to 2nd year renal)
- Making PowerPoints available before lecture
- Improving the quality of lecturers who are consistently rated poorly

** "May I suggest setting more rigorous guidelines for creating notes by the professors?" (MS1)*
** "Notes need to be updated by professors teaching them so they line up with what is taught in class." (MS1)*
** "We should have more interaction with actual patients during second year." (MS3)*
** "Increase interaction with seasoned clinicians during MS2." (MS3)*
** "Lectures should stimulate thinking." (MS3)*
** "Educate your professors on the most effective teaching methods. Have good teachers mentor younger or less experienced teachers. Teach your teachers!." (MS3)*

♦*Ways to improve ECM:*

- Decrease quantity of assigned readings
- Fewer PowerPoint presentations; more guest lecturers/panels/patient perspectives
- Fewer PCP sessions
- Standardization of small group leaders
- Biostatistics as a free-standing block
- Increase focus on the workings of a healthcare team (RN, PT, etc.)
- Increase leadership training
- Follow the same patients throughout the four years of medical school (through an outpatient clinic)
- More PE skills earlier (during MS1)

**On "the art of being a physician": "It was very difficult to be exposed to this topic before really having had any relevant experience. I'm sure what was covered was important, but I didn't take much away from it, and probably would have gotten more out of it had some of the lectures been done early third year after more practical experience." (MS4)*
**"PowerPoint lectures are an ineffective method of teaching empathy." (MS3)*

"More one-on-one interaction with attendings who can share h&p skills." (MS3)
"Physical exam skills should be taught starting MS1 year alongside anatomy." (MS3)
"Increased time seeing, touching, meeting and spending time [with] patients." (MS3)
"I think the readings are helpful learning tools but difficult to be able to complete all the readings with all the other work that we must do in MS1. I think we should decrease the amount of readings so we can actually complete them all." (MS1)
"I thought the standardized patients were a great way to gain exposure to the patient-doctor experience and to gain feedback on how the patient views the interaction. I don't think it is necessary to make the PCP sessions go so long (12). I probably could have had the same experience in 8 sessions and would benefit from the extra time with all the ECM reading that is assigned." (MS1)
* *"I found the didactic PowerPoint-style lectures on things like US Healthcare […] or Culture/Disparities/Health to be dry. These would be far more effective in small groups and/or with guest speakers speaking from anecdotal and personal experience." (MS1)*
* *"Patient perspectives are VERY important. The film about the woman who survived breast cancer offered a lot of insight about the patient experience. In a setting where we are taught to treat diseases scientifically, it is very important to keep in mind what it means for the patient to have an illness." (MS1)*
* *"There were FAR too many lectures about how to be empathetic and after the first 1 or 2 we start to tune it out. I learned the most when I actually attempted it." (MS2)*
* *"Being a good physician comes through practice. You can listen to someone talk about it all day long and still be terrible at it at the end of the day. It's all about practice, practice, practice. The physical exam teaching sessions, standardized patients, and the preceptorships are invaluable teaching tools that should be expanded upon." (MS2)*

♦*Blocks to emulate:* Cardio (emphasis of "big picture" concepts); Renal (good notes and objectives); Triple I (organization and patient presentations); Neuro (integration of clinical medicine with the basic sciences)
♦*Blocks not to emulate:* GI (not relevant to clinical situations encountered in MS3/MS4)
♦*Improving mentoring services:*

- More centralized information on residency programs
- Implementation of a mentoring program among students (MS4s mentor MS1s)
- More guidance starting earlier and more often
- Central office to guide students
- Current mentoring lunches are ineffective

* *"A more structured approach would have been helpful for me (ie scheduled events within the curriculum to interact with physicians within various specialties)." (MS4)*
* *"I do [attend] the career mentoring lunches, but that is not mentoring. That is having lunch with somebody who barely remembers you from visit to visit. A mentor relationship is a one on one relationship with somebody who knows you and cares about you. Downstate does not offer mentorship to its MS1 students." (MS1)*
* *"I feel lost in terms of how to spend my career as a medical student, what activities would help me decide which residency would be a good fit, and what types of opportunities there are in terms of research, expanding my experience as a student at Downstate, and other opportunities that would expose me to new challenges." (MS1)*
* *"I haven't actively started to seek career counseling. However, I would like to know*

that I could talk to people who are familiar with different residency programs and how I can think about choosing them. There doesn't seem to be a central place to compare and contrast residency programs besides by word of mouth of visiting them. It would be helpful to have a resource where the information is compiled." (MS1)

♦*Grading system:*

- Most MS1 and MS2 want Pass/Fail only
- MS3 and MS4 are evenly split between Pass/Fail only and Honors/High Pass/Pass/Fail with class rank

♦*Length of first and second years:* Over all four years, most students think the first two years of medical school should stay the same length; however, many want more elective time or want to integrate more clinical material during the first two years.

Third-year Themes (retrospective of MS1-MS3)

- TBL was overwhelmingly voted the most ineffective learning method used during MS2.
- MS3 students want more patient interaction, and earlier.
- Triple I was a favored block due to its tight organization and integrated approach. Neuro was noted to have great integration of material with patient care. Renal was considered to have the best lecture notes, with study guide being particularly useful.
- MS3 students were somewhat to slightly satisfied with the board preparation and their readiness for floor work. They thought they needed better training with writing SOAP notes, presenting patients, taking a history, IVs, injections, and preparation to do a physical exam.
- Many MS3 students wanted exposure to more subspecialties during the MS3 clerkships, specifically more surgical sub-specialties.
- 65% of respondents were not interested in a research requirement.
- Overall, MS3 students feel lost during the residency application and preparation period and would appreciate a medical doctor for counsel and advice outside of their clinical Dean.

Fourth-year Themes (Retrospective MS1-MS4)

- Most MS4 students are dissatisfied with MS1/MS2 exposure to the workings of a healthcare team, their role on a healthcare team, and leadership training.
- Most MS4 students are also dissatisfied with their MS1/MS2 education in medical ethics and in medical decision-making, concerning living wills, DNR, etc.
- Specific areas in which MS4 students wanted more training in prior to MS3 included IV placement, writing a SOAP note and presenting a patient during the preclinical years. In contrast, most thought that an appropriate amount of time was spent on phlebotomy, physical exam, PPD placement, injections, and history taking.

•Although most students thought that the clerkships were the appropriate length, 55% thought geriatrics/palliative care was too long, 43% thought surgery was too long, and 36% thought Primary Care I was too long.
•Multiple students thought there should be a required course in Radiology/Diagnostic Imaging.
•51% of MS4 students thought that MS3 and MS4 students would benefit from leading small group learning sessions for MS1 and MS2.