

Minutes of the meeting of Committee on Educational Policy and Curriculum
SUNY Downstate College of Medicine
September 22, 2011
Seminar Room 2-1

Present: L. Eisner, J. Libien, S. Ostrow, R. Ovitch, B. Trauner, K. Perkins S. Hahn, K. Twomey, E. Lukovic, D. Cucco, D. Wong,

Guest Speaker: Dr. Jeanne Macrae

Minutes of August 4, 2011 meeting were approved. Dr. Libien was asked to review the minutes in advance since Dr. Eisner was not present at the August 4 meeting.

It was reported that Dr. Ostrow recruited students from CEPC to the newly formed Student Admissions and Promotions Committee. CEPC now has 6 student members, 2 students each from MS1, MS2 and MS3. They were asked that at least one student from each class attend every meeting.

Last month, the committee reviewed results from the Residency Program Director's Surveys 2003-2009. Committee members felt that there was not enough information to make these useful for evaluating Downstate's curriculum and how well prepared the Downstate students were. Dr. Jeanne Macrae (the soon-to-be Associate Dean of Clinical Medicine, the current Residency Program Director in Medicine and the faculty member in charge of design of the clinical years in the new curriculum) was invited to CEPC to provide clarification and give her input on the quality and usefulness of the surveys.

Questions posed to Dr. Macrae to discuss at the meeting:

- 1. Are there plans or changes already in place this year for the MS4 transition to new curriculum?*
- 2. How can Residency Director surveys be used to evaluate our curriculum and prepare our students better? Do you think they are useful? Any comments on how our residents from Downstate compare to the residents from other medical schools?*
- 3. What contribution can CEPC make in planning new electives?*

**CEPC is in the process of looking for ways to evaluate and propose improvements to the current non-credit and for-credit electives in the curriculum. We have already created a set of guidelines for faculty who want to offer new electives (for current curriculum). What will happen in the new curriculum?*

**How will the requirements for electives change? How will the elective catalogue change? What useful information can we provide to you to help in improving future electives?*

**Some students are concerned about the 8-week limit within a specialty, especially as some electives may be sponsored by one department but apply to many (EKG, Ultrasound). Can some electives be "interdisciplinary"?*

**CEPC is preparing a list of recommended electives for each specialty. What format should they take to be most useful based on the responses we have already received from some departments?*

Residency Program Director Surveys

Dr. Macrae discussed issues of timing of the survey request, who should fill it out and the value of the Dean's letter and the reputation of the medical school in choosing residents. The survey requests are voluntary to complete. She commends Downstate for their brief form that asks that their students be rated: Below average, Average, or Above average in overall performance, clinical skills and didactic knowledge. On the Downstate form the program director is also asked whether the resident is better than expected, as good as expected or not as good as expected based on the Dean's Letter. The form is not daunting and therefore probably has a high rate of return. She questions, however, whether we get enough information from them to be useful assessments of our curriculum.

There is a serious issue with timing of the requests. It is hard to assess their performance at this early stage. She said it probably would be best if there were at least two inquiries, with a second one at the end of their training.

All medical schools have different forms and the questions are very variable. Some schools don't send any requests for evaluation of their former students. Some schools have an electronic system. Einstein

requires you to set up a username and a password to get in to fill out the form. Some schools have very long electronic forms with mandatory fields in which you can't go forward if you leave a question blank. Some schools send the electronic version and if there is no response, they will then follow up with a letter in the mail asking you to fill out the form. The trend is to now ask about the resident's performance in core competencies, including detailed questions on patient care. Some specifically ask how the resident is at taking a medical history or doing a physical exam. Some forms do not even give you the name of the resident, but expect the program director to remember who came from that school. Downstate's Medicine residency program is very large and Dr. Macrae thinks it is difficult for a program director of a large program to answer all these questions on all the residents. On the other hand, even if the form is more detailed she's not certain that it will be any more useful if the program director doesn't really know the resident well enough to answer the questions. Discussion was raised about whether faculty other than the program director could fill out the evaluations.

Dr. Macrae does not feel that the Dean's Letter is particularly helpful except to identify the student's ranking and thinks that high class standing is a good indicator that the student can multi-task and fit into multiple environments. She says that it would be valuable for the medical school to come up with ways to assess the student's ability to function capably under difficult situations. She went on to distinguish between the different ways to evaluate residents: how they perform in the domains of competency, the quality of their technical skills and what kind of employee they are. These do not necessarily overlap. A resident can perform these competencies adequately, but yet still be non-functional in the setting. They are not functional if they cannot multi-task nor reason clinically and show common sense. There's nowhere on any of the forms sent to program directors to make those comments to medical schools about their former students. Does the student have the potential to have the resident and employee behaviors necessary to be a good resident? These are to be hard-working, interested, collegial, accepting that work comes before social life, reliable, friendly, pleasant, accepting the inevitable unfairness of life, go the extra mile for a patient or colleague, looking like you care about the patient, pitching in and covering for colleagues without whining, being respectful to those junior to you, and accepting criticism without being defensive. She talked about whether medical schools are honest in describing a student and whether in the clinical years in clerkships and MS4, relationships are strong enough to be able to write a meaningful letter on behalf of a student. Dr. Macrae believes these qualities are assessable and should be reinforced or taught in medical school.

It was suggested that if a student does poorly on these residency program director evaluations, it may reflect that the student is in the wrong residency program. It could be a bad fit clinically or academically.

Someone recommended that new residents should also be asked to fill out a survey on how well the Downstate curriculum has prepared them for the residency. Members questioned whether an intern would bother responding to such a survey given the demands on their time.

Dr. Macrae stated that her experience showed that Downstate students are well-trained and their didactic knowledge is strong. In the past they had not been exposed to ultrasound and enough other diagnostic imaging. Many Downstate students go to North Shore, Downstate and Montefiore for residencies. Maybe it would be productive to call or send detailed surveys to these hospitals where Downstate students go to ask them how Downstate students are doing.

CEPC faculty members were asked if those who sit on the Dean's Council and other committees have ever reviewed residency program director survey results? None of those present had ever seen or discussed these residency program director surveys.

New Curriculum

Dr. Macrae told us about some elements of the proposed third and fourth years which will no longer be called "third and fourth years" in the future new curriculum. There will be a transition period to the time when all students arriving at the clerkship year will have all gone through the new Foundations of Science curriculum. She explained how the school would handle the transition year. Starting in 2015 when the students will be coming from the newly redesigned Foundations of Science curriculum, the third year will start in April and end in March of the following year. The fourth year will start in April and will be longer

than the current MS4. The future fourth year will be 13 ½ months long extending into mid-May. Within the 13½ months, there will be required courses that will occupy four and a half months of that time. Those required elements are the current Sub-internship, the current Primary Care 2 (a Geriatrics-guided patient care experience) and a new required course in Radiology. Emergency Medicine will also move into the fourth year and it is going to be four weeks long instead of two. The remaining elective time will be a minimum of 5 months allowing 3 additional months time for vacation, interviews and study for Step 2. She shared a sample tentative schedule from a future fourth year.

They hope to give more guidance to students on how to construct a fourth year. Each specialty discipline will come up with a list of electives to recommend to students that are interested in going into that specialty. This does not mean that all the electives should be in that specialty. Much thinking still needs to be done to determine what the policy will be for this. Do students have to do this if they are still not decided on a path until February? They considered having students having a major and minor specialty in mind and taking electives in those.

There are many logistical and policy issues to be worked out. There are going to be periods of time where there is going to be a very large number of students who are trying to get into an elective all at once and many other logistical issues to figure out to accommodate all the students. Emergency Medicine and Radiology will have to decide what other electives to offer and when if there will be required electives in these specialties. Some have suggested including in the clerkships periodic TBL sessions that incorporate basic sciences.

Dr. Macrae has asked CEPC to provide her with any information that we collect on elective registration or recommended electives by specialty disciplines.

Elective Registration Data

Elective registration data compiled by the Registrar was distributed. The meeting ran out of time to have Anne Shonbrun explain the Registrar's analysis. This will be postponed until the next meeting. Hard copies were distributed to the committee for review.