Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
July 21, 2008

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, J. Ranck, I. Harwayne-Gidansky and L. Wilson

Minutes of May's meeting were approved.

Dr. Clark-Golden announced that this would be her last meeting. Dr. Michael Lucchesi and Dr. Keith Williams will be appointed to the position.

There were discussions regarding extending the membership of the CEPC Committee and taking a major look at the curriculum from the NBME.

Report on Core Clinical Clerkships - See attachment I

The Meeting was adjourned at 5:00 p.m.

Attachment I

CEPC REPORT ON THE CORE CLINICAL CLERKSHIPS

SUNY Downstate has a justified reputation for providing its students with a rich clinical education, in which our students get a great deal of hands on experience and an appropriate amount of autonomy as they progress through the clinical years.

The practice of medicine has evolved dramatically in the last two decades, and shows every indication of undergoing an accelerated rate of change in the next two. Thus it is timely for the School to review what we are currently doing in clinical education, and plan how we can prepare our students to be physicians in the environment of the future—an environment which may differ in very fundamental ways from the one we know. For instance, rapid scientific advances have intensified care at every level, from primary care with ever new vaccines and screening modalities, to care of acute and chronic illnesses. The settings in which care is delivered have multiplied, which has permitted extraordinarily high quality care for selected problems, but fragmented care of the whole patient. The advent of electronic medical records (EMR) offers unprecedented possibilities for coordinated, computer-supported care; it also raises barriers to clinical learning. In the last 10 years, physicians have been striving to reclaim and rebuild the patient-doctor relationship in the face of these unprecedented challenges.

Hence, starting in September of 2006, the CEPC undertook of review of each of the 10 core clerkships: Anesthesia, Emergency Medicine, Medicine, Neurology, Pediatrics, Primary Care 1,Primary Care 2 (Geriatrics and Palliative Care), Psychiatry, Surgery, and Women's Health.

Methods

We began with a brainstorming session in which the Committee generated a list of questions about the clinical experience as a whole—see the attached list. The Group also asked to review the following background materials:

The Eight domains of Competence
The official Course Descriptions of each clerkship
The LCME standards related to required clerkships
The content Description and Sample Test Materials of the STEP 2 CK
Our students' performance on the STEP 2CK in recent years.
Student feedback on the clerkships

Review of these materials led to some revision of our overall question list, and helped us finalize the questions to be posed to each of the clerkship directors. The process and the questions were presented at a Clerkship Director' Meeting before the actual review process began. The Clerkship Directors we asked to consider the following broad questions:

1. What do you want students to take away from your clerkship?
2. How well are you succeeding? (And how are you measuring your success, in terms of student learning and in terms of student feedback, students choosing the specialty, etc.)
3. What else would you like to do? What would you need to do those things?
4. Do you have problems with the mechanics/organization of your clerkship? Are you satisfied with your clinical affiliates?

We then scheduled a CEPC meeting with the Director of each of the clerkships; the Director was encouraged to bring anyone else involved with the clerkship. We have just completed a review of all 10 of the clerkships, and the minutes of each of those 10 meetings is also attached.

Findings

The rest of this report will describe what we have learned in answer to our initial questions about the clinical experience as a whole.

Note: the letters before each question below refer to the lettering on the original list of questions, entitled "Review of MS3 and MS4", which is appended at the end of this report.

f. Do the clerkships have common or similar standards for grading, didactics, etc?
Most clerkships use clinical assessments plus a written exam as the basis for assessing student performance. Several clerkships also use written work—patient write-ups or a research paper; it was not felt that the grading schemes needed to be identical for each clerkship. All clerkships could benefit from having more accurate methods for assessing clinical skills; this need may be met in part by the proposed Clinical Skills center.
All clerkships now have some formal didactic sessions as well as a variety of web based learning resources. All the clerkships also feel the time tension between clinical work and purely didactic activities.

g. What are the required basic skills, and where are they covered?
All clerkships address the most basic of skills—history taking, physical examination, "thinking on your feet", and thinking expansively. There are subsets of those basic skills---detecting heart murmurs, otoscopy—which can be learned in a variety of settings. Task trainers or whole body simulators may be helpful to make sure each student gets a "minimalist core" exposure—this core would need to be agreed on by the group of clerkship directors, and monitored across clerkships. The Committee agreed that exposure to standardized patients on a regular basis (eg—once a clerkship?) would be a useful way of keeping these basic skills on the radar screen for students and faculty alike.

h. How can we coordinate content across sites?
This question seems to require a corollary: what is the "minimalist core" of exposures that each student should have? (Content—defined by which disease each student sees—varies not just by site, but also by student.) For instance, in medicine, every student is likely to see a patient with CHF; they may not see a patient with SLE, but it is important for them to be knowledgeable about this rarer but important disease. The simulator center provides one method for insuring that everyone can get exposure to rare but important diseases, for instance. PRIME was felt to be another method—but the 4 clerkship directors who are members of the Committee have been frustrated with the tech support for them for PRIME. It would help to have an "EIO"—Education Information Officer—dedicated to the clinical education endeavor—somebody with expertise in both clinical education and web-based methodologies.

k. Are students required to use/improve knowledge of basic science?

This was a difficult question to answer—and not just because it wasn't addressed by the clerkship directors in their reports. The off-the cuff response was that we rarely ask students to use basic science knowledge in the clinical arena, but with some probing, there emerged a sense that in fact we do review basic science concepts at some level. There were questions about "what do we mean by basic science?"— how basic—or detailed— are the concepts we ask students to retrieve and review. In neurology, for instance, which may be an exceptional case, every patient encounter requires review of anatomy and physiology, at least in general terms. The average clinical neurologist, on the other hand, is not likely to discuss channelopathies.

It was recognized that this question is being asked nationally. Other schools are addressing this question by revising their curricula, and these new curricula with more longitudinal integration of both basic science and clinical science have been one of the reasons for the proposed change in the USMLE exam.
If the Board does implement the new exam, one thing we could do would be to change the requirements of the patient write-ups or other written exercises, and require that students address 2 or 3 basic science domains each time. (Anatomy, physiology, and pathology are probably the easiest to access from the clinical end of the tunnel.)

l: Do we promote lifelong learning?
m. Are we teaching evidence-based medicine?
v. Do students need to learn more informatics skill?

These three questions were discussed together. The student member reported that the emphasis on self-directed learning varied enormously with the particular team, and also with the student. However, the learning during the clerkships seems to be highly focused towards learning for the shelf exam. She is having a wonderful experience this month during her pediatric sub-I, partly because her attending expects daily reports on questions that team members have researched. This student reported on her experiences looking up specific questions—she found it very hard to find answers, while her husband who is a third year peds resident, could find answers to those questions quickly. This speaks to the need for students to have solid clinical knowledge, as well as specific skills with informatics, to become adept at finding answers in the literature.
The group agreed that the abilities to search and critically evaluate the literature needs to be modeled at the resident and attending level in order for students to absorb the ethos of evidence-based medicine. Dr. Wallace made heroic efforts to inculcate these skills into residents and faculty, especially in the Dept. of Medicine; since her death, this effort has languished, and needs to be revived.

n. Should we be promoting clinical research by students?
o. Do students have adequate knowledge of research methods?
r. How many students get research experience?

These three questions were also discussed as a group, hinging off of the previous discussion. The group felt that knowledge of research methods, and personal experience with clinical research, would be very helpful in making students better "consumers" of the medical literature. A large number of students get research experience during Primary Care I—the continuation of that opportunity was strongly endorsed, along with a recommendation to shoehorn in some didactic sessions/exercises on research design. The Committee had also

discussed working with the IRB to design a template for expedited review of brief student projects. The creation of such a course could be a collaborative effort with the School of Public Health.

s. Where are we teaching management of chronic disease?
t. Where are we teaching prevention?
u. Do we have the right balance of out-patient/inpatient experience?

These questions were also discussed as a group. The clinical faculty felt that students in fact learn a fair amount about the management of acute exacerbations of chronic disease during inpatient rotations, but that the day-to-day "preventive" management of chronic disease is hard for students to learn in the brief ambulatory experiences (6 weeks in Primary Care 1 and 2 weeks in Pediatrics)**.** The Brooklyn Free Clinic (approved and set up in fall 2007) has already involved 170/770 COM students, and does give the students a taste of continuity care over a longer time span than six weeks. There was a strong interest in looking at programs at other schools which can give students a weekly primary care experience over the course of the third year. Perhaps Primary Care 1, instead of being a 6 week block, could become such a longitudinal experience. (Such a reformatting would give other clerkships more of a time span for students to assimilate and practice skills, even if the contact hours were not changed.) Transformation of Primary Care1 into a longitudinal experience might also permit more students to complete all the core clerkships during year 3. This is important both for the weaker students, as well as for students who are interested in competitive subspecialities. U. of Nebraska, Rochester, and Harvard, among others, have piloted such courses recently.

In closing, we have not directly addressed the felt need of several clerkships for more time or revisions to the schedule. One way to relieve some of the time pressure being felt by the clerkships might be to focus on how to develop specific student competencies with interdepartmental collaboration.

Recommendations

Based on this review, the CEPC makes the following recommendations to enhance the clinical education of our students:

1. Reliable, quality assessment of student competence in clinical skills requires use of the most advanced methods available: standardized patients, task trainers, and clinical simulators. Hence the CEPC heartily endorses the plan for a Clinical Simulation Center on campus, for both formative and summative assessments of our students' progress. We also propose that the school seek grants to be able to budget one SP assessment/clerkship.

2. The clerkship directors need an "Educational Information Officer" dedicated to the clinical years to assist in mounting and maintaining Web based didactic materials. The Web is gaining in importance as a way to insure comparable didactic experiences across our diverse sites. This individual needs to be knowledgeable about clinical education as well as skilled in growing an Educational IT system.

3. The school needs to revive a concerted effort to train faculty and residents in Evidence-Based medicine, so that the students will be learning in a climate which is

permeated with the philosophy and practice of turning regularly and thoughtfully to the literature for patient care decisions.

4. We need to develop a brief didactic course in clinical research methods, including study design and research volunteer protection. The school should continue to support the recognition of student research effort as part of clerkship evaluations.

5. We should look at curriculum designs which would give our students real life experience in longitudinal management of chronic disease. Such a clinical experience ideally would be interdepartmental, and might provide a way to decompress the block rotations. This would require identification and recruitment of additional ambulatory care sites—which might have a fringe benefit of improving access to primary care for the residents of Brooklyn.

6. We should look at interdepartmental teaching for some of the clinical skills currently taught in isolated clerkships—eg, the neurologic exam in pediatric, ambulatory, or general medicine settings; evaluation for depression and anxiety disorders in settings other than the psychiatry clerkship; coordination of teaching about gyn and ob care between pediatrics and women's health.

7. The clerkship directors are very receptive to thinking about ways to keep basic science concepts percolating through discussions of actual patients. This integration will require repeated opportunities for dialog between the basic science and the clinical faculty. It might be productive to start with a work group to develop something like the Eight Domains of Competence specifically for the basic science of clinical practice.

Conclusions

This review has been informative, partly for bringing to light specific concerns of individual clerkships, and of the clinical faculty in general. The process of having regular discussions of curriculum and teaching methods was also warmly regarded.
Some of the recommendations— reviving the EBM curriculum, developing a research methods course, hiring a clinical "EIO"—are relatively easily to implement without major curriculum or institutional overhaul. Others—finding a path to better integrate basic science in the clinical years, finding ways to give students longitudinal ambulatory experience and to develop interdepartmental teaching of important clinical themes—will take a much more intensive look at the curriculum, and the mobilization of resources.

The planning for a Clinical Competence Center is underway, but will need ongoing input from the Clinical Course Directors to be sure that the Center's programs meet the changing needs of the clinical educators across the board.

Lastly, it is vital that students on all services continue to be active members of the clinical team, which means being able to document in their patients' charts. Hence the College of Medicine needs to specify standards of student EMR access in it affiliation agreements.

REVIEW OF MS3 AND MS4
September 18, 2006

Items to be considered:

1) Catalogue
   a) No sub-internship description in the catalogue.
   b) The rules for distribution of electives are not in the catalogue.

2) CEPC should review the Downstate Clinical Skills Examination results.

3) Brainstorming session:

   a) What are the LCME standards that relate to required clerkships?
   b) What's the USMLE content of Step 2?
   c) When do students take Step 2 related to completion of clerkships?
   d) Why do students take the major clerkships in the 3rd year? (Examine the grid and enrollments by rotation.)
   e) How much elective time should students have in the 3rd year?
   f) Do the clerkships have common or similar standards for grading, didactics, etc. across clerkships?
   g) What are the required basic skills, and where are they covered?
   h) How can we coordinate content across sites?
   i) What are the grade distributions for the clerkships?
   j) What assessments are used in each clerkship?
   k) Are students required to use/improve knowledge of basic science?
   l) Do we promote lifelong learning?
   m) Are we teaching evidence-based medicine effectively?
   n) Should we promoting clinical research by students?
   o) Do students have adequate knowledge of research methods?
   p) Are we assessing professionalism effectively?
   q) Is there a general dress code?
   r) How many students get research experience?
   s) Where are we teaching management of chronic disease?
   t) Where are we teaching prevention?
   u) Do we have the right balance of out-patient/in-patient experience?
   v) Do students need to learn more informatics skills?

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
May 19, 2008

Present: M. Clark-Golden, M. Augenbraun, R. Gordon, R. Singhal, L. Merilin and L. Wilson

Minutes of April's meeting was approved.

The motion passed by CEPC last meeting about Histology grading was presented to the Dean's Council and provoked some very heated discussion without any resolution. Most of the discussion there focused on why Histology Labs are not required activities; there was some general acceptance of the idea that a skill-such as being able to identify tissues microscopically— does represent a fundamental competency, and as such should be explicitly taught and assessed. There was also discussion of whether the histology labs could be made more interactive; that seemed to be a question which should not be discussed unless the histology faculty was also present.
The student members of the CEPC, referring to their survey of their classmates, felt strongly that the quality of histology teaching and notes needs to be reviewed, because there are some weaknesses. It was suggested that it might help if the Block Directors reviewed the Histology teaching in each block, to be sure it is congruent with the rest of f the teaching in that block. It is likely that attendance in Histology lab will become mandatory, which does mean that the lab teaching should be reviewed to be sure it accomplishes very defined goals.
(Have requested the student evaluation for the MS1 courses fall of 2006-present;. In the evaluations from 2005-2006, Histology labs were rated positively: 15-46% strongly agree; 33-49% somewhat agree. Very few comments.)

We then turned to answering the global questions we had posed for the review of the core clerkships:

f. Do the clerkships have common or similar standards for grading, didactics, etc?
Most clerkships use clinical assessments plus a written exam as the basis for assessing student performance. Several clerkships also use written work—patient write-ups or a research paper.; it was not felt that the grading schemes needed to be identical for each clerkship. All clerkships could benefit from having more accurate methods for assessing clinical skills; this need may be met in part by the proposed Clinical Skills center.
All clerkships now have some formal didactic sessions as well as a variety of web based learning resources. All the clerkships also feel the time tension between clinical work and purely didactic activities.

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"minimalist core" exposure—this core would need to be agreed on by the group of clerkship directors, and monitored across clerkships. Agreed that exposure to standardized patients on

a regular basis (eg—q clerkship?) would be a useful way of keeping these basic skills on the radar screen for students and faculty alike.

h. How can we coordinate content across sites?
This question seems to require a corollary: what is the "minimalist core" of exposures that each student should have? (Content—defined by which disease each student sees—varies not just by site, but also by student.) For instance, in medicine, every student is likely to see a patient with CHF; they may not see a patient with SLE, but it is important for them to be knowledgeable about this rarer but important disease. The simulator center provides one method for insuring that everyone can get exposure to rare but important diseases, for instance. PRIME was felt to be another method—but the 4 clerkship directors were frustrated with the tech support for them for PRIME. It would help to have an EIO—Education Information Officer—dedicated to the clinical education endeavor—somebody with expertise in both education and web-based methodologies.

k. Are students required to use/improve knowledge of basic science?
This was a difficult question to answer—and not just because it wasn't addressed by the clerkship directors in their reports. The off-the cuff response was that we rarely ask students to use basic science knowledge in the clinical arena, but with some probing, there emerged a sense that in fact we do review basic science concepts at some level. There were questions about "what do we mean by basic science?"—meaning how basic—or detailed—the concepts we ask students to retrieve and review. In neurology, for instance, which may be an exceptional case, every patient encounter requires review of anatomy and physiology, at least in general terms.
The average clinical neurologist may not discuss channelopathies.
It was recognized that this question is being asked nationally. Other schools are addressing this question by revising their curricula, and these new curricula with more longitudinal integration of both basic science and clinical science have been one of the reasons for the proposed change in the USMLE exam.
If the Board does implement the new exam, one thing we could do would be to change the requirements of the patient write-ups or other written exercises, and require that students address 2 or 3 basic science domains each time. (Anatomy, physiology, and pathology are probably the easiest to access from the clinical end of the tunnel.)

The meeting was adjourned at 5:00 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
April 28, 2008

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, J. Ranck, M. Nowakowski, B. Lawrence, C. An, I. Harwayne-Gidansky, J. Lewis and L. Wilson

Minutes of previous meeting was approved.

Compendium of our minutes on the clerkships distributed, along with list of questions we had posed at the outset. Members asked to review this material before May 19, 2008 meeting, so that we can turn our attention to creating a report for the Executive committee.

The meeting was then turned to the question posed by the Histology faculty at our February, 2008 meeting. To review, the Histology faculty is deeply concerned about the decline in student performance on the histology practical exam in recent years. Although this decline in performance is probably multi-factorial in origin, the major factor is believed to be that this skill simply does not receive enough weight. With the exception of the renal/endocrinology block, it is possible for a student to pass the other blocks which include Histology practical's WITHOUT passing histology. The CEPC affirmed that the skills set, assessed by the histology practical exams is an absolutely fundamental competency for physicians. We reviewed trends in grades in histology, trends in student performance in histopathology, a survey produced by the students, and discussions with faculty in histology and histopathology. Therefore the committee considered 3 proposals for remedying this under-valuation of this key skill set:

1. Give a separate grade in histology.
2. Make passing the histology practical a "minimal competency" for passing the blocks which include a histology practical.
3. Raise the percentage weight given to the histology practical—it would need to be raised to at least 10% to make it matter for the honors level students, and that would not address the weaker students.

(A fourth option, which had not been discussed by the histology faculty, was to test histology skills 2x a year, in large enough chunks to register for all students on the block grade.)

The CEPC voted on and passed the second option: that passing the histology practical be considered a minimal competency for students to pass the block which includes such a measure of this core skill. A student who fails the histology practical will show a grade for "conditional" for that block; the committee left it to the histology faculty how to remediate students with deficiencies in the practical skills of histology, given that the material is cumulative over the year. The motion passed with 4 in favor and 1 abstention.

The group understands that this resolution will be presented to the Executive Committee and to the Dean's Council. The group also recognizes that this decision may have implications for other disciplines in the basic science years.

The meeting adjourned at 5:00 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
March 17, 2008

Present: M. Clark-Golden, S. Miller, M. Augenbraun, L. Terracina, J. Ranck, B. Lawrence, C. An, E. Langenau, and L. Wilson

Guest: Dr. Paul Harris

Minutes of previous meeting was approved.

Dr. Harris presented the **PC2 clerkship**: Geriatrics and Palliative Care.
This 4-week clerkship is offered 9 times a year, which means that the clerkship has to use a large number of sites. (Since it is offered in the 4th year, three months are blocked out for interviews and ECM4). There was some resistance from students the first year or two it was offered, but it is now a very highly rated experience—a tribute to the quality of the sites, which like all of our clinical teaching, is completely voluntary.

There is no call or weekends; there is an extensive lecture series, and Tuesday afternoons are devoted to lectures and experiences in Palliative Care, which includes one visit by each student to the Calvary Center. In addition, there is an on-line Pain Management Module which the students are required to complete. A Grade of Honors in the course requires honors level clinical work as well as the preparation of an honors project, which is usually more of a topic presentation than a research project, given the limited time frame.

Since SUNY Downstate is in the forefront in offering a Geriatrics Clerkship, our students face almost no competition from students from other schools at the clinical sites. Some 40+ schools offer a thread in geriatrics over the 4 years, with lots of input from geriatric consultation services during other core clerkships. (We have done a survey of our curriculum looking for where content related to geriatrics is presented; the data has been collected but not coded.)

At present, there is no shelf exam in geriatrics, although POGOE (?acronym for…?)does have a question bank which could be used for an objective measure of knowledge to complement the valuable but less rigorous assessments of clinical performance. Another challenge for this clerkship is that the Palliative Care services at our flagship hospitals are still quite rudimentary.

The Meeting adjourned at 5:00 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
February 25, 2008

Present: m. Clark-Golden, S. Miller, L. Terracina, H. Durkin, M. Nowakowski, J. Ranck, L. Medlock, C. An, E. Langenau, R. Singhal, R. Gordon and L. Wilson

Guests: Drs. Lewis, Ojakian, Chirico

It was recommended that the ER elective at the VA be a separate course, because it is only 2 weeks, and does not include pediatrics or OB. We ask that the course description specify that this elective does not fulfill the requirement for the 2 week core clerkship in ED, which does include pediatrics and OB.

Dr. John Lewis then presented the concerns of the Histology faculty re: declining performance by students in the histology portions of the first year blocks. See attached letter from the faculty, along with the report from Dr. Lawrence on student performance for the last several years. The teaching by the histology faculty has not changed significantly in this time interval, and the assessment has not changed until this year (see below.) The faculty have been working on addressing this for some time, including meeting with Dr. Magzamen last summer about the review sessions. This year's scores to date may reflect the decision on the part of the Histology faculty to make the questions more integrative; the students have been alerted that the histology portion of the upcoming Urinary-Endo block exam is cumulative, and counts for 20% of the block grade. (It is one of the few exams which is cumulative in the first year.) The integrative cumulative aspect of this exam will be whether students can identify slides of "unknowns"—a skill which requires students to use the microscope efficiently, to orient themselves by recognizing tissues and structures, and to identify the source of the specimen by integrating information learned throughout the year.

The group held a lively discussion of the differences between the histology review session run by the Office of Academic Development and taught by MS 3 and 4 students, and the histology labs taught by the faculty. Are student grades in histology declining because the students rely too much on the student-lead sessions, which can promulgate significant errors? Other factors which may impact performance include difference in learning styles, the possibility that students are spending less time on campus with the availability of pod casts of lectures, and the emerging availability of "virtual microscopes" which could change the delivery of teaching and assessment in histology.

While The Histology faculty do have concerns that many students are relying more on a student taught than on a faculty taught curriculum, the main issue seems to be that histology does not carry enough weight in the students' grades—yet it is an essential skill for pathology in the second year, and for evaluation of patients in many clinical arenas. Hence the Histology faculty are proposing giving more weight to histology in each block, or to making histology a required competency, which needs to be passed in addition to passing each block.

No resolution could be reached in the time allotted. The group agreed to do the following before reconvening on this topic in April:

1. Student members will survey classmates about the various options presented by the histology faculty.
2. Committee chair will try to get information from second year pathology about student performance in those labs and that subject domain.
3. The Histology faculty should choose a preferred solution.

The meeting adjourned at 5:10 pm.

Attachments: letter of March 5, 2008 from the Histology Faculty to Dr. Sass; Histology Practical Grades 2000-2006; cumulative histology exams grades 1992-2006.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
January 28, 2008

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, M. Nowakowski, B. Lawrence, L. Medlock, C. An, E. Langenau, R. Singhal, P. Harris

Dr. Clark-Golden opened the meeting. Minutes of December's meeting were approved.

Proposal for a 2 week elective rotation in Emergency Medicine at the Brooklyn VA was reviewed. Dr. An will review the current elective offerings in her department and see if this needs to be listed as a new course (possibly, since it is a two week, not a 4 week elective) or a section of an existing course.

Dr. Harris then presented the Primary Care 1 clerkship, beginning with its history. The 1984 LCME review cited the school for not offering enough ambulatory care. Dr. Harris was actually hired to the institution in 1985 to design and set up a required clinical experience in ambulatory care, which was inaugurated in 1987 as an 8 week clerkship in the 4th year. With the curriculum renewal of 1998, ambulatory care was moved from the 4th o the 3rd year, shortened to 6 weeks, and renamed Primary Care 1. In 2001, a required 4 week experience in geriatrics and palliative care, PC2, taken during the 4th year, was started.

Over the last 20 years, the Ambulatory Care/Primary Care 1 clerkship has been the highest rated clinical experience by the students. The students are assigned to any one of a number of sites which range from hospital based clinics to private offices; each cycle, some 5-8 students fulfill this curricular requirement by taking a "family Practice" experience (which differs in some ways from the main PC experience.) Part of the success of the clerkship is that Dr. Harris has access to a range of very good sites; this clerkship runs its own lottery for site placement the month before students start. The sites administered by Dr. Harris include all medicine, all peds, and some medicine peds sites. About 50% of the students' time is spent in continuity care/comprehensive preventive care; the students also spend some time in urgicare settings and medical/surgical subspecialty practices. Tuesday afternoons is devoted to didactics, labeled ECM3, which is doing much better this year under the leadership of Dr. Sass than it had been doing in prior years.

In addition to seeing patients—and being precepted directly by an attending, the students are expected to do a topic presentation at their site. The students get fairly detailed feedback from the faculty preceptors on their clinical encounters, and most students are in fact observed for some or all of several encounters. They must pass the ECM3 component, and must also take a new assessment, an encounter with a standardized patient. To get Honors for the course, the students need to be rated as doing honors level work by the clinical faculty at their site, and do an honors project.

A great deal of discussion was devoted to these honors projects—which are done by the majority of the students. Many of these projects are potentially publishable, or could be presented at national meetings. These projects represent one of the few occasions in our curriculum when most of our students in fact plan and carry out a research project. One issue

with this enterprise is IRB approval—many of the projects received expedited IRB approval, or are done under the umbrella of a faculty member's project, but in deed, some of these projects are "flying below the radar screen." The committee felt strongly that we need to find a way for the students to secure IRB approval for all the projects which involve patients; to do any kind of study, even a chart review, without that process sends the wrong message. It should be possible to come up with a template for a chart review project or a patient questionnaire which would be eligible for expedited review, permitting the design and execution of a project in the 6 week time frame.

Dr. Harris had a number of items for his wish list.

1. He would like to stimulate more studying If there were a shelf exam in primary care (which is currently being discussed on a national list serv) he would be interested in using it.
2. He would like to be able to use more SP exercises over the course of the clerkship.
3. He would like to find a way to show case the honors projects done by the students. Two possibilities were proposed: a Primary Care Fair, a poster session for the primary care projects; and providing the students at the beginning of the clerkship with a list of local and national meetings which would be likely to accept such student projects for presentation.
4. The students need resources to help them apply statistics to the data they collect.
5. Dr. Harris is asking that the CEPC examine re-integration of family practice and the rest of primary care 1.

Meeting adjourned at 5:00 p.m.

Next meeting : February 25, 2008

Minutes of the meeting of the
Education Policy Curriculum Committee
of the SUNY-Downstate College of Medicine
December 17, 2007

Present: M. Clark-Golden, S. Miller, M. Augenbraun, L. Merlin, J. Ranck, C. An, E. Langenau, T. Brouette and L. Wilson

Minutes of November19, 2007 meeting were approved.

New Business

Dr. Brouette, who has been the Clerkship Director for Psychiatry for two years, presented the objectives and structure of his clerkship. His predecessor, Dr. Selzer, had been the Director for more than 10 years.

His first comment is that, although his clerkship is 6 weeks long, which is about the same as other schools, there is much less basic psychopathology and other fundamental material presented in the first two years than most other schools (8 hours of lecture, vs. 30-50 hours at some schools.)It is hard to get a firm count, because some of the basic material is presented in the ECM courses in an integrated fashion. Hence he devotes 24 hours of his clerkship time to lectures, which are posted on line.

The clerkship uses a variety of sites: DMC inpatient, KCHC inpatient, DMC/KCHC liaison service, Kingsborough (most severe), Lenox Hill, LIJ, and recently, Methodist, Lutheran, and Brookdale. Most of the students' experience is with the care of psychiatric inpatients, although the students assigned to DMC/KCHC spend half a day/week in an outpatient setting seeing patients with depression/anxiety. All students take 4 calls in the KCHC psychiatric ED. A big hole in the clinical offerings is child psychiatry; Lutheran does have a child team. (A big chunk—up to 25%--of the Psych shelf is child development and other child psych problems; students' scores on the shelf exam correlate with whether the student has taken pediatrics. This is a national problem, so in comparison with other schools, our students are not at a disadvantage.)

The students are expected to take a great deal of responsibility for "carrying" their own patients; they do the first H and P, document progress notes in the chart, participate in family meetings. They often work directly with an attending; the residents tend to carry patients without a student.

Clinical evaluation of the student by the attending counts for 30% of the grade. (Most of the evaluations are in the above average range.) The shelf exam contributes 30%, and a written clinical skills assessment contributes another 30%. Dr. Brouette has 10 points for "miscellaneous" factors.

The written clinical skills assessment requires that the students watch a ½ hour interview with a patient; they then have 45 minutes to summarize what they saw, come up with a differential diagnosis, suggest treatment and mode of psychotherapy. Dr. Brouette personally

grades all of these essays, so there is very good reliability. (He has protected time from his department to run the clerkship, which is why he is able to do this.) About half the students also elect to do a 2500 page "Honors" paper and oral presentation, which might also boost the student's grade. Dr. Brouette reviews the topics beforehand, and also personally grades each one of these papers. He has found them very interesting, and the student feedback on the exercise has been very favorable. Some of these papers are probably publishable; in 3 or 4 instances, he has suspected plagiarism, which is why he is pleased that our school is signing up to use the TurnItIn software to screen for plagiarism.

He recommends one textbook (Anderson and Black—spelling?). He knows that students use review books, and so on PRIME, he lists the errors in the commonly used review books.

In terms of what he wants students to take away from the clerkship, he points out that 40-60 % of psychiatric care is actually done in primary care. And students in all fields of medicine need to be able to screen for the "lethalities": mania, psychosis, suicidality.

As for his wish list—he feels he has most of what he wants. He has been using PRIME more and more, and he is happy to have TurnItIn.

Meeting adjourned at 5:00 p.m.

Next meeting: January 28, 2008

Education Policy Curriculum Committee
of the SUNY-Downstate College of Medicine
November 19, 2007

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, M. Nowakowski, J. Ranck, L. Medlock, R. Gordon, R. Singhal, I. Harwayne-Gidansky, C. Hill L. Merlin and L. Wilson

Minutes of previous meeting were approved.

New Business

Emergency Ultrasound elective approved, as well as non-credit elective for ms1 on nutrition.

Dr. Constance Hill then presented the Anesthesia Clerkship.
The 2 week anesthesia clerkship (perioperative care) used to be part of the 12 week surgery clerkship. Many schools have a free-standing clerkship in peri-operative care, although by no means all. This clerkship runs 20 times per year, with a maximum of 13 students/rotation. The program uses 6 sites—and could use more: SIUH, Maimonides, LICH, Lutheran, KCHC, and UHB. The clerkship does it own site assignments. At SIUH and Lutheran the student works directly with the attending, who is often someone trained in our program. KCHC can only take one student, because they also run a program for nurse anesthetist students.

Dr. Hill does the orientation, spelling out the expectations, and reviewing the main points of the syllabus and required readings. The syllabus is quite explicit about which topics is the student's responsibility to read about. A clinical director at each site will direct the 1-3 students to particular cases; the aim is for students to be involved in cases where they can in fact do something, although that will always be under direct supervision of the resident or (usually) attending. A challenge has been to coordinate students getting some experience in pre-operative testing to learn about the pre-operative history and physical exam. There is no night call, since emergency cases are not ones in which students can do much. Students are expected to keep a daily case log, and to solicit feedback from a supervising physician each day. The students must attend Grand Rounds, morning conferences, and visiting Professor Lectures. There are also seminars aimed specifically at the students. The students are expected to give a case presentation in the second week; this presentation is given to the designated faculty member who is the "student liaison" at that site. This case presentation has replaced the multiple choice exam or essay, which had been used in the past. Students also solicit summative evaluations from 2 MDs for their final grade. There is an airway management skills form that must be completed to show that they have obtained some proficiency with mask ventilation. The clerkship is graded fail/pass/high pass. There is no grade of honors, and failing grades are extremely rare.

Dr. Hill would be very interested in using a full body simulator for the clerkship. She feels that having peri-operative care as a separate course means that the students give it more attention. On the other hand, there is information about anesthesia on the surgery shelf exam.

Meeting adjourned at 5:00 p.m.

Next meeting: December 17, 2007

Education Policy Curriculum Committee
Of the SUNY-Downstate College of Medicine
October 22, 2007

Present: M. Clark-Golden, L. Terracina, H. Durkin, M. Nowakowski, B. Lawrence, C. An, R. Gordon.

Minutes of the September 17, 2007 meeting were approved.

New Business

The non-credit elective, "Brooklyn Chinatown Flu Vaccine Outreach", was approved and Dr. Ko will be notified.

Dr. Taylor was in attendance by the committee's invitation. We discussed the importance of reviewing non-credit electives such as Dr. Ko's, and other opportunities for students to engage in "service learning", as this is now an aspect of the students' experience which will be reviewed by the LCME. There are important benefits in offering community service activities as non-credit electives, because the students are then covered by the school's insurance.

An issue raised by the approval of Dr. Ko's elective is whether each elective needs to belong to a "department"—Dr. Ko is in cardiovascular surgery, but this elective opportunity is more of a primary care project. No verdict was rendered.

Dr. Taylor then informed the CEPC members about a proposed change from the NBME, which may go into effect as early as July , 2011: The NBME, which has always stressed that the USLME is a **licensure** exam, is proposing to do away with a basic science exam to be given at the end of the basic science years of medical school (and often used for promotion /advancement decisions) and to replace step 2 CK, given after the core clerkships, with a comprehensive, integrated clinical/basic science exam which would measure the student's readiness to assume supervised practice as a resident. The step 2 CSE would continue.

Dr. Taylor had been thinking in terms of curriculum review, not a major restructuring. It is possible, however, that this shift on the part of the NMBE might occasion a much more profound look at our curriculum. There was a lively discussion of possible variations, such as having one year of full time classroom work to present normal anatomy/function, and then begin clinical rotations with integrated pathophysiology didactic sessions taught by basic science faculty in the second year.

This need to review the integration of basic science and clinical teaching may pose a conflict with the need to review another aspect of our curriculum. While the majority of our clinical education continues to take place in in-patient settings, more and more basic health care delivery takes place in ambulatory settings. The patient mix on inpatient settings has shifted dramatically in recent decades; more patients either have extremely high acuity of illness, or extreme chronicity, or in some cases, both. In-patient services are less likely to have patients with basic presentations of common and important clinical problems, for which our students should gain mastery. Can we simultaneously review both the locus of our clinical educations, and its basic science content?

Dr. Taylor expects to learn more about the proposed changed in the USLME exams during the upcoming AAMC meetings, and will update us on his return. We also need to be sure we keep our students informed about these new developments, as soon as we can do so with accurate information.

Meeting adjourned at 5:00 p.m.

Next meeting: November 19, 2007

of the SUNY-Downstate College of Medicine
September 17, 2007

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, H.Durkin, J. Ranck, C. An, E. Langenau and L. Wilson

Minutes of the July 16, 2007 meeting were approved.

New Business

Discussion of non-credit elective for ms1-2 at Brooklyn free clinic: group had request for further information, which was forwarded to Dr. Kastor. Questions, and her responses circulated by e-mail; will take vote by e-mail.

Dr. Gabbur presented the Women's Health Clerkship, which is a 6 week clerkship offered 8x a year. The students spend 2 weeks on OB, 2 weeks on GYN, and 2 weeks in the clinic, and the clerkship uses 9 affiliated hospitals. Each student is expected to do 6 overnight calls, and to complete clinical encounter forms for each patient seen. By the end of the clerkship, each student is expected to have certification of having had experience with 75% of the items on a list of problems/procedures. (eg. normal vaginal delivery, pelvic exam, pre-eclampsia, history taking…)The students need to get signatures from an attending at each of the sites (three different attendings). The students are not expected to do formal write-ups, but they are each expected to do a powerpoint presentation with their preceptor, with whom they meet once a week. (all the students at a given site.)
The encounter form includes prompts for the attending to rate the students performance (basically satisfactory or needs improvement.) The students have been diligent about returning these forms, and have not complained that the process is burdensome; they know that they will get a grade of Conditional if they do not hand in the required paperwork. (Dr. Gabbur, on the other hand, is inundated in paper and is working with the educational technology group to try to capture this information electronically.)
Traditionally, Monday has been devoted to lectures, to insure that students at all the sites get the same didactic experience. When Dr. Gabbur assumed solo responsibility for the clerkship, the lectures ran from 8 am to 6pm. He has captured most of the lectures electronically, and posted them on PRIME; for many of the lectures, the PRIME posting includes power points synchronized with a video of the lecture, via the Tegrity technology. Specific learning objectives are posted for each of the lectures, even if the lecturer chooses not to be videotaped or not to post powerpoints. Dr. Gabbur has also arranged with University Counsel about copyright protection for these lectures.

The Monday didactic day is now devoted to Case Based seminar type discussions, based on a group of lectures which the students can review on their own time. (*I missed some of the discussion here because I was taking a phone call).*

Dr. Gabbur's philosophy is to point students to a variety of resources, and to spell out what it is they need to learn. He actually uses the learning objectives spelled out by APGO (Association of Professors of Obstetrics and Gynecology), which are also used by the textbook he recommends. This textbook has an extensive on-line component, including a large question bank. The Women's Health shelf exam covers the material defined by the

APGO objectives quite closely. Dr. Gabbur recognizes that different students learn differently, and he trusts that each student has figured out his/her own personal learning style by now as a graduate student.

The week before the shelf exam, he holds “electronic office hours” using the discussion board feature of PRIME. He may have 1 “visitor” or a group of 10.

The final grade is based on clinical performance, (40%), shelf exam score (40%) and oral exam (20%). He uses a formula worked out with Dr. Lawrence . The clinical evaluations are put together by the site directors, and the clerkship administrator has been very effective in getting these back in a timely fashion. When he has made site visits, Dr. Gabbur has found documentation of reports from attendings and residents to support the assignment of the clinical grade. The shelf exam passing score is 5^{th} percentile, although the raw score corresponding to 5^{th} percentile increases as each academic year progresses. The oral exam is administered by Dr. Gabbur on the last Thursday and Friday of each rotation, and consists of 3 questions which are disclosed in advance. The assignment of questions to a particular student is essentially random, and Dr. Gabbur uses a standardized sheet for scoring each response.

Dr. Gabbur is also residency program director. He finds the responsibilities very similar, although he keeps the didactic sessions for the students and the residents mostly separate. (The run concurrently.)

His wish list includes more time to manage the PRIME site, and specifically, to parse the posted lecture so that each segment supports a specific objective. He is also interested in finding ways to improve the assessment of students’ clinical skills.

Meeting adjourned at 5:00 p.m.

Next meeting: October 22, 2007

Minutes of the meeting of the
Education Policy & Curriculum Committee
Of the SUNY-Downstate College of Medicine
July 16, 2007

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, M. Nowakowski, C. An, E. Langenau and L. Wilson

Minutes of the June 18, 2007 meeting were approved.

New Business

Dr. An presented the Emergency Medicine clerkship.

We had learned from Dr. Dresner that when the surgery clerkship was 12 weeks, the vast majority of students elected to do 2 weeks of ED as a "surgical subspecialty" experience during the longer surgery clerkship. In fact, in many schools, the Department of Emergency Medicine arose from the Surgery Department.

The school now requires all students to take a two week clerkship during the third year, starting in September after the student has done at least one major clerkship. The enrollment is capped at 18 students/cycle, and the students do shifts in the ED at both UHB and KCHC. They do 9 8-hour shifts, with a mixture of Critical Care/Trauma, Pediatrics, Adult ED, Fast Track; day, night and weekend shifts. In addition, they have 3 hours of mandatory lectures on Thursdays, and are encouraged to come to morning report 7A weekdays, and resident conference on Wednesdays if the subject matter is appropriate for them. (4^{th} years can take the Clerkship anytime during the year).

Students are expected to keep a daily patient log, and to get an evaluation card completed by a supervising physician (resident or attending) at the end of each shift. On average, students see 4 patients/shift, although the number can vary from 1-2 in the critical care area to 6-8 in the fast track area.

Very broadly, the goals of the clerkship are for students to get experience seeing a broad variety of patients with "undifferentiated" complaints, and to do a focused, chief- complaint-driven history and physical in a limited amount of time, to see acute presentations of common inpatient problems (eg., stroke, MI, GI bleed) and to recognize acuity and have experience—usually as an observer/assistant—with initial management. The clerkship also hones interpersonal skills, since the ED clinician needs to establish rapport in just a few minutes, and needs to communicate effectively with a host of other clinical teams. The clerkship also gives students a first hand understanding of the social and economic constraints that impact on health care delivery and on public health.

Evaluation of student learning is based on a 25 question MCQ exam (home grown), which counts for 40% of the grade, and the evaluations from the students clinical work (60% of the grade). Majority of test questions are case-based—forward think questions.
As with most clerkships, the numerical scores given to students tend to be high—4 or above, with "3"—"meets expectations" more rare.

The ED is interested in expanding the clerkship to 4 weeks, to allow more clinical experience, work with simulators, and possibly include certification of students in ACLS/PALS before graduation. Most medical fields have some level of interaction with the emergency room, or at least their patients do. So the belief is to give students a better understanding of what goes in the ER. The ED would also like to be able to run a fixed 4 week lecture schedule, and possibly have a day each week devoted to a particular theme, including lecture, cbl and simulation all interrelated. (The current lectures may be more variable based on the lecturer. It also includes case-based lectures "CBL" with progressive disclosure as the material is presented. The students are questioned along the way about next step in evaluation, about management options, and about the evidence base for their decisions. These cases (10 or so) were developed by the department as a whole, and are on power point, so they can be presented by almost any faculty member or resident with little advance preparation. This core of cases helps assure consistency of coverage from one cycle to the next, but two weeks is too short to cover the minimally important material.) Currently CBL cases are being updated.

There was some discussion about whether students should be competent to initiate resuscitation by the time they graduate, and whether they should also have inpatient critical care experience as the acuity of inpatient medicine climbs.

Meeting adjourned at 5:00 p.m.

Next meeting: September 17, 2007
Review of OB/GYN Clerkship – Dr. Gabbur

Minutes of the meeting of the
Education Policy & Curriculum Committee
Of the SUNY-Downstate College of Medicine
June 18, 2007

Present: M. Clark-Golden, L. Medlock, E. Langenau, L. Dresner and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of the previous meeting were approved.

New Business

Dr. Dresner presented the surgery clerkship.

The clerkship is now 8 weeks. Before the Curriculum change, the surgery clerkship was 12 weeks, with 2 weeks of that time for anesthesia/peri-operative care, and 2 weeks for "elective" subspecialties, which most students fulfilled by taking Emergency Medicine. Anesthesia and Emergency Medicine are now free standing 2 week required clerkships. The length of our clerkship is typical nationally, although many schools do have a required 4th year experience as well. Although we offer a "surgery sub-I", it does not count for the required fourth year sub I.

The goals for the surgery clerkship are for students to learn sterile technique, pre-op and post-op care, wound management, and to recognize surgical problems and be comfortable referring patients for what is often life-saving and time-critical intervention.

The students spend 4 weeks at an affiliate with its own housestaff,(List A) (Brookdale, Maimonides,SIUH, St. Vincent's in Staten Island (terminating?) and Lenox Hill.) and 4 weeks at a hospital which has SUNY residents (List B): LICH, VA, KCH (2 services) and UHB. At UHB, the students may spend 1-2 weeks on the transplant service.

The Surgery Clerkship needs more sites; Dr. Dresner has been investigating New York Hospital (Beekman), which is accessible by public transportation and has many of our graduates as faculty.

The experience focuses on following the care of surgical inpatients and going to the OR. The experience of going to the OR is a sine qua non for students to decide on a career in a surgical field. Most students get some outpatient experience, including seeing patients in the office (pre- and post-op) and for ambulatory surgery, but this varies some with the site.

There is a lecture series here, Thursday afternoons, as well as small group lecture/seminars at each site. Dr. Dresner has updated with the list of topics, and would like the seminars to be case-based, but the lectures often reflect the interests of the available and willing faculty. The Clerkship is exploring putting together a suturing lab, and the use of simulators and "wet" labs (meaning?) . There are now some very good simulators for laparoscopic surgery, which have become the standard for training surgery residents. All students see a video on sterile technique on the first day; however, each site needs to do a local orientation to the surgical suite(s).

There is a “preceptor” at each of the sites who orients the students, assigns them tasks, follows their progress and gives them a grade. At Maimonides, each student has a personal preceptor; the student works with that faculty member in the office and the OR, but may “slide” during the rest of the time, because the student may not integrate as well into a floor team as at some other sites. At Maimonides, the precepting arrangement keeps the Downstate students separate from the students from other schools.

The surgery clerkship has a significant WEB presence; some students use it widely, many students don’t use it at all.

Students are expected to do a presentation or a paper, which counts towards the grade; most students choose to do a presentation. They must also hand in a skill/procedure card; some of this tracking is done on PRIME; and to do one patient write-up/week, which should be critiqued by a faculty member at the site. (Implementation of this requirement has been somewhat lax.) The students are expected to take call, and call has been made more consistent across sites, but the students are not required to stay overnight if the site does not have sleeping facilities for the students. Dr. Dresner encourages the faculty to observe students during physical exams—especially the abdominal exam—and doing suturing.

The grade is based on evaluations by the faculty preceptor at each site, the chief resident at each site, the presentation/paper, and performance on the shelf exam, which counts for 50% of the grade. Students are given 1-2 days before the shelf exam to study.

Since assuming responsibility for the clerkship, Dr. Dresner has dispensed with the oral exam (which consumed an enormous amount of faculty and student time, and effectively reduced the clerkship to 7 weeks.) The pass rate and median score on the shelf exam has increased from 90% pass rate and median<national average to the national average. The weight given to the shelf has increased from 40 to 50%.The passing score is 5th percentile, and there is talk among the surgery faculty about raising that level. Part of the improvement has come from specifying where to read and what to read—the students are given a long list of surgical conditions, and Dr. Dresner feels that the length of the list motivates them to read from day one.

Dr. Dresner assigns the final grades; most of the data she needs is entered into a spread sheet. She feels that she can be consistent and hence fairer by assigning the grades herself, in contrast to the earlier method which involved “grading meetings”—the faculty who actually came often had undue influence on the grades of certain students.

Student evaluations of the surgery clerkships have reflected some problems with teaching, especially by residents, and especially by residents at the “List A” affiliates. In response, Dr. Zenilman has been arranging regular meetings of the site directors, which have been well attended, and has devoted a number of faculty meetings to student teaching. Dr. Giuliano, from the Dean’s office, has also worked with a number of the surgery residents on teaching skills; unfortunately, he did not have access to the residents at the “List A” affiliates, and the residents he has coached have now completed the program.

The spin-off of Anesthesia/peri-operative care from the surgery clerkship has made running the clerkship easier; Dr. Dresner cannot answer how it has impacted on learning peri-operative care. She commented however, that she thinks the students could benefit from

some critical care/surgical ICU experience, to see applied physiology, and gain skill in critical care which probably generalizes to every field of practice.

She would like to see more support for faculty/resident gaining didactic skills—many are in fact quite interested in teaching, although the hierarchical culture of surgery is at variance with many of the teaching styles promoted in other departments.

She also thinks we need to address the conflict felt by faculty at the affiliated hospitals which take other medical students. While the Downstate students are usually more capable than the other students, they may not be as gratifying to teach. This is compounded by the fact that the faculty at many affiliates are expected to teach our students because "it is the right thing to do", but they get no tangible compensation for doing so.

In closing, Dr. Dresner is pleased to report that the College of Medicine is arranging to buy more of her time to be clerkship director, so that she can have more time to devote to managing and developing the clerkship. Currently, Dr. Dresner works full time as trauma surgeon at KCH, has a private practice in general/breast surgery at UHB, is chair of the COM admissions committee, and runs the surgery clerkship—and is an ECM preceptor!

Meeting adjourned at 5:00 p.m.

Next meeting: July 16, 2007
Review of Emergency Medicine Clerkship

Minutes of the meeting of the
Education Policy & Curriculum Committee
Of the SUNY-Downstate College of Medicine
May 7, 2007

Present: M. Clark-Golden, S. Miller, B. Lawrence, J. Ranck, L. Merlin, L. Medlock, I. Harwayne-Gidansky and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of the previous meeting were approved.

New Business

Drs. Merlin and Anziska presented the neurology clerkship, Dr. Anziska present as a guest of the committee.

The neurology rotation was made a required clerkship in 1983, starting as a 3 week clerkship and moving to a 4 year clerkship in (year?0. Until the Curriculum Revision of (year?), all students took the Neuro clerkship in the third year, but now up to 20% of students take it in the 4th year, which creates problems. As of July 2007, no fourth year students will be permitted to take the neurology clerkship any later than November.

The focus of the clerkship is for students to gain fluency in performing the neurological history and examination, which is often neglected by clinicians at all levels of training. Although the second year students are given an OSCE on the techniques and applications of the neurological exam, they do not routinely integrate the neurological exam into their assessment of patients in most clinical settings. There was some discussion of this problem, because it is a behavior widely modeled by the residents and even attendings. How much of a neurological exam is appropriate for a general medical or surgical patient—is there a "screening" neuro exam for the patient with no symptoms? Dr. Anziska conceded that there probably is such a thing (and that it would include, for example, among other elements, the testing of 7 carefully selected muscle groups). Drs. Merlin and Anziska review the neuro exam at the beginning of PC1 for those students in tracks in which PC1 precedes the neuro clerkship**.** Should we explore more team teaching of neurological assessment of patients on all clerkships?

Most of the formal teaching is done by attendings, with some bedside teaching by neurology residents. The bulk of the experience is on various inpatient services at KCH, UHB, LICH, North Shore, Maimonides, SIUH or Methodist. KCH has both a dedicated neurology service and a consult service. The students also spend 4 half days in an outpatient setting, two of which usually expose them to pediatric neurological problems. On the inpatient services, approximately 50% of the patients are stroke patients, with the remainder being patients with assorted other problems such as Guillain Barre, temporal arteritis, myasthenia gravis**,** seizures, and multiple sclerosis. The clerkship directors feel that more outpatient experience would be useful for students to learn about the evaluation of other entities such as headache, back pain, dementia, and movement disorders, although it is important that the outpatient experience have enough space and staffing for the students to see their own patients rather than be observers.

In addition to clinical learning, there are seminars, 1/3 of which are pediatric. Most of these are conducted as case conferences. The seminars take place at Downstate over three full days, so all students get the same seminars. The "teaching preceptor" at the assigned site meets with the students every day. The students are required to take 2 calls during the 4 weeks **(**one weeknight and one weekend**).**

The students are assessed on 1) their clinical performance, 2) two patient write-ups (which emphasize the ability "localize the lesion" based on the history and exam, and to generate a reasonable differential and management plan, based on clinical findings and readings, 3) an oral exam, which is based on 4 patients the student has actually seen, and 4) a written exam (essay format, based on one adult and one pediatric vignette). Each student is expected to be observed by an attending, sometimes resident, doing a neurological exam, and submits a signed credentialing card as evidence of completion of this requirement. Beginning July 2007, the clerkship is planning to introduce a shelf exam to replace the essay exam, worth 10% of the clerkship grade initially.

Neither of the required textbooks are used in the first or second year neurosciences courses, although Dr. Anziska thought that perhaps the text by Blumenfeld, *Neuroanatomy through Clinical Cases*, might work as a textbook in the pre-clinical years. (This might help cement learning of neuroscience between the pre-clinical and clinical years, and help to counter the "orphaning" of the clinical neurological exam.)

The timing of this clerkship is problematic at both ends, because students taking it early in the third year lack general clinical skills (this probably affects all clerkships), but students taking it in the 4th year do not give the material the attention it deserves. Dr. Anziska suggested a more extensive "transition to clerkship" course to prepare all students to function on a clinical service.

Meeting adjourned at 5:15.

Next meeting: June 18, 2007
Review of Surgery Clerkship

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
February 26, 2007

Present: M. Clark-Golden, S. Miller, M. Augenbraun, L. Terracine, L. Merlin, M. Nowakowski, J. Ranck, L. Medlock, C. An, E. Langenau and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of the previous meeting were approved with one correction.

New Business
Dr. Augenbraun's Medicine Clerkship was reviewed.

DESCRIPTION OF CLERKSHIP:
The Medicine Clerkship is a 10 week clerkship and is entirely for in-patients. There is no ambulatory care in medicine and no ICU. The clerkship is split up between two clinical sites. The students spend 5 weeks at either University Hospital, Kings County Hospital or any of the affiliated sites. The affiliated sites consists of Methodist Hospital, Maimonides Medical Center, Long Island College Hospital, Lenox Hill Hospital, Staten Island Hospital, North Shore University Hospital and the V.A. Hospital. There is usually more than enough patient volume, so that students from other schools don't dilute the experience, and there is good equivalency across sites. (Students sometime say they enjoy having students from other schools, because they get to learn a different frame of reference.)

The students meet with Dr. Augenbraun and the Administrator at the beginning of the clerkship for orientation. The Friday at the end of the 5th week is the last day at that site. They have the weekend off and on Monday they meet with Dr. Augenbraun again on campus and they do evaluations, talk about examination and review things that were discussed during rotation sessions.

The work is the same at every site. There is an expectation that students will be assigned to a ward team and will function as a member of that ward team. They are given schedules of the team they have been assigned to and are expected to work 6 days a week and take short calls with their resident. (No overnight calls.) On the day they begin, the student is expected to show up and make work rounds and participate in attending rounds. They are expected to admit and workup patients in a manner in which they were taught and present their patient to the attending. Students are expected to document the patient's care in the chart, but this is becoming a bit of an issue with electronic medical records. get access to electronic medical records. Students are expected to hand in a full patient write-up to the preceptor, with whom they meet once a week (not the ward attending) and the preceptor will critique it and give it back to the student. Dr. Augenbraun collects all the write-ups every ten weeks. When the students are on this campus they meet with Dr. Bourke and Dr. Augenbraun every week for sessions on EBM and ethics. Each affiliate runs a series of student conferences; there is no defined curriculum for these conferences, because each site is invited to "teach from its strength."

EXAMS AND ASSESSMENTS:

The shelf exam counts for 35% of the grade, and covers health maintenance which is not well covered in the clerkship. During the last two weeks of the clerkship the student performs a 50-minute physical exam on their patient in front of a faculty member. Students also get written and numerical evaluations from their preceptor, attending and resident; these evaluations tend to cluster in the mid-to high 80's, and count for 65% of the grade.

What Would You Do Differently?

- Addition of an ambulatory opponent –ideally, a longitudinal experience throughout the third year, perhaps as a new configuration for primary care 1.

- Make use of web resources for core curriculum

- Guaranteeing that students have access to patients' electronic medical record at all sites is something that needs to be addressed at the College level; it is usually beyond the authority of any one clerkship.

Agenda for next meeting

Review of Surgery Clerkship

Next meeting is scheduled for March 19, 2007 at 4 p.m. in the Pediatric Library, SUH 4th Floor, Room B4-462

The meeting was adjourned at 5:00 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
January 22, 2007

Present: M. Clark-Golden, L. Merlin, M. Augenbraun, L. Terracina, J. Ranck, B. Lawrence, C. An and L. Wilson

Dr. Lisa Merlin was acting chair for this meeting and opened the meting. Minutes of the previous meeting were approved with one minor correction.

New Business
Dr. Clark-Golden's Pediatric Third-Year Clerkship was reviewed.

DESCRIPTION OF THE CLERKSHIP:
The Pediatric Clerkship is a 6 week clerkship, the usual length of peds clerkships nationwide (although some institutions do have 7-8 weeks). Affiliated sites are Brookdale Medical Center, Long Island College Hospital, Maimonides Medical Center and Staten Island Hospital. Students assigned to King County Hospital and University Hospital spend 3-4 weeks on the wards and 2-3 weeks in a combined nursery OPD program.

Students meet with their preceptor for at least two hours weekly. The same preceptor works with his assigned group of 2-6 students for the entire 6-week rotation. A new didactic series has been implemented this year; ALL STUDENTS attend the student lectures held 8-11 a.m. Monday Mornings in the Pediatric Library at Downstate.

Each student at KCH/UHB is assigned three short calls and three overnight calls. As 70% of pediatric admissions come in on night float, students are expected to take 3 overnight calls with their resident, continuing with the night float team after the resident leaves at around 9 p.m. One of the overnight calls should be on a weekend, 8 a.m. to 8 a.m., and should preferably be done with the student's resident. (NOTE: students assigned to affiliates get different amounts of calls and no overnights)

WHAT SHOULD STUDENTS TAKE AWAY FROM THE CLERKSHIP?
As 50% of the typical pediatric practice is the care of the normal child, this rotation is a prime opportunity to learn about what's normal – nutrition, fluid and electrolytes, preventive medicine. Students should consider every patient encounter as an opportunity to review and strengthen their knowledge of the core areas, such as, physical/physiological growth and development, developmental/behavioral pediatrics, nutrition and health maintenance and preventive pediatrics. Students should also begin to recognize the different needs of different kids.

USE OF PRIME:

CLIPP **(part of the Core Curriculum in pediatrics)** is a comprehensive internet-based learning program for use by third-year medical students during their pediatric clerkship. This will help the students direct their reading and practice clinical problem solving. The

Powerpoint presentations for the didactic sessions are also posted on PRIME, although different lecturers in different months will use different Powerpoints. There is no required textbook, but the "recommended" text is First Exposure to Pediatrics. Blueprints is discouraged except for review purposes only; students are told NOT to use the First Aid books.

EXAMS AND ASSESSMENTS:
The students are evaluated by their preceptors and attendings on the ward and in the nursery. The student resident will comment on the students' attendance, interest and attitude, as well as their clinical skills. The students submit three write-ups, but are only given feedback on the first two - only the third write-up is graded. So the clerkship grade is comprised of the 3rd write-up, the preceptor recommendation, the ward attending recommendation, and the performance on the shelf exam (at least 70th percentile for HP or H). The cut-off for passing the Shelf is 9th percentile (i.e. anything 9th percentile or lower FAILS).

WHAT WHOULD YOU LIKE TO CHANGE?

- Clinical skills assessment exams – especially the well assessment, developmental assessment, and nutritional evaluation, and the pediatric history and physical
- Money for Administrator (needed to implement CSA exams)
- More exposure to ambulatory sick visits
- Send student to day care center
- Send student to a family with a disabled child.

Agenda for next meeting
Review of Medicine Clerkship

Next meeting is scheduled for February 26, 2007 at 4 p.m. in the Pediatric Library, SUH 4th Floor, Room B4-462

The meeting was adjourned at 5:20 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
December 18, 2006

Present: M. Clark-Golden, L. Merlin, L. Terracina, J. Ranck and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

New Business

Feedback on clerkships were reviewed—specifically, Women's Health, Surgery, and Pediatrics had overall ratings in the unsatisfactory range.
Again there was a discussion of the importance of getting feedback not only from students, which we do rather well, but also to get feedback from other faculty about teaching in the courses, both basic science and clinical.

A plan was made to move forward with meetings with faculty from each clerkship, starting with Pediatrics in January. Each clerkship will take a full meeting, so it should take us a year to complete this review.
Dr. Merlin has agreed to be acting chair for that meeting.

The clerkship directors will receive notice of this review process at the next clerkship directors' meeting. They will be invited to bring as many colleagues who are involved in student teaching as they like to give the group the fullest sense of what each clerkship is about.

The clerkship leaders will be asked to address the following broad questions:

- What do you want to teach? (what do you want students to take away from your clerkship?)

- How well are you succeeding? (and how do you measure your success—this includes measures of student learning, but may include other measures, such as student choosing the specialty.)

- What else would you like to do? What would you need to do those things?

- Do you have problems with mechanics/organization? Thoughts about your clinical affiliates.

Ms. Wilson will be contacting the individual clerkship directors to schedule these meetings.

Agenda for next meeting

Elective Reviews
Review of Pediatric Clerkship

Next meeting is scheduled for February 26, 2007 at 4 p.m. in the Pediatric Library, SUH4th Floor, Room B4-462.

The meeting adjourned at 5 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
November 20, 2006

Present: M. Clark-Golden, M. Augenbraun, M. Nowakowski, C. An, L. Merlin, L. Terracina and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

New Business

Two new electives were approved. The elective in Pediatric Nephrology was approved. The elective in Palliative Care needs some clarification: a clinical elective, according to school policy, must have at least one clerkship as a prerequisite. The form does not ask for the Course Director's credentials for even title; presumably, signature by the department chair attests to the qualifications of the proposing faculty member to offer such an elective, but it would be helpful to the committee to have more details. The committee would also like to know about the patient volume on the palliative care service, without specifying the number of patients necessary for a meaningful experience.
The Course Director will be asked for more information.

The group agreed to table the review of the feedback on the clerkships, because Dr. Lawrence was not present. (Request for a power point presentation if possible, to avoid excess paper flow, and to help everyone focus on the same charts.)

Dr. An reported on her research from our LCME self-study. See attached. Although our answers to the various questions about the clerkships seemed to satisfy the LCME, they may not satisfy this group, as we dig into the clinical experiences more. She was unable to find an answer to the question of how the NBME defines the various levels of "management" in the questions on Step 2. We also discussed the proposed revisions to the LCME accreditation standards, which are still open to public comment.

Dr. Golden reported on her meeting with Dr. Taylor, who encouraged this group to think strategically about the clinical years. To that end, an article from JAMA on Changing Premed Requirements and the Medical Curriculum was distributed for discussion at our next meeting. Dr. Taylor hopes to attend our January meeting.

Agenda for next meeting:
Review of clerkship evaluations.
Report from Reading Task Force
Report from Task Force on Human Sexuality.

Finalize list of questions for clerkship director interviews.

Next meeting is scheduled for January 15, 2007 at 4 p.m. in the Pediatric Library, SUH4th Floor, Room B4-462.

The meeting adjourned at 5 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
October 16, 2006

Present: M. Clark-Golden, M. Augenbraun, L. Terracina, L. Merlin, C. Roman, H. Durkin, L. Medlock, I. Harwayne-Gidansky, C. An, E, Langenau

Dr. Clark-Golden opened the meeting. Minutes of last meeting were approved with small—but important-- edits.

Discussion of LCME Standards for Clerkships.

Functions and Structure of a Medical School (October 2004 edition; with updates as of June 2006.) was distributed. The standards which seem to be relevant to our review of the clerkship experience are: ED 10, 11, 13, 14, 15, 16, 17,(18), 20 and 21. None of these standards are ones on which we were cited by the LCME. (Dr. An has been asked to review the LCME self study report to see how we answered these standards.) Of note is the fact that clinical experience in neurology is not a "must" or even a "should." Some issues which we might want to explore include continuing care and rehabilitative care. The challenge of providing a continuity care experience is not trivial. Like other schools, we have discussed a half day a week continuity experience throughout the 3rd year—but even in the Pediatric Resident clinics (which have had this requirement for over 20 years), continuity is hard to come by. (For instance, at one pediatric program, "continuity" has been defined as two visits with the same provider.) We should probably also look at the balance of outpatient and inpatient experiences within and among the clerkships. "Primary Care" is not clearly defined in the standards, but we can ask how we would like to define it. Chronic care and preventive care (especially preventive care of chronic illness) are addressed in various settings. The group had questions about how much emphasis they should received in the third year, which should really focus on helping students develop skill in applying pathophysiology and making a diagnosis. Questions of management, which are often emphasized by the residents, should not displace attention from the diagnostic process. Students need to be observed gathering information from patients, they need repeated practice, they need coaching and feedback.

Discussion of Step 2 CK

STEP 2 CK Content Description and Sample Test Materials 2007 was distributed. We need clarification under "Principles of Management" ; the NMBE seems to be a making a distinction between "Pharmacotherapy only", "Management decision (treatment/diagnosis steps) and "Treatment only." (These do not seem to be mutually exclusive categories; will check NBME Web site for FAQ's to see if we can get clarification.)
Consensus was that we do cover the range of diagnoses listed in the content guide—and that most of the entities are in fact presented during the second year. Which of the many diagnostic entities will be seen clinically by each student is somewhat variable, although ED2 does require us to set a bare minimum of types of patients/encounters.
Although content for STEP 1 and 2 are quite similar, the types of questions on the material are very different. For STEP 1, although the student may need to be familiar with the

diagnosis, the vignette is much shorter than the sample vignettes given for STEP2, and the responses would involve, for instance, which gene or which muscle is involved. (Interestingly, the example given by the student was a functional anatomy question—one of our self-identified weaknesses.) For STEP 2, the vignettes are much longer (which requires skill in sorting out pertinent and irrelevant information quickly) and the questions are often of the type, "What would you do next?" The next step is often a diagnostic step, but since some of the options are treatment decisions, clarification of the headings under "Principles of Management" is pertinent.

Discussion about the differences in reasoning demands from second year to third year indicated that most students do in fact make the transition from forward reasoning to backward reasoning fairly early in their clerkship year, if not before. (Eg: "This is what happens when you damage the nucleus of the 6th nerve" vs. "A patient has an eye that deviates in. Where is the lesion?). However, the students acknowledge that this transition can be daunting.

It was proposed that we could look at the CBL cases, to see if they can do more to foster backward thinking; one tactic would be to make the CBL cases more cumulative (somewhat like the Overview Block case), so that the universe of possible causes for the CBL patient's problem would be larger than heart disease (even though this is the cardiac block.)

For our next meeting, we should review data on how our students perform on the in-house and NBME Clinical Skills exams. (See also ED27, 28, and 32.)

We also need to settle on what our mission is as we review the clerkship years:

Is it to:

1. create a general curriculum map of the clinical rotations?
2. Identify and fix holes?
3. Standardize grading/didactics/etc. across clerkships?
4. Propose major revisions in nature of the clerkship experiences, as was done in the late 1990's?

Before the next meeting, Dr. Golden will be meeting with Dr. Taylor to discuss this clerkship review project. Dr. Taylor is an ex-officio member of the CEPC, and will be invited to come to the next meeting.

Agenda for next meeting:

Review of Clinical skills exam data

Finalize scope of project and plan for executing it.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
September 18, 2006

Present: M. Clark-Golden, S. Miller, M. Augenbraun, L. Merlin, M. Nowakowski, J. Ranck, B. Lawrence, L. Medlock and C. An

Minutes of July meeting reviewed and approved.
Dr. Lawrence added comment on Pulmonary Block—Block director was on sabbatical, so some one was filling in for the year. Block director, Ross Hill, will resume leadership for this year.

Turned to planning review of clinical years, starting with review of process which resulted in our current calendar. Recommendations made by a small task force—Dr. Mandel, Dr. R. Cracco, Dr. Shalita and Dr. Golden, at time of Curriculum Revision. That revision shortened the surgery clerkship to 8 weeks (from 10 or 12?), the medicine clerkship to 10 from 12, the pediatric clerkship from 8 to 6, moved ambulatory care form the 4th year to the third year (Primary Care I) (and increased it from 4 weeks to 6?), created the anesthesia, emergency medicine, and geriatrics clerkships.
Interest with the process we are about to undertake is to get input and buy-in from as many faculty as possible.
The relevant materials from the COM Bulletin were distributed—the Eight domains of Competence, and the descriptions of the required courses in the clinical years.
Group seemed to agree with process as discussed at last meeting and outlined in the July minutes. Also, CEPC Chair has spoken briefly with new Dean, and offered to outline project and solicit his input and support before our next meeting.
The Clerkship Directors should be encouraged to solicit input from their teaching faculty before this Committee meets with each one, and should be encouraged to bring faculty members who are very active with the students to the meeting.

List of questions/issues to address before and during meetings with Clerkship Directors was generated—see attached notes.
Step 2 content guide, and LCME accreditation standards to be distributed to members before next meeting, for review and discussion then. We may also have student reviews of the 2005-2006 Clerkship Year by the student

Next meeting will be October 16, 2006

REVIEW OF MS3 AND MS4
September 18, 2006

Items to be considered:

4) Catalogue
   a) No sub-internship description in the catalogue.
   b) The rules for distribution of electives are not in the catalogue.

5) CEPC should review the Downstate Clinical Skills Examination results.

6) Brainstorming session:

   a) What are the LCME standards that relate to required clerkships?
   b) What's the USMLE content of Step 2?
   c) When do students take Step 2 related to completion of clerkships?
   d) Why do students take the major clerkships in the 3rd year? (Examine the grid and enrollments by rotation.)
   e) How much elective time should students have in the 3rd year?
   f) Do the clerkships have common or similar standards for grading, didactics, etc. across clerkships?
   g) What are the required basic skills, and where are they covered?
   h) How can we coordinate content across sites?
   i) What are the grade distributions for the clerkships?
   j) What assessments are used in each clerkship?
   k) Are students required to use/improve knowledge of basic science?
   l) Do we promote lifelong learning?
   m) Are we teaching evidence-based medicine effectively?
   n) Should we promoting clinical research by students?
   o) Do students have adequate knowledge of research methods?
   p) Are we assessing professionalism effectively?
   q) Is there a general dress code?
   r) How many students get research experience?
   s) Where are we teaching management of chronic disease?
   t) Where are we teaching prevention?
   u) Do we have the right balance of out-patient/in-patient experience?
   v) Do students need to learn more informatics skills?

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
July 17, 2006

Present: M. Clark-Golden, S. Miller, M. Augenbraun, M. Nowakowski, J. Ranck, C. An and L. Wilson

Revised minutes of June meeting approved; they will be forwarded with pertinent parts of Dr. Lawrence's report on our students' NBME performance to the Executive committee for posting on the faculty governance web site.

Discussion of MS 2 Spring Course Evaluations

Most of the courses received satisfactory evaluations, comparable to previous year. The MS 2 respiratory block is an exception: Only 31% of students felt strongly that the clinical relevance of the material was made evident, in contrast to 67% of students evaluating the cardiovascular block, for example Of even more concern, only 60% of students were in agreement that the block was effective overall, in contrast to 93 % of students rating the Cardiovascular Block, or 89% of students rating the Renal and Endocrine block.
The student comments reveal problems with leadership of the block—many students stated that they did not know who the Block Director is—in contrast to most other blocks.

Discussion of how this problem might have come about suggested that the weakness of the MS2 Respiratory Block reflects the current understaffing of the Pulmonary Division in the Department of Medicine. As an educational imperative, the College of Medicine needs to insure that there are appropriate faculty available and supported to teach this crucial body of information. (Pulmonary diseases account for a very significant number of admissions in both Medicine and Pediatrics.) Possible resources include the Critical Care specialists, and/or the Pediatric Pulmonary division.

Discussion of Curriculum Oversight by Faculty

Committee members who have lead CBL sessions felt that the student impressions of the Respiratory Block corroborated their own. For instance, the CBL case presented lots of facts, but did not succeed in helping students develop a structure for their knowledge of respiratory pathophysiology and disease. These observations led to a discussion of the value of having more over-arching faculty review of the curriculum. For instance, there is a group of faculty involved in teaching neuroscience/psychiatry who are charged with auditing teaching events across the four years. There is no comparable review for other disciplines; the logistics of doing a four year monitoring for other disciplines are formidable, because they are dispersed among all the clerkships, not as "self-contained" as the clinical teaching of neurology and psychiatry. Could this be a role for the CEPC, to appoint ad hoc committees to the review the teaching of organ system-related material across the curriculum?

The meeting concluded with introduction of a plan for reviewing the clerkships. Although the immediate impetus for this review was concern by various clerkship directors about length of clerkship and scheduling, this is an opportunity to do a more in depth review. The clerkships serve two very important, but sometimes contradictory functions. On the one hand, they help student pick a specialty—a function which is vital to both the student, and the specialty. On the other hand, the clerkship years are the last opportunity for the College to equip the students with the knowledge and skills essential to any "pluripotential, nascent physician." Hence our review process should include some or all of the following steps:

1. Brainstorm about the essential core knowledge and skills which need to be imparted to students during the third year
2. Review the clerkship descriptions in the course handbook
3. Draw up a list of questions we have about how each clerkship addresses elements of the essential core
4. Meet with each of the clerkship directors
5. Meet with students who have completed the third year
6. Review curricula of other schools (Dr. Lawrence has access to a data base of medical school curricula.)
7. Formulate recommendations to the Executive Committee about the Clinical Years

This project will take time—at least twelve months—and needs to include input from as broad a base of faculty as we can manage. It may be worthwhile presenting the project to the new Dean, to get his endorsement and support. The registrar's office is willing to help with reviewing actual scheduling proposals down the road.

Next meeting will be September 18th. August Meeting is cancelled

USMLE STEP 1
1995-2005

The statistics in the table below are based on data from first attempts of SUNY-HSCB students to pass Step 1 of the USMLE and the NBME national means for all first-time test-takers from U.S. and Canadian medical schools. What these data tell us is that the percentage of students who passed on the first attempt increased between 1995 and 1996 and has remained relatively stable until 2001 and 2002, when there are decreases. The means are generally equivalent to the national means except in 1998, when they were significantly higher. The pass rate in 2000 is significantly higher at Downstate than in the population as a whole; the pass rate in 2004 is significantly lower. There is a small negative skew in the Downstate distributions in all years.

1994 required passing step 1

New curriculum

Year	Percent Passing On 1st Attempt		Mean		Standard Deviation		Median
	Downstate	All*	Downstate	All*	Downstate	All*	Downstate
1995	93%	93%	205	205	19.0	20	206.5
1996	90%	93%	209	205	19.9	20	210.0
1997	95%	95%	211	212	21.9	20	213.0
1998	96%	95%	217	210	19.8	20	219.0
1999	96%	93%	215	215	19.2	22	217.0
2000	96%	92%	218	215	20.0	24	219.0
2001**	93%	90%	213	215	23.1	24	214.0
2002	91%	91%	213	216	23.7	24	214.0
2003	92%	92%	215	216	21.0	24	214.5
2004	87%	92%	210	216	23.0	23	212.0
2005	96%	93%	218	218	21.3	23	222.0

* All first-time test-takers from U.S. and Canadian medical schools.

** Pass score increased from 179 to 182 .

USMLE STEP 2
1994-2004

	% Passing		Mean	
	Downstate	**All**	**Downstate**	**All**
1995	92	93	187	202
1996	96	94	202	206
1997	95	95	203	209
1998	94	95	207	210
1999	95	95	211	213
2000	92	95	209	215
2001	97	96	215	216
2002	94	96	211	216
2003	90	94	212	218
2004	94	94	215	220

Retrospective Assessment
Of MS1 and MS2 by MS3 Students
Classes of 2001, 2002 and 2006

Office of Institutional Research

Retrospective Assessment of MSI and MS2 Questions

Evaluate your current skills and abilities with respect to what you learned in the first and second years:

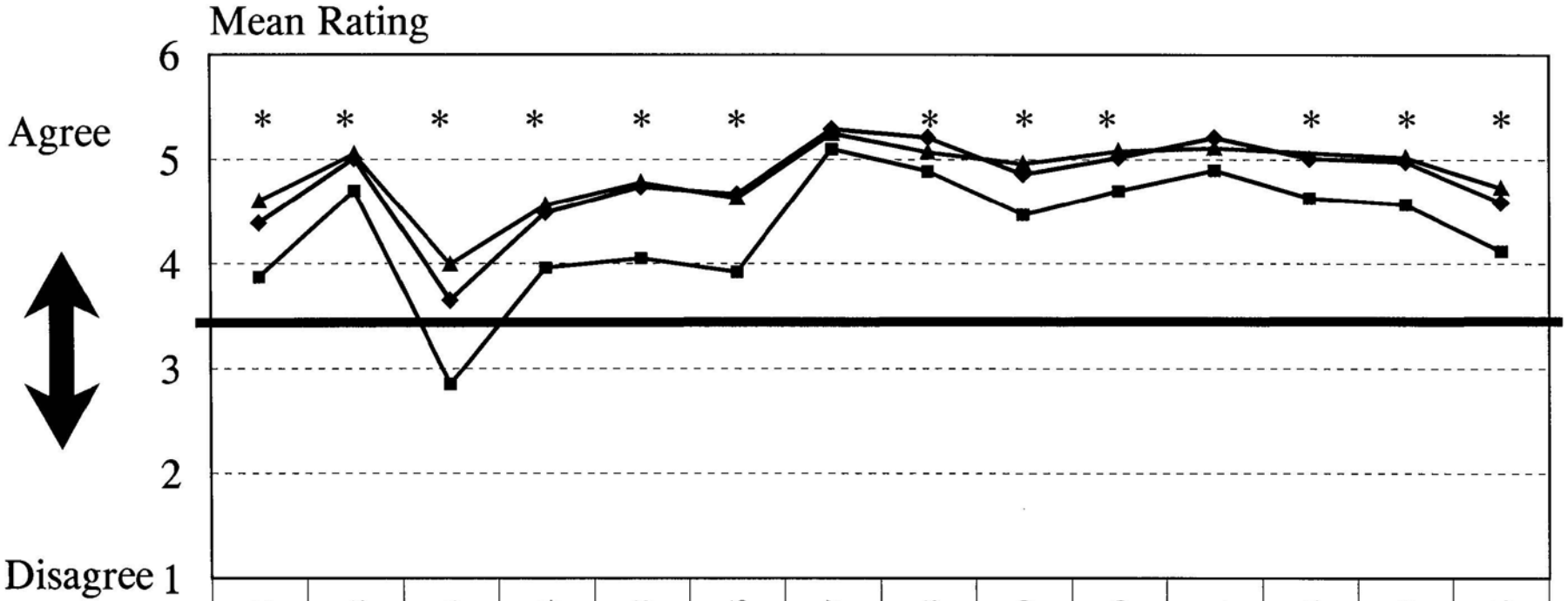
1. I know how to determine the preventive health care needs of a patient of any age
2. I can search literature effectively and evaluate the materials needed to answer questions
3. I understand enough about the health care system and the health care payment structure to help patients get services for common problems
4. I can identify which members of the health care team and community resources that are needed to implement a patient's treatment plan
5. I know how to explore a patient's social and cultural context and belief system so that I can plan effective treatment
6. I had some preparation for deciding what should be done in a clinical situation that raises ethical conflicts
7. I can do a comprehensive medical interview
8. I can do a comprehensive physical examination on an adult patient
9. I can provide patients with information about their diseases and treatments
10. I use basic science knowledge to understand differential diagnoses
11. I use basic science knowledge to understand disease processes
12. I use basic science knowledge to understand a diagnostic workup
13. I use basic science knowledge to understand treatment plans
14. Overall, the first two years of medical school prepared me well for starting my clerkships

Questions 12 and 13 were collapsed in 2003 to a single question relating to basic science.

Retrospective Assessment of MS1 and MS2

Classes of 2001 (Old Curriculum), 2002 (New Curriculum) and 2006

Knowledge, Skills and Abilities



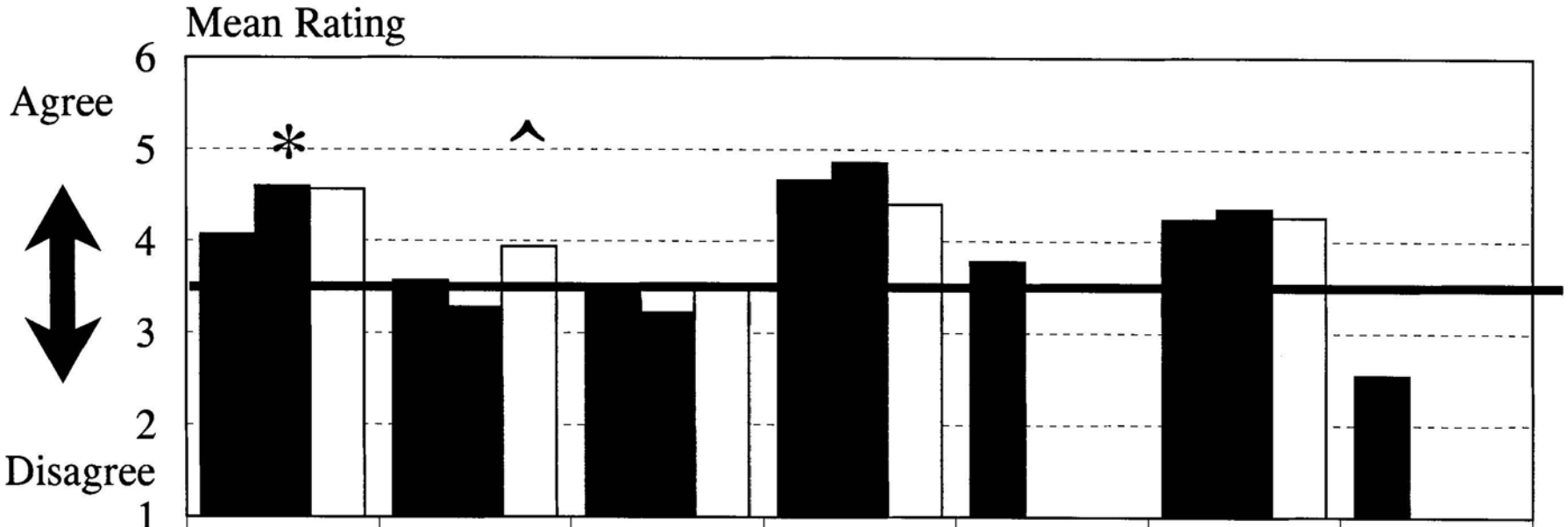
	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10	Question 11	Question 12	Question 13	Question 14
2001 ■	3.87	4.7	2.85	3.96	4.05	3.92	5.1	4.89	4.47	4.7	4.9	4.63	4.57	4.12
2002 ◆	4.39	5.01	3.65	4.49	4.74	4.67	5.29	5.21	4.86	5.02	5.21	5.01	4.98	4.59
2006 ▲	4.6	5.05	3.99	4.56	4.78	4.63	5.25	5.07	4.96	5.08	5.11		5.02	4.73

*=Significant differences between Classes of 2001 and 2002. Intervening years (2003 - 2005) are not displayed but are not significantly different from 2002 and 2006.

Retrospective Assessment of MS1 and MS2

Classes of 2001 (Old Curriculum), 2002 (New Curriculum), and 2006

Curriculum Elements



	MS1 Basic Science	ICM/ECM I	MS1 Preventive Medicine/Biostats	MS2 Basic Science	MS2 Preventive Medicine	PCM/ ECM II	Nutrition
2001 ■	4.07	3.57	3.47	4.67	3.78	4.24	2.54
2002 ■	4.6	3.28	3.22	4.86		4.35	
2006 □	4.57	3.94	3.49	4.4		4.26	

*=Significant differences between Classes of 2001 and 2002. Intervening years (2003 - 2005) are not displayed but are not significantly different from 2002 and 2006. ^=Significant differences between Classes 2002 and 2006.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
June 19, 2006

Present: M. Clark-Golden, S. Miller, M. Nowakowski, H. Durkin, J. Ranck, B. Lawrence, I. Harwayne-Gidansky, L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

Dr. Lawrence had prepared materials for the group to review on student NMBE performance for the last 10 years, as well as review of the course evaluations for the basic science years. This is part of the mission of this committee; Dr. Norin, chair of the Executive Committee, asked that we move this up on the agenda because it has been a topic of discussion in the search for the new dean.

We discussed and decided that the results of the NMBE exams should be posted—for instance, as part of the minutes of this meeting, and possibly separately on PRIME—but perhaps with some comments on the significance (or rather lack of it) of some year-to-year fluctuations.

In general, Downstate students have had a pass rate on Step 1 similar to that of the national mean, and the mean score is likewise close to the mean. The first students taking the new curriculum took Step 1 in 2000, and there is no change in performance before or after that point. The pass rate in 2004 was a bit lower than other years (87%), but back to 96% in 2005. Since the exams can now be taken over a range of dates, the school is allowing students with course deficiencies to complete their make up exams before studying for and taking Step 1. (In previous years, all students were expected to take Step 1 by a certain date., including students who were also studying for make-up course work)
As for content areas where our students perform below the national mean, biostatistics/epidemiology and musculoskeletal have been consistently less than we would like. The school has made major revisions to the teaching of epi-biostats, and we will see the effects of that change when the current second years complete step 1. Item analysis suggests that the weakness in musculoskeletal material reflects a deficiency in coverage of functional (as opposed to static) anatomy; interestingly, this is also an area of deficiency on Step 2.

Passing rates and mean scores for our students on step 2 have also been very close to the national mean. We would of course like to see our students consistently do above the mean, but at least we are doing no harm. There was some discussion about giving students more time to study for Step 2, and requiring passage of step 2 for graduation (About 80% of schools nationally now require it, up from a much smaller percentage just a few years ago.) When we required students to pass Step 1 before going to the clinical years (instituted in 1994) , our step 1 pass rate jumped dramatically.

MS 1 block reviews did not show any serious issues with ratings of the courses over all or with specific issues. Comments on the amount of biochemistry covered in the GI block stimulated a discussion about whether biochem should be required for admission (about 70% of incoming students do have it; not having a requirement for biochemistry helps us get some

of the less traditional students, who do enrich our class.) On the other hand, it is difficult to teach biochemistry to the 30% of students who have no background without making it too boring for the students who are knowledgeable. Dr. Feinman has been sending a biochem primer to the students over the summer. Although the primer is agreed (by the faculty) to be quite good, very few of the students in fact look at before the start of medical school.

Finally, the value of reviewing the student comments was affirmed. Although all agreed that their feelings about the course does not tell us that they have learned what we think they need to learn. On the other hand, the student comments have identified important issues in coverage, and over the years, have identified individual faculty members who have not been invited back to teach in particular venues.

In closing, Dr. Ranck called for the need of more faculty evaluation of the curriculum—eg sitting in on lectures.

Meeting adjourned at 5 pm

Agenda next meeting:
MS2

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
April 24, 2006

Present: M. Clark-Golden, S. Miller, M. Nowakowski, J. Ranck, C. An-Em and L. Wilson

Old Business

Neuroradiology elective

Dr. Mangla has submitted additional specifications for the interventional neuroradiology elective, which satisfies the concerns expressed by this Committee . The elective was approved, and Dr. Mangla will be so notified.

Human Sexuality

Dr. Faber's report on the teaching of human sexuality was reviewed. It appears that there were significant changes in the last year, so that there is more parity between presentation of male and female sexuality. However, the question was raised about whether the amount of coverage, not only in the pre-clinical years but also the clinical years, is sufficient for this topic. What do other schools do? What do clinicians—regardless of specialty—need to know and understand about human sexuality? Dr. Faber's suggestion to work on a task force to review these questions was approved, and Dr. Faber has agreed to lead this task force. Dr. Ranck mentioned that he had been part of writing a grant application (sponsored by Pfizer) with Dr. Judie LaRosa on the teaching of human sexuality; if the materials prepared at that time (1-2 years ago) are still available, we might find that the job has at least been started.

Presentation of the Overview Block

Dr. Ranck presented the structure and the purpose of the Overview Block, which ahs now been given 5 or 6 times since the curriculum was renewed. Most of the members were unfamiliar with it, and perhaps that means that this exercise, which is unique for our school, should be better publicized. It might be analogous to exercises given at other schools named "triple jumps"—in that the students work in groups without a faculty facilitator, and need to produce both an oral report and a written essay on an assigned topic. (So this would be a "double jump"?) The Overview Block is meant to give the students an integrated review—or overview—of their learning during the first year. The exercise revolves around a very complex clinical case, which, however, does not require knowledge of pathology, microbiology or pharmacology. In addition to the case report—which is 6-9 pages!—the students get a very detailed discussion of the underlying processes. This discussion models expert reasoning from basic science principles to clinical findings. The written assignments given the students can be answered from the detailed discussion, but calls for the students to synthesize information and concepts to answer different questions than the ones posed during the group discussion of the case.

The students are graded pass/fail on their written essay—they have 4 hours in which to craft their response, and the exercise is completely open-book. They may collaborate, but are told that since all 18 essays on a give question are read by one grader, they need to be sure that each student's essay is his/her own work.

In the first years, the Overview Block was given at the end of the first year. Although students saw the value of an exercise that reviewed the entire year, they disliked having it

come at the end of the very taxing neuroscience block. For the last two years, the Overview block has been given in August as a “warm-up” exercise for the second year.

Most students pass; at most 5-6 students/year need to take an oral make up exam the next day. Interestingly, these 5 or 6 students are not always ones who have had difficulty in earlier blocks, which suggests that essay writing assesses a different kind of learning/skill.

A print out from the Colorado School of Mines web site on developing essay exams was distributed.
(http://www.trcc.commnet.edu/Ed_Resources/TASC/Developing%20essay%20exams.htm)

The committee felt that we were not quite ready to make a recommendation about increasing the use of essay exams in the basic science years. We need to revisit this at the next meeting.

Meeting adjourned at 5 pm

Agenda next meeting:
Essay assessments: do we want to make a recommendation to the Executive Committee?
Begin review of clinical years:

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
March 20, 2006

Present: M. Clark-Golden, M. Augenbraun, J. Ranck, B. Lawrence, H. Durkin, M. Nowakowski, I. Harwayne-Gidansky, S. Miller and L. Wilson

Report on teaching of female sexuality: Dr. Faber not able to make Monday meetings—unfortunately. She will provide a written report for our next meeting.

Reading skills

Dr. Markinson has agreed to chair the task force on reading skills. The group will get administrative support through the Executive Committee, and should expect to spend about 6 months defining our learning goals, mapping our curriculum, and "assessing our assessments" of these skills. Hopefully, Dr. Faber can be part of this Task force.

Alternative assessment for ECM

This discussion generalized into a discussion of the importance of writing skills for our students, which have not been strongly emphasized in the first two years. It seems that many of the current first year class also value these skills. Reports from the clerkship years suggest that almost 50 % of the students write barely acceptable or unacceptable patient write-ups (perhaps 10-15% are in the unacceptable category.) The big obstacle to including more essay type assessments of student learning is the faculty effort involved in reading essays/papers and providing feedback. Alternatives, such as using graduate students, or the medical school equivalent—residents—as graders was discussed, as well as using peer review. Hand-written essays on exams make the task of grading much more difficult; schools which use more essays on exams have the technological capability to give secure exams on-line.

Group was unanimously in favor of exploring ways to include more essay type assignments so that we can assess and develop students' writing skills. Dr. Ranck agreed to present his experience with the Overview Block at the next meeting. In addition, the block directors should be asked for volunteers to pilot essay assignments. One proposal was to include an essay question at the end of CBL cases, which could be graded by the facilitator in lieu of the evaluations which are currently being completed by the facilitators. This strategy would not require recruiting a new batch of faculty just to read essays, and would replace one form of assessment of CBL with another one. Thirdly, Dr. Lawrence and Dr. Golden will try to find some literature on the use of essays in medical school.

Collaborative Research Project by the Associated Medical Schools Clinical Skills Consortium

This group, which includes representatives from each of the 14 medical schools in New York State, is interested in ideas for a collaborative project on the outcomes of the member schools' teaching of clinical skills. Since 50% of graduates of New York State schools go on to residencies in New York State, there is potential for some fairly powerful studies. This group was asked to think of questions to study, taking advantage of the large number of students and residents we can access through this organization.

Next Meeting;
Monday April 17, 2006 at 4 pm in the Pediatric Conference Room

Report on Overview Block
Discussion of literature on essay exams and other “expository” assessments in early medical education.
Report on teaching of female sexuality

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
February 21, 2006

Present: M. Clark-Golden, M. Augenbraun, L, Terracina, L. Merlin, C. Roman, M. Nowakowski, B. Lawrence, L. Medlock, I. Harwayne-Gidansky and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of last meeting were approved.

Electives
Two new radiology electives were reviewed. The elective in diagnostic neuroradiology was approved, with the recommendation that a two week version also be offered. (Doing so would permit more students to fit it into their schedules.)

Committee asks that the description of the elective in interventional neuroradiology be revised: no pre-requisites are indicated, and the description of clinical responsibilities is for radiology residents. The clinical responsibilities need to be defined for a medical student level. (3^{rd} year? 4^{th} year?). See attached letter to Dr. Mangla.

Coverage of female sexuality in ms 1 and 2: deferred, because Dr. Faber unable to attend.

Reading Skills
A subcommittee will be formed to evaluated this issue in depth. The sub-committee is charged with: 1. defining the skills students need to acquire by the completion of medical school in terms of accessing appropriate literature on medical topics, establishing habits for reading and internalizing information on new topics, and on critically evaluating the literature.2. Reviewing the curriculum across the four years to see how these skills are taught. 3. Reviewing assessments of learning across the four years, which will help us and the students know if the learning goals have been met.
Drs. Augenbraun and Nowakowski agreed to serve on this sub-committee. Other members should include Dr. Volkert, who oversees CBL, the EBM group (Drs. Wallace, Markinson, Dinkevich), and students. It was suggested that Dr. Markinson might be a candidate to chair such a committee. Dr. Golden will ask her.

ECM
One of the student members made a plea for different kinds of assessment in ECM1, which would permit students with more of a humanities/social science background to show their strengths. So far the exams in ECM1 have reportedly been only multiple choice and short answer. Feedback on the patient profiles and other writing assignments has been scant.
ECM has assigned term papers in previous years (primarily in second year); the practice was discontinued because of complaints from students about how much work went into producing papers, without direct benefit in terms of preparing for the boards, and because of the difficulty of getting timely, consistent feedback to students on their efforts.

The student was asked to submit possible topics for an ECM1 paper, given that ECM has been dealing with a range of new topics this year. This question will be referred to the ECM leadership.

Attendance during late 4th year cycles of Neurology clerkship.
Dr. Merlin presented her concerns about poor attendance by 4th year students taking the required neurology clerkship after the Dean's letters have been submitted. She made a plea for emphasizing that attendance is an essential element of professionalism (which is done during the Transition to Clerkships), and for re-visiting the timing and sequencing of required clerkships. The committee agreed that it is probably appropriate to review the timing/sequencing of clerkships as a whole; scheduling changes for one clerkship cannot be made in isolation, because the schedule in the clinical years is such a tight jigsaw puzzle. In the meantime, since passing all required clerkships is essential for receipt of the MD degree, perhaps the Neurology clerkship can find a way to make it clear to students of all levels that non-attendance can result in a failing grade. It was also suggested that having a mix of third and 4th year students on the later electives may motivate the 4th year students to rise to the occasion.

Meeting adjourned at 5:10
Next Meeting: March 21, 2006

Agenda:
Report on presentation of female sexuality: Dr. Farber

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
January 17, 2006

Present: M. Clark-Golden, M. Augenbraun, L. Merlin, C. Roman, H. Durkin, M. Nowakowski, J. Ranck, B. Lawrence, H. Harwayne-Gidansky, S. Salmanzadeh and L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of last meeting were approved.

Old Business:
Elective
Change of Dr. Su's Toxicology Elective to a clinical elective was approved—with the modification of 5 hours/week at the Central Poison Control, and rounds on patients hospitalized at KCH/UHB with toxicological problems. The school apparently has no rules about how much of the 40 hours/week of a clinical elective must be spent in direct clinical experience; therefore, the committee will ask for a report from Dr. Su and the student after this upcoming elective.
A letter will be sent to the Registrar indicating that this change has been approved.

"Pal Weigarts": Report by Drs. Merlin and Ranck (with many thanks.)

Discussion of "Pal Weigarts" was initiated by the committee because of a half dozen student comments questioning the value of studying and being tested on this type of image.

"Pal Weigart" refers to stain, which stains myelin (hence long tracks) black, and reportedly is the only form of imaging which adequately shows the interrelation of spinal cord, brain stem and sub-cortical structures. Current clinical imaging modalities do not visualize these structures well. We were unable to project Dr. Kubie's remarkable web-based neuro-anatomy atlas; selected images were printed—see attached.

Apparently, the inclusion of Pal Weigart images in the curriculum has been contentious for 20 years or more. This group had a strong consensus that the neuro-atlas is a valuable resource with the level it detail it provides. While most students would not need to know all the tracks illustrated, the atlas should not be "dumbed down."

In recent years, these sections/images have been used primarily in conferences to demonstrate pathway problems; recent neuro exams were not reviewed to see if the images are actually included on the exam.

The group discussed the broadest learning goals for neuroanatomy: students need to know the major pathways and where they cross; they need to know that a neurological lesion will usually affect a combination of long tracts, and that it is often now intuitively obvious which ones; at some point (maybe in 3rd year?), students must know vascular syndromes.

In light of this discussion, the CEPC would ask the neuro faculty to consider whether being more selective in the presentation of major pathways may help students come away with a solid orientation to the clinically detectable consequences of lesions at various levels of the neuraxis. Schematic drawings to supplement gross sections can also be very helpful in pointing out constant relationships, not one which are peculiar to an individual specimen.

Teaching of Blood Gases in MS1 and MS2: Dr. Ranck (with many thanks.)

Dr. Ranck reported on reviewing all the materials for the MS1 and MS2 respiratory blocks, including lecture notes, CBL, and reading assignments. He found that with the exception of the alveolar-gas equation, the groundwork for interpreting blood gases is indeed presented in the first two years. The student member reported that the alveolar-gas equation was taught during the first year in this academic year. * What is missing is opportunities for students to practice interpreting blood gas reports, and making predictions using the relevant equations. This practice could come in the form of conferences and problem sets, and should ideally appear in several blocks—cardiac, respiratory, renal, and metabolism—because blood gas disturbances cut across organ systems.

A recommendation to that effect will be made to the Executive Committee.

Reading

The discussion of what and how students read was resumed. The student member reports that she has been noting that the recent reading assignments have been very broad—"read your histology text." Students choose different textbooks, so specifying reading assignments in textbooks in more detail might be difficult. Students do read the lecture notes very closely; roughly half of them will read the notes before the lecture.

Our goal may not be simply "to get the students to read the text." Our goal should be to prepare students to find, read, and appraise literature in the third year and beyond, where there will be no lecture notes. How do we make sure that the students are developing the necessary skills, and how do we assess that each students is developing them? While Case-Based learning is one setting, in which facilitators can insist that students cite their sources—and choose sound sources. It may be more difficult to know how well the student has processed and appraised the information provided by that source. Some blocks, but not all, have "journal clubs" in which students do practice critical appraisal. This educational goal may be one for a sub-committee to review.

Meeting adjourned at 5:10
Next Meeting: February 21, 2006

Agenda:
Report on presentation of female sexuality: DR. Faber
Conclude discussion on equipping students with **Reading Skills**

- A decision was made, about 15 years ago, not to present the alveolar-gas equation in the first two years, because it describes an empirical relationship, but doesn't tell about basic mechanisms.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate college of Medicine
November 15, 2005

Present: M. Clark-Golden, L. Terracina, L. Merlin, E. Faber, H. Durkin, M. Nowakowski, B. Lawrence, L. Medlock, I. Harwayne-Gidansky, L. Wilson

Dr. Barbara Lawrence open the meeting: Minutes of previous meeting were approved.

Old Business:
Discussion of how can we encourage students to do more primary reading: Dr. Merlin suggested we decide what our goals and objectives are. If there weren't any handouts there would only be reading assignments and the students would have no choice but to read or rely on whatever notes they took in class.
Ms. Harwayne-Gidansky, a student, feels lecture handouts should be sufficient to cover what the student will be tested on. She also feels that the people who excel tend to do the supplemental reading and people that are aiming to pass are not going to do the supplemental reading.

Assigning responsibility to follow-up on items identified at last meeting.

Dr. Faber volunteered to review first year materials related to female sexuality/reproduction.

Dr. Ranck agreed to review the treatment of blood gasses, drawing on his experience with this material in the Overview Block.

Drs. Ranck and Merlin will prepare to answer the question of whether the Pal Weigart exercises are still useful, based on reviewing the block materials, the block exam, and the available sample questions for Step 1. (It might also be useful to ask someone from radiology to advise us here, given the increasing resolution of new imaging modalities.) AT our next meeting, we will arrange to be able to project the Pal Weigart images for general discussion.

Although there was some interest in looking at integration in the first year GI block, given the fact that it is 7 week block, this is not a task for a single member to take on.
Dr. Golden volunteered to look at the block materials to get a better sense of how to approach this task.

No one was interested in reviewing the reading assignments in the various blocks without some context. Perhaps we in fact were asking ourselves the wrong question here. What we really need to focus on is how to equip students to become life-long readers/learners—so perhaps we should make this a focus of a future discussion: what are the skills students need to have to be able to continue to read and learn after they have been weaned from lecture notes?

Meeting adjourned 5pm.
Next meeting: December 20, 2005

Agenda:

1.Discussion of Pal Weigarts in ms 1 Neuro block: What do students need to know when they enter second year and beyond, and how do we get them there?

2. Reading skills—groundwork for life-long learning.

Minutes of the meeting of the
Education Policy & Curriculum Committee
Of the SUNY-Downstate College of Medicine
September 20, 2005

Present: M. Clark-Golden, S. Miller, C. Roman, B. Lawrence, L. Medlock, L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

Old Business:

The director of the Clinical Toxicology Elective is exploring with the New York Poison control center, the possibility of a student on the elective, spending some time (8 hours a week?) at the center listening in on calls. The student would also make rounds at KCH on any patients hospitalized with toxicology problems. Dr. Su will get back to us regarding the details.

New Business:

The student feedback on the MS1 and MS2 basic science courses for academic year 04-05 was reviewed. By and large, the summary data indicate continued satisfaction, and even improvement in some areas. Reading of the comments, and input from the student member, indicated a number of areas which warrant further research and discussion.
These topics include:
MS1

1. Variability in how faculty specify reading assignments: entire chapters vs. specific pages. We need to review examples of instructions about reading assignments which students have found helpful, and too broad; perhaps we can give block directors some guidance on a more uniform format.

2. We need to review the integration of histology, anatomy, biochemistry and physiology in the MS1 GI block — students commented that the GI block seems like 4 separate courses running concurrently.

3. We need to review coverage of the female sexual response, the menstrual cycle, and pregnancy.

4. Are the "Pal Weigert" exercises still useful? Is this sort of material/approach tested on the boards?

MS2

1. Although the students appreciated the value of exam questions which require clinical reasoning, the comments suggested that the way material was presented in the heme/onc block did not prepare the students for the level of clinical reasoning required on the exam. The block notes and the exam questions need to be reviewed. (Note: the exam questions will need to be reviewed at a meeting that does not include the student members.)

2. Some students commented that the GI block seemed to give short shrift to the liver, gallbladder and pancreas—this material was crammed at the end of the block. We need to review the lectures, the readings and the CBL cases.

3. Several students commented that blood gases were not well covered in the respiratory block—one lecture? Is this material also covered in the lectures or in CBL?

Dr. Lawrence's office can provide the committee with the relevant materials from the syllabi from the previous year. Each of these topics could be reviewed by a subcommittee, which should include at least one content expert, which can then report to the committee as a whole. In some cases, it may be useful to invite the block and discipline directors to educate us about how the material is covered.

The meeting adjourned at 5:10.

Next meeting: November 15, 2005 at 4:00 p.m. in the Microbiology Conference Room, 3rd Fl., BSB, Rm.3-5.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
July 19, 2005

Present: M. Clark-Golden, M. Augenbraun, M. Nowakowski, B. Lawrence, L. Terracina, L. Merlin, C. Roman, J. Ranck, B. Lawrence, R. Beckford. L. Wilson

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

Old Business

1. **Review of feedback on Clinical Elective**
   Physical medicine and rehabilitation (Dr. Pipia)
   This elective was returned to course director for elaboration and was resubmitted. The revised description was satisfactory, and elective approved.

New Business

1. **Review of new course offerings (electives):**
   Dr. Golden presented a proposal to re-classify elective in Medical Toxicology. The committee felt that there needs to be more clinical experience, therefore, the elective was not accepted. Dr. Golden will speak with Dr. Su.

2. Student evaluations of second semester courses and of clerkships will be deferred until our next meeting in order to give Dr. Lawrence's office more time to finish preparing reports. Committee members should expect reports 1-2 weeks before next meeting, to allow time for members to review them.

   Discussions of scheduling of ECM was also deferred until we have reviewed student feedback for second semester.

3. **Essay Type Assessments:**
   There were discussions on use of essay assessments of student learning. This question arose from a discussion in the fall, in which the group identified that our current method of assessing student learning in the first two years do not match our stated goals of fostering the ability to reason. Including some essay questions on exam and in basic science exams would be one way to determine if students are learning how to reason with the facts and concepts they have learned. The school has some experience with essay exams: in the Overview Block and ECM4, where essays are the only assessment tool. These two courses are pass/fail. Essays are also included in exams given in ECM 1 and 2 and in Neuroscience.

   Students also produce written products for CBL sessions, and there was some discussion about these products. Many students produce cut-and-paste products, and seem to have not read any of their own material until actual CBL session. Can we set clear expectations for CBL that would reduce or eliminate this behavior? For instance, if preceptors insist that hand outs for CBL be drawn from textbooks or

medical journals, not web sites, except in exceptional circumstances, and (somehow) that the hand-outs be in the student's own words? (How do we police this?)

Advantages and challenges in giving essay exams:
MCQ exams can assess analytic thinking, but not synthesis. On the other hand, while essay exams can assess the student's ability to synthesize information, they can only cover a limited scope of the material which is typically covered in a block. (Neuro and ECM, which use essay questions, also use MCQ's to cover some of the material.) Essay exams also assess the student's ability to synthesize information, which they can only cover a limited scope of the material and is typically covered in a block. (Neuro and ECM, which use essay questions, also use MCQ's to cover some of the material). Essay exams also assess student's ability to give a line of reasoning and to write well, which was felt to be very important in future practice. One study was cited which indicated that students learn material "better" when studying for an essay exam than for a multiple choice exam. (Get this article—what do researchers mean by "better"—length of retention, active integration of material, confidence in knowledge?)

All agreed that good essay exams are hard to write—because of the challenge of asking a clear and focused question, which is not unduly prone to multiple interpretations, and also for higher level reasoning.

The most salient problem with essay exams is with grading: the labor involved and the problems with consistency in grading. The neuro block has two readers for each short essay, which improves reliability but doubles the labor. Students complain that you only get credit if you use certain "buzz words". (What's the difference between a "buzz word" and the appropriate term for a key concept?) Students also raised the problem of many of the essay exams being treated as secure exams, so that they can't learn from weaknesses in their essays.

The relevance of essay format to other high states assessments was discussed. The step 2 CSE does include post-encounter notes, in which students demonstrate their ability to summarize the data they have learned from the history and physical with the standardized patients, and to develop a differential diagnosis and diagnostic plan. We are in the process of scoring the post-encounter notes for our in-house CSE, and are finding that the majority are barely passing. In summarizing the history, the students include too much, and have not learned to filter (is this related to the behavior of many physicians practicing defensive medicine who order all possible tests?). In reporting the physical exam, students again may list everything, and rarely take the step to explain how this finding or maneuver helps confirm or eliminate diagnostic possibilities. Sometimes the items listed in the differential are not supported by anything mentioned in the history or physical—and also show a lack of knowledge about the settings in which some of the diseases occur.

Next meeting is scheduled for September 20, 2005 at 4 p.m. in the Microbiology Conference Room, 3rd Fl., BSB, Rm. 3-5

Agenda:
Review of course evaluations

Continue discussion of assessment methods which will measure critical thinking (Will try to provide some articles for review by the group.)

The meeting was adjourned at 5 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
June 21, 2005

Present: Dr. Golden, Dr. Merlin, Dr. Durkin, Dr. Nowakowski, Dr. Lawrence, Ms. Wilson and Guest, Dr. Judith Ahronhein

Minutes of April 19th meeting reviewed and approved with one edit to section on review of clerkships

Old Business:

1. **Review of proposed electives**

   Physical medicine and rehabilitation (Dr. Pipia).
   This looks like a very valuable opportunity for students. Course description needs to be fleshed out a bit—include a description of the knowledge and skills the student should expect to acquire during the elective.
   In general, clinical electives for credit should involve more than observation of clinical encounters by the student. Although observation is appropriate for some learning objectives, it should not be the only learning modality. It must be supplemented by reading, literature review, some patient interaction, seminars, etc.

   Disposition: return to course director for elaboration

   Research elective in ob-gyn (Dr. Gabbur)
   Very valuable opportunity for students; description of experience needs to be fleshed out a bit. Does the student design a study, or participate in an attending's on-going study? Is the research clinical or bench? Are there core readings or tutorials (on research methods; human subject protection, lab methods, statistics?)

   Disposition: return to course director for elaboration.

   Research Experience in Psychological Issues in Infancy
   Disposition: Approved

   These recommendations have been forwarded to the registrar's office for revision by course directors.

New Business:

1. **Longitudinal thread in geriatrics.**
   Dr. Ahronhein presented a proposal for a working committee to evaluate and strengthen our teaching of geriatrics across the four years. See attached document. Although we do have a clerkship in geriatrics during the last year, she sees a need for introducing a number of core principles of geriatrics before students encounter geriatric patients on other clerkships (medicine, psychiatry, surgery), and before unproductive attitudes become engrained in the students. The discussion explored how much these core principles belong in the basic science years, and how much they are really issues of clinical application of principles which may in fact have been

introduced in other courses. The CEPC agreed to support a Geriatrics Thread Committee, charged with 1: mapping what and where the geriatric principles are currently being taught; 2: identify educational gaps, and 3: recommend modifications to the existing curriculum to address these gaps. (These recommendations would include faculty development for clinicians who are not geriatricians, but who do have significant clinical involvement with older adults.)
The Geriatrics division is applying for an educational grant, which might help support the work of such a committee. The Committee also endorsed conduct a survey of faculty/clinicians to identify individuals who would be interested in working on a geriatrics curricular assessment and plan.

Next Meeting: July 19

Agenda:

1. **Review of course evaluations—spring semester, clerkships**

2. **ECM curriculum: is it delivered more effectively as a longitudinal thread, or in blocks?**

3. **Essay type assessments of basic science learning: advantages? Costs? Is there a net advantage for our students?**

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
April 19, 2005

Present: Dr. Golden, Dr. Merlin, Dr. Lawrence, Dr. Miller, Dr. Terracina, Dr. Ranck, Ms. Medlock and Ms. Wilson

Meeting called to order at 4:10.

The minutes were reviewed and accepted.

Old Business:

1. Review of feedback on the clerkships:

A number of clerkships were changed with the new curriculum: New clerkships include emergency medicine which is a two week required clerkship, primary care one , which is 6 weeks, primary care 2 which is 4 weeks (geriatrics). Anesthesia, 2 weeks, is now separate from the surgery clerkship, which used to be 12 weeks and is now 8. Medicine was also reduced from 12 to 10, and peds from 8 to 6.

Over the last year we have managed to get electronic capture of student feedback for all the clerkships. We will have much more complete data for the clerkships for this academic year. On review of this data, one of the things we should look at is, are we asking the questions of the students that we need to be asking regarding the clerkship experience in the questionnaire? Overall, the clerkships are favorably reviewed. There is room for improvement on most clerkships in "quality of bedside technician"--range from 2.5-3.26 on a 4 point scale. Note that this question does not elicit the amount of bedside teaching. The average on this item was 2.87 for the clerkships overall. It was also noted that students rated surgery below 3 on many measures; however, it is known that Dr. Dressner has made changes in the clerkship for this year.

The groups agreed to recommend to the Executive Committee and to the Clerkship Directors that the clerkship survey reinstate the questions about how often the students were observed during patient encounter. It would be useful to break this item out according to whether the observer is an attending or a resident.

New Business:

1. Review of new course offerings (electives):

Dr. Golden handed out 2 handwritten proposals for new electives. One was a non-credit elective for first and second year students for family planning and the other was a credit elective for third and fourth year student for interventional radiology

The committee looked at the elective offering and decided they had educational merit. The two proposals for new electives were approved.

2. USMLE Step 2 CSE:

In addition to the multiple choice exam of the step 2 USMLE, they have now added a clinical skills exam which is a 10 station encounter with 10 standardized patients. This is a standardized test of the ability to gather information, perform a physical exam and communicate with patients.

The National Board own 5 locations in which the USMLE Step 2 exam is held.
They are as follows: Philadelphia, Atlanta, Texas, Boston and Chicago. The Board feels they need another location on the east coast.

The school is looking at our students' performance on this exercise with an eye to reviewing our teaching of clinical skills.

The meeting adjourned at 5:00pm.
Next meeting: June 14, 2005 at 4 p.m. in the Microbiology Conference Room, BSB-Rm. 3-5.
Rescheduled for June 21, 2005 at 4 pm.

Agenda for next meeting:

1. Essays
2. Looking at the organization ECM
3. Guest : Dr. Aronheim to discuss longitudinal thread in geriatrics.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
March 15, 2005

Present: Dr. Golden, Dr. Merlin, Dr. Faber, Dr. Durkin, Dr. Nowakowski, Dr. Lawrence, Ms. Beckford and Ms. Wilson

Absent: Dr. Roman, Dr. Rank, Dr. Terracina, Dr. Miller, Dr. Augenbraun and Ms. Leia Medlock

Meeting called to order at 4:10.

The minutes were reviewed and accepted.

Old business:

1. **Review of the written comments from the students for the first and second year blocks:**
   Dr. Golden reported she thought the students were very thoughtful about their comments on what they have been experiencing.

   Ms. Beckford, our student representative, reported comments from students regarding changing the questions around on the exam: Some students believe that if the teachers would start asking integrated questions or questions similar to the ones on the board now, then this would prepare them for the second and third year. Sometimes CBL comes up before the topic is covered in lecture and therefore, the student is not fully able to participate or fully understand and that is why the presentations end up being a cut and paste.

   There were a lot of comments on all of the lectures on collagen, and the sometimes contradictory information given by different lecturers. This observation seems to point to an important, broader issue—that of uncertainty in medicine. Students need to be prepared for it, and come to terms for it, although it is difficult to accept uncertainty when the main testing modality is multiple choice.

New Business:

2. **MS1 and MS2 Essentials of Clinical Medicine**
   Dr. Lawrence distributed folders containing ECM-1 and ECM-2 first evaluation, fall, 2003, 2004 and Retrospective Assessment of MS1 and MS2 by MS3 students, classes of 2001, 2002 and 2006.

   By and large, the evaluation of both courses has improved quite a bit since last fall, ECM1 more than ECM2. Some of the reasons for the improved rating by the students include the new leadership for ECM1 (both Dr. Erogul, who started in the winter of 03, and now Dr. Landesman); the use of standardized patients in the small groups, better quality readings, and written assignments to hand in at small group, which may be motivating students to prepare more for the small groups, hence making those sessions more valuable.

The students feel that the biostats sessions are too separated; although the students do feel that Dr. Sinnert is an effective lecturer, the time between biostat sessions means that the students have to relearn everything from several months ago in order to tackle each assignment. There was some discussion about whether this might be in fact be a very useful model, since that is often how clinicians use biostat/study design knowledge—at intervals, not daily.

The first year students believe ECM is a valid course but they don't feel that the ECM Directors and the Directors of the other blocks collaborate enough, because some of the exams are timed very close together and as a result the students are sacrificing ECM or something else. Most of the students feel they should have an entire block of ECM to itself or to have ECM separated at the beginning or at the end of the year with two separate dates. The preceptorship should be continued throughout the year. This will be put on the table for discussion at a later date.

Dr. Merlin reported that the ECM schedule does interfere at times with the concurrent block. The neuro-block in MS2, is that they learn the neuro-exam before the neuro-block comes up, which cannot be delayed because they have already had the session on "putting it all together" before the neuro-block starts. (Comment: this arrangement of sessions related to neuro was actually done at the request of the Dr. Anziska some years back, with the hope that it would make the neuro exam an integral part of the complete physical exam. We have not been testing the neuro exam on the practicum, however, which may defeat this purpose. On the other hand, it prepares the students to perform the neuro exam on patients during the bedside preceptorships, which begin before the neuro block.)

The meeting adjourned at 5:00pm.
Next meeting: April 19, 2005 at 4 p.m. in the Microbiology Conference Room, BSB-Rm. 3-5.

Agenda for next meeting:

- Review of feedback on clerkships
- Review new course offerings (electives.)
- Do we want to recommend to the Executive Committee that more blocks include essay questions on assessments of student learning?

- Discuss how to proceed with discussion of proposal to make ECM several blocks: who do we need to invite to the Committee? What background materials do we need to assemble?

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
February 15, 2005

Present: Dr. Merlin, Dr. Durkin, Dr. Augenbraun, Dr. Nowakowski, Dr. Miller, Dr. Lawrence, Ms. Medlock

Absent: Dr. Faber, Dr. Roman, Dr. Rank, Dr. Terracina, Ms. Wilson

Meeting called to order at 4:10.

The minutes were reviewed and accepted. Several members mentioned not having received notice of the meeting. Ms. Wilson will be asked to be sure that the e-mail list matches the membership list, and to use return receipt so we can track if there are people who are not receiving minutes.

Old business: At our last meeting, we had discussed sending a questionnaire to the faculty about whether they are satisfied with the amount of teaching they do. Dr. Merlin was the only one to respond to the draft questionnaire circulated by e-mail, so Dr. Golden agreed to try to put in the changes suggested by Dr. Merlin, and re-circulate the survey for approval by the membership.

New Business:
Dr. Lawrence distributed folders including the results of the student surveys of the basic science blocks to date, and of the clerkships for last year. Dr. Lawrence pointed out that the clerkship data from last year is better than it has been in the past, but is still less than complete response, because electronic responses were only obtained for half of the year; the first half of the year was still relying on paper responses.

Discussion then turned to the first year basic science blocks. In general, satisfaction with the blocks is good, and there has been significant improvement in several of the blocks compared to the first year of the curriculum.

The following specific issues were discussed:

Assigned reading. The surveys show that the number of students reporting that they have done the assigned reading has declined over the years. The student member pointed out that many faculty members do not give assigned readings beyond the detailed lecture notes. Is the heavy reliance on lecture notes motivated by direction from the administration, or the preference of students? (the administration in fact discourages heavy reliance on lecture notes). Apparently Academic Development advises students to read the lecture notes in advance of the lecture, but to NOT take extensive notes during the lecture so that the student can concentrate on listening and understanding.

In any event, the reliance on lecture notes does not support the students in using textbooks or primary sources during the first year.

Exams: Most of the exams in the first two years are multiple choice. Over the years since the new curriculum was introduced, the exam questions have tended to become "cleaner"—less tricky. The move towards higher level questions—application vs. recall of

facts for instance—has been slower. Hence in some ways, the first year blocks especially have become "easier."

Fostering Critical Thinking: Although the students report that the basic science curriculum does foster thinking, the faculty who see the students in the clerkships feel that the students have not developed the level of critical thinking required for the tasks they face in the clinical setting. Perhaps the students at the beginning of the first year need to be given some bench marks for what constitutes critical thinking—benchmarks which apply during CBL, and another set of bench marks for the clerkships.

It was pointed out that fostering critical thinking will only really happen if we measure whether students are achieving it—that is if we test it. Do we need to institute the wider use of essay exams to measure this outcome? If so, isn't this truly a curricular issue: that the school needs to allocate resources to permit meaningful measures of student learning?

Using the literature: This issue relates to the first—to what extent students read materials other than the lecture notes. CBL is certainly an arena for encouraging students to become "better consumers" of the literature. Ways in which students could be better consumers include using search engines other than Google, citing sources in presentations for CBL, making decisions about which sources are more reliable/valid/useful, creating handouts which reflect synthesis of information from several sources instead of uncritical (and often unread) cut-and-paste productions.

What are the obstacles to doing this in CBL? Several were identified. For the faculty, there may be reluctance of CBL facilitators, who are often transients, to impose standards on the students; possible lack of comfort on the part of some of the facilitators in critically evaluating the sources offered by the students. The student mentioned the need for a session/tutorial on critical appraisal, similar to the on-line tutorial and assessment on accessing the library resources.

The meeting adjourned at 5:00pm.

Next meeting: March 15 4pm.

Agenda for next meeting:

Review of the written comments from the students for the first and second year blocks. (Committee members are asked to read the comments before the next meeting and raise any salient issues that they identify.)

Review of ECM;

Review of the Clerkships;

Summarize recommendations for presentation to the Executive Committee and the Dean's Council.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
November 16, 2004

Present: M. Clark-Golden, M. Augenbraun, S. Miller, L. Merlin, L. Terracina, L. Medlock and L. Wilson

Old Business

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

Introduction of basic sciences in the clinical areas: Dr. Merlin stated that in family practice they have a 6 week rotation. Also Dr. Merlin gives a workshop every 6 weeks in every cycle. Core diseases used to implement basic sciences in the clinical areas are type II diabetes, COPD and CHF.

New Business

Dr. Augenbraun suggested we do a power point presentation for the last academic year for the clerkships and the basic science blocks to date.

Dr. Golden stated that part of the committee's mission is to solicit input from the faculty and the students on the curriculum. There are several ways to achieve this. We could put our minutes on the web page. Dr. Golden will make a presentation at the semi-annual assembly meeting. This meeting has been better attended now than they have been in the past. Another alternative is to have the departments send an e-mail to all faculty of their department. We would like faculty to comment on the following: Are there teaching and assessment methods that we need to explore? Does the faculty think they are involved too much or too little regarding teaching? Dr. Golden will send out a very brief questionnaire to faculty requesting their input on the curriculum.

Dr. Golden proposed our next meeting take place in January.
The meeting adjourned at 5 p.m.

Next meeting is scheduled for February 15, 2005 at 4 p.m. in the Microbiology Conference Room, 3rd Fl., BSB, Rm. 3-5

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
October 19, 2004

Present: M. Clark-Golden, S. Miller, M. Augenbraun, L. Merlin, E. Faber, C. Roman, H. Durkin, J. Ranck, L. Terracina, L. Medlock, L. Wilson

Old Business

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved.

New Business

How do we continue to thread the basic science teachings in the clinical years? Dr. Golden asked Dr. Merlin to speak on this because neuroscience has a model for doing this. Dr. Merlin's point of view was that their mission was keeping the clinical into the basic and getting the basic into the clinical.

Dr. Merlin chairs the Neural and Behavioral Science Education Committee. On that committee they have most of the leaders of blocks and clerkships that pertain to the nervous system. Basic science as well as neurology and psychiatry meet every 2-3 weeks to review what they are doing and try to figure out how to do it better and where there is room for improvement.

This committee has been looking at lectures that look like they have a potential bearing on the nervous system. The neuroscience faculty have been sitting in on the lectures and looking at the handouts, then coming back reporting to one another of what is being covered, how it is being done and looking at areas that are recommended for improvement.

For the curriculum as a whole, there are 2 mechanisms of communication to permit integration between blocks – one mechanism is the block director's meetings which tend to deal with schedules and AV. The other mechanism is that at the end of each block. Each block does a presentation to Stan Friedman, Barbara Lawrence and Fred Volkert and the presentation consists of the evaluations by the student and a self assessment by the block leaders.

Dr. Helen Durkin reported on the approach to training of medical students in clinical and basic research taken by the interdepartmental Allergy and Asthma Research Center Group, which includes 23 interdepartmental research collaborations in 9 departments (Pathology, Medicine, Pediatrics, Surgery, Dermatology, Physiology/Pharmacology, Microbiology-Immunology, Otolaryngology, Public Health) is to integrate medical students into ongoing immunology research projects in participating laboratories. While performing research projects in a laboratory of choice, the medical students also can elect to work in any of the other laboratories to take advantage of the expertise and technology which they require for their research project, under the supervision of Faculty and Technical Staff. Approximately 10 Medical students are currently participating; they are productive and appear to be enjoying themselves.

Attention then turned to the clinical clerkships. It is well recognized that the diseases seen by any given student during a clerkship can be the luck of the draw; on the other hand, there are some diseases which really are "core" to mastery of the material for a given specialty. Would it be useful to develop some "paper cases" for the clerkships for some of these core diseases, and use these paper cases as a mechanism for reviewing key basic science concepts? Dr. Faber agreed to sketch a proposal at the next meeting.

The meeting adjourned at 5 p.m.

Next meeting is scheduled for November 16, 2004 at 4 p.m. in the Microbiology Conference Room, 3rd Fl., BSB, Rm. 3-5

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
September 21, 2004

Present: M. Clark-Golden, M. Augenbraun, H. Durkin, M. Nowakowski, B. Lawrence, L. Wilson

Old Business

Dr. Clark-Golden opened the meeting. Minutes of previous meeting were approved with an amendment of initiating Dr. Christopher Roman to join the committee.

Dr. Clark-Golden explained the mission of the CEPC Committee to new members of the committee.

New Business

Review of data before and after curriculum renewal: Dr. Lawrence prepared a summary of the USLME Part 1 scores – 5 years pre and 5 years post. In the year 2000, 168 students tested and 161 students passed. Bio stats in epidemiology were variable.

Dr. Lawrence reported that faculty groups need to work on reviewing the student survey of courses.

There is a sample question bank on the website for the USMLE step 1.
The website address is as follows: http://www.usmle.org/step1/default.htm

Student learning and assessments:

- Pre-identify students at risk of failing and try to help them.
- Locate residency placement data and follow-up data on our doctors.
- Send students to Morschand Center at Mt. Sinai and collect data.

It was decided that the meeting will take place on the 3rd Tuesday of each month.

At the next meeting Dr. Clark-Golden would like to start with this question: How do we continue to thread the basic science teachings into the clinical years?

Dr. Clark-Golden requested that Chris Roman attend the next meeting because he has been involved in the "Back to Basic Science" two week course in the 4th year which was a chance to bring all the students back so they could see each other but also to give them a series of lectures and discussions on cutting edge on developments in Basic Science. Dr. Clark-Golden also hoped that Dr. Lisa Merlin will attend the next meeting because neuroscience is one discipline that has looked at their teaching systematically from year one.

Next meeting is scheduled for October 19, 2004 at 4 p.m. in the Microbiology Conference Room, 3rd Fl., BSB, Rm. 3-5

The meeting adjourned at 5 p.m.

Minutes of the meeting of the
Education Policy & Curriculum Committee
of the SUNY-Downstate College of Medicine
July 20, 2004

Present: M. Clark-Golden; A. Norin; S. Miller; M Augenbraun: L. Merlin; George Ojakian; L. Wilson.

Declined: V. Anderson; M. Makowske

Introduction

Dr. Golden opened the meeting by presenting the rationale for resurrecting the Committee on Educational Policy. The CEPC, as an elected committee of the faculty, has a history of very intense activity, (including the discussions which led up to a trial of Problem Based Learning), but lost momentum when the curriculum renewal process began in 1997. One issue was that faculty with interest in curriculum were heavily involved in designing the new curriculum; another issue was that the CEPC had often felt that the committee's recommendations were not heard in the Dean's office. Subsequent to the curriculum renewal, the Dean's Council on Education was created to provide centralized oversight of the curriculum, as required by the LCME. The LCME also requires that the faculty as a whole have a voice in the curriculum; in addition, the current Dean is quite receptive to input from a representative group of faculty on curricular issues. Hence the by-laws of the faculty were revised to make the CEPC an appointed subcommittee of the Faculty Executive Committee.

Mission

The remainder of the discussion was devoted to potential projects for the new committee, These include:

1. Review of data on success of curriculum renewal: student surveys, trends in board scores; residency placement; faculty satisfaction with teaching.
2. Review of what we have learned with the remediation of the standardized patient assessments of our third year students.
3. Review of integration and re-inforcement of basic science teaching in the clinical years.

Next meeting scheduled for September 21 at 4pm.

The meeting adjourned at 5 pm.