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MEDICAL EDUCATION COMMITTEE AND SUBCOMMITTEE ACTIVITIES, 2003-2004

Curriculum

- A new course (Genetics in Medicine) was reviewed, approved, and implemented in the Fall term of the MS1 year.

- The entire clinical education program was reviewed by a Clinical Education Task Force (see information later in this report). The purpose of this review was to identify how to implement an additional week for the Neurology Clerkship. See a description of the outcome and the process in the report to the Dean dated March 4, 2004 (also later in this report). The results were that for students on the Birmingham campus (1) an additional week was added to the Neurology Clerkship, (2) the Rural Medicine Clerkship was eliminated as a requirement, and (3) several 3-week Selectives in clinical disciplines that do not have required clerkships (and including Rural Medicine) were created.

- The curriculum strategic planning process is still in progress.

- The Scholars' Week program was continued, and several new courses designed by faculty or students have been added.

- Following the Clinical Education Task Force recommendations, which applied to the Birmingham campus, the branch campuses were asked to review their curricula in the light of their individual campus strengths and weaknesses and identify curriculum changes that would enable them to provide the best medical education program possible to students assigned to their campus.

- Modified the frequency, location, and sequence of curriculum committee meetings to better achieve time efficiency and effectiveness. MEC meetings were switched from bi-monthly to quarterly and Assessment and Integrated Medical Sciences Subcommittees were each switched from monthly to bi-monthly. More attention is being given to planned and purposeful meetings, leading to better attendance and more meaningful outcomes.

Teaching

- In response to expectations by the LCME, the process of developing a set of pre-clinical competencies was begun.

- The number of computer stations in the computer lab was expanded from 48 to 77 to better accommodate the higher usage needs.

- With completion of the new addition to Volker Hall, greatly improved small-group instructional space and individual study space has been organized, using a "learning community" concept.

- Also within the new addition to Volker Hall, the 22-room Clinical Skills Lab has been completed, wired for monitoring, and tested. It is being used for both instructional activities and assessment activities (Senior OSCE), both using Standardized Patients.
• A MEC-sponsored but CDM-developed and prepared electronic newsletter is sent to faculty, residents, fellows, and students on all three campuses and to community-based preceptors [approximately 1800 recipients]. The newsletter contains news of interest to faculty and students and for more than a year in each issue delivers one of a series of suggestions on instructional improvement. In addition, it contains summaries of medical education research articles, titles from most current medical education journals (with an offer to send article copies), a listing of UASOM, national, and regional meetings and workshops. Since 1999, 362 medical education journal articles have been provided in response to UASOM faculty members’ request.

Assessment

• A quartile grading system that was approved by the MEC in the last reporting period but delayed because of some departmental concerns, has received endorsement by departments and is being implemented with the class entering in July 2004.

• Near the end of this reporting period, the Dean appointed Roger Berkow, MD, to be responsible for preparation for the LCME accreditation. Preparation procedures have been designed, and plans are underway to begin the data gathering and self-study phases.

• A new procedure and new criteria for peer review of courses and the same for clerkships have been established and are underway (see appendices of this document)

• A new electronic evaluation system (E*Value), which is a Web-based evaluation and student activity log system, was purchased and is being implemented for use in courses and clerkships.

Medical Education Research

Publications:
• Richard Sims, Bill Weaver, John Caldwell, et. al. Geriatrics Curriculum: University of Alabama School of Medicine, Academic Medicine 79:7, July 2004 Supplement

• Bill Weaver, Julie Walsh, James Jackson, et. al, Basic Science Educators and Medical Education Organizations, Teaching and Learning in Medicine (in press)


Presentations:
• James Sheetz and John Caldwell, Modification of commercially available testing software for computerized histology practical exams, Poster at 21st Annual Meeting of the American Association of Clinical Anatomists, June 2004, St Mary's College of California, Moraga, CA


• Frank Franklin and Christopher Lorish, CVD Prevention Training Using 5A’s Brief Behavioral Counseling: An Undergraduate Medical Education Curriculum. Innovations in Medical Education Exhibit at AAMC Annual Meeting, Washington, DC, November 2003


• Julie Walsh, Diane Heestand, Chris Candler, and Jeanie Schlesinger, What issues need to be considered to effectively integrate technology into the medical school curriculum?, Small-Group Discussion at Annual Meeting of the Association of American Medical Colleges, Washington, DC, November 2003

• Dennis Baker, Julie Walsh, J., Tysinger, A. Davis, and R. Smith, Conducting faculty development electronically: Methods, challenges, and lessons learned, Panel Discussion at the Generalists in Medical Education, Annual meeting, Washington, DC, November 2003

• Julie Walsh, (moderator) Faculty Topics, Descriptive Session at the Generalists in Medical Education, Annual meeting, Washington, DC, November 2003

• Peter Anderson, Julie Walsh, Jeanie Schlesinger, and C. Stephens, Developing and delivering online instructional content for the health sciences, Invited Workshop at the International Association of Medical Science Educators, Annual meeting, Washington, DC, July 2003

• Peter Anderson, Julie Walsh, Jeanie Schlesinger, and C. Stephens, Intermediate Web-based Teaching, Invited Workshop at the International Association of Medical Science Educators, Annual meeting, New Orleans, LA (scheduled)

National Committee Activities

• AAMC Project Medical Education Steering Committee (member), Dennis Boulware

• AAMC Genetics Education Panel Member – Medical Student Objectives Project, Dennis Boulware

• AAMC Musculoskeletal Education Panel Chair – Medical Student Objectives Project, Dennis Boulware

• AAMC Medical Student Performance Evaluation Advisory Committee (member), Dennis Boulware

• Award of Excellence, Association of Professors of Gynecology and Obstetrics (for the design/development of UASOM Ob/Gyn Web site), 2004, Julie Walsh
• Manuscript review: Medical Education Online, John Caldwell and Julie Walsh

• Abstract review: Journal of International Association of Medical Science Educators, John Caldwell and Julie Walsh

• Abstract review: AAMC’s Southern Group on Educational Affairs (SGEA) annual meeting, Julie Walsh

• Abstract review: Generalists in Medical Education, Julie Walsh

• Proposal review: Edward J. Stemmler Medical Education Research Fund, John Caldwell and Julie Walsh

• Member, Nomination Committee, AAMC Southern Group on Educational Affairs, 2003, Julie Walsh

• Member, Faculty Development Project Committee, AAMC Southern Group on Educational Affairs, Mentor in a Manual: Web-based Faculty Development Guide, 2004, Julie Walsh

• Co-Treasurer, Membership Director, and Co-Webmaster, Generalists in Medical Education, Julie Walsh

• Member, Technology Task Force and Local Organizer for the Webcast Audio Seminar Task Force, International Association of Medical Science Educators, Julie Walsh

### MEDICAL EDUCATION COMMITTEE (MEC)

**Membership (as of June 30, 2004)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Name</th>
<th>Department</th>
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<tbody>
<tr>
<td>Chair</td>
<td>Nathan Smith, MD</td>
<td>Psychiatry</td>
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<tr>
<td>Vice Chair</td>
<td>Peter Smith, PhD</td>
<td>Physiology</td>
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<td>Immediate Past Chair</td>
<td>Michael Wyss, PhD</td>
<td>Cell Biology</td>
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<tr>
<td>Chair, Assessment Subcommittee</td>
<td>Steven Carroll, MD, PhD</td>
<td>Pathology</td>
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<tr>
<td>Chair, IMS Subcommittee</td>
<td>Stuart Frank, MD</td>
<td>Medicine</td>
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<td>Basic Science Course Director</td>
<td>Peter Anderson, DVM, PhD</td>
<td>Pathology</td>
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<td>Birmingham Clerkship Director</td>
<td>Siene Chiang, MD</td>
<td>Ob/Gyn</td>
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<tr>
<td>Huntsville Clerkship Director</td>
<td>May Jennings, MD</td>
<td>Medicine</td>
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<td>Tuscaloosa Clerkship Director</td>
<td>Ashley Evans, MD</td>
<td>Pediatrics</td>
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<td>At-large Faculty</td>
<td>Julie Harper, MD</td>
<td>Dermatology</td>
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<td>At-large Faculty</td>
<td>Jeff Engler, PhD</td>
<td>Biochemistry</td>
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<td>At-large Faculty</td>
<td>Richard Sims, MD</td>
<td>Medicine</td>
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<tr>
<td>MS 1&amp;2 Student Rep.</td>
<td>Philip Weems</td>
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<tr>
<td>MS 3&amp;4 Student Rep--Birmingham</td>
<td>Banks Petrey and Alex Leigh</td>
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<td>MS 3&amp;4 Student Rep--Huntsville</td>
<td>Ha Nguyen</td>
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<tr>
<td>MS 3&amp;4 Student Rep--Tuscaloosa</td>
<td>Michael Bindon</td>
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# MEDICAL EDUCATION COMMITTEE

**July 15, 2003, 3:30pm**  
3rd Floor Conference Room, New addition to Volker Hall

**PRESENT:**  
In Birmingham: Peter Anderson, Jeff Engler, Ashley Evans, Stuart Frank, Craig Hoesley, James Jackson, Stan Massie, Kathy Nelson, Banks Petrey, Nathan Smith, Peter Smith, Julie Walsh, Bill Weaver, Philip Weems;  
In Huntsville: Lanita Carter;  
In Tuscaloosa: Eugene Marsh

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## MINUTES

**Purpose:** Approval

**Info/Discussion:** Minutes are currently sent as an attachment to persons on the MEC emailing list, but in the future, the notice will merely note that the minutes have been posted on the web.

**Action:** No objection to most recent minutes

**Responsible:** Bill Weaver

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## LEARNING COMMUNITIES AND MENTOR GROUPS

**Purpose:** To explain the purpose and process

**Info/Discussion:** Drs. Kathy Nelson and Stephen Smith described the purposes and arrangement and how the communities might interact with the courses' groups, etc. In an effort to encourage interaction among students with different backgrounds and life experiences, learning communities are being established here as at a few other medical schools. Students are assigned to one of the two learning communities on the basis of a variety of factors. One learning community will be housed on the 4th floor of the new addition to Volker Hall, and the other will be housed on the 5th floor. A process is underway to select names for each learning community. Students on a learning community will have small-group rooms, kitchen facilities, and their mailboxes and lockers on that floor. Course directors are urged to match up their groups as much as possible to enable students to remain with their fellow-members of the learning community.

**Action:** None

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## IMS SUBCOMMITTEE REPORT

**Purpose:** Update

**Info/Discussion:** Efforts have been made to assure that all Scholars' Week courses have a full week of activities for students. Also, a discussion has begun about the adjustments that will need to be made in the 3rd year in order to accommodate an additional week for the Neurology Clerkship.

**Action:** A clinical education task force is being appointed to review and present options to the IMS for consideration

**Responsible:** IMS Chair and Vice Chair

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## ASSESSMENT SUBCOMMITTEE REPORT

**Purpose:** Update

**Info/Discussion:** No actions since previous meeting of the MEC

**Action:** None
## MEC PRIORITIES AND MEDICAL EDUCATION STRATEGIC PLANNING

**Purpose:** Update

**Info/Discussion:** The MEC Executive Committee is ranking items on the extensive list we have compiled over the years. That ranking will be used to provide information that may guide the work of the strategic planning process. The Dean endorsed the idea of a strategic planning process and recommended a faculty member in the School of Business as someone who might be considered to coordinate that effort.

**Action:** Rankings to be used inform the strategic planning process. A meeting is scheduled with someone who might consult on the strategic planning process.

## COURSE PEER REVIEW PROCESS

**Purpose:** Update

**Info/Discussion: Plan for Establishing Course Peer Review Process**

*Development and Approval of Course Review Criteria and Template for Reporting*

- A workgroup Chaired by the Course Director member of the Assessment Committee will develop course review criteria and a template for reporting the reviews. Review criteria will reflect the overall goals of Medical Education Committee and LCME requirements. The purpose of the reviews is to ensure quality instruction and to promote continuous improvement of the courses.

- The Chair of the Workgroup will appoint members of the workgroup as needed and complete the task by October 1, 2003.

- The criteria and template will be submitted for review, input, and approval by the Assessment Subcommittee

**Chair of Course Peer Review Workgroup:** TBA (person who replaces the late Mike Casey as basic science course representative on the Assessment Subcommittee)

**Members:** Pre-clinical course directors appointed by and number decided by the Chair of the Workgroup

**Deadline for completion:** October 1, 2003

**Course Peer Review Process**

- The Office of Undergraduate Medical Education will establish the order in which the courses will be reviewed, assign the reviewers, and establish the deadlines for completing each review. Each course director will use the established criteria and template in preparing for his/her course review. Standardized information will be provided by the Office of Academic Information Management and Institutional Research. Each reviewer will conduct the review by a stated deadline and will report his/her findings in a regularly scheduled Course Directors Committee meeting. A written summary report, based on the prescribed format, will be submitted to the Integrated Medical Sciences (IMS) Subcommittee.

- The IMS Subcommittee will provide integrative oversight to the pre-clinical course and clinical peer review processes.
- Each pre-clinical course will be peer reviewed once every 4 years.
- This review process will be initiated by December 1, 2003.

**Action:** A proposed plan was distributed for review and comment

### CLERKSHIP PEER REVIEW PROCESS

**Purpose:** Update

**Info/Discussion:** Plan for Establishing Clerkship Peer Review Process

The process for developing and implementing the Clerkship Peer Review Process will occur concurrently with and will mirror the process for Courses. A similar process will be used to assess Acting Internships, Electives, and Scholars' Week courses.

**Action:** A proposed plan was distributed for review and comment

### PRE-CLINICAL CORE COMPETENCIES PROJECT

**Purpose:** Update

**Info/Discussion:** Plan for Development of a Pre-clinical Competencies Document

- A set of pre-clinical competencies will be developed by a Pre-clinical Competencies Steering Committee (PCSC) comprised of 3 pre-clinical past or current course directors (one of whom will be designated by the MEC to chair the group) and 1 clinician.

- The PCSC is authorized to obtain competency lists from course directors and all other potentially relevant sources, categorize those competencies in a meaningful manner, and eliminate redundancies as is necessary.

- This work should be completed by December 1, 2003 and submitted to the Integrated Medical Sciences Subcommittee for review and suggestions at its December 2003 meeting.

- Following the IMS review, the PCSC will address concerns raised in the IMS review before the final draft is submitted to the IMS Subcommittee for its approval and recommendation for MEC consideration.

- Final recommendations will be submitted to the MEC by February 1, 2004.

**Chairman:** Peter Smith, Ph.D.

**Pre-Clinical Course Direct Committee Members:** At least two pre-clinical course directors, preferably at least one from the Freshman year and one from the Sophomore year, and a clinician (Roger Berkow, M.D.).

**Deadline for Submission to the MEC:** February 1, 2004

### REPORT ON ITEMS RECENTLY APPROVED BY THE MEC

**Purpose:** Update

**Info/Discussion:** Three items recently approved by the MEC and sent to the Dean were asked by the Dean to be presented to the UASOM Executive Committee.
• **USMLE Clinical Skills Exam and the UASOM OSCE.** The proposal approved by the MEC and sent to the Dean was submitted for advice by the UASOM Executive Committee (preclinical and clinical department chairs). The MEC recommendation was greeted favorably.

• **Quartile Grading.** The UASOM Executive Committee had several questions and advised the Dean to table it pending further explanation. We are awaiting formal word from the Dean.

• **Elimination of Course Weighting.** The UASOM Executive Committee had several questions and advised the Dean to table it pending further explanation. We are awaiting formal word from the Dean.

Summary by Bill Weaver, PhD

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**MEDICAL EDUCATION COMMITTEE**  
September 16, 2003, 3:30pm  
3rd Floor Conference Room, New addition to Volker Hall

**PRESENT:**  
In Birmingham: Gary Abrams, Roger Berkow, Dennis Boulware, Ashley Evans, Stuart Frank, Craig Hoesley, James McLester, Kathy Nelson, Banks Petrey, Scott Plutchak, James Schafer, Jim Sheetz, Peter Smith, Bill Weaver, Philip Weems and David Weiss;  
In Huntsville: Ha Ti Nguyen and Tarak Vasavada;  
In Tuscaloosa (Tuscaloosa representative, Dr. Evans, was present in Birmingham.)

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**INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE REPORT**

**Purpose:** Update  
**Info/Discussion:** The Subcommittee reviewed and approved a new course entitled "Genetics in Medicine" to begin this fall in the Freshman year.  
**Action:** The report on the Genetics course was presented for information only.  
**Responsible:** Dr. Frank made the report.

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**REPORT FROM THE CLINICAL EDUCATION TASK FORCE**

**Purpose:** Update  
**Info/Discussion:** In order to accommodate the additional week that has been promised to the Neurology Clerkship, changes in the current Junior year are necessary. Since there are other concerns that need to be considered, it was decided that this is an appropriate time to review the clinical education program as a whole. Two meetings have been held and a third has been scheduled. However, the work is in still in the information gathering and discussion phase.  
**Action:** None  
**Responsible:** Dr. Hoesley

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**PRECLINICAL COMPETENCIES PROJECT**

**Purpose:** Update  
**Info/Discussion:** Learning objectives from the preclinical disciplines have been collected; review
of them and consideration of how they are to be developed into the preclinical core competencies will begin shortly.

**Action:** None  
**Responsible:** Dr. Peter Smith

### COURSE AND CLERKSHIP PEER REVIEW PROJECT

**Purpose:** Update

**Info/Discussion:** For the courses, Drs. Hal Thurstin, Peter Anderson, and Dennis Pillion have compiled a draft of the review procedures and sources of information that should be used by each course director in preparing the self-study. The next step is development of a list of precise questions for use in the process. For the clerkships, Dr. Andree Stoves has drafted the process and guidelines, which have been reviewed by other clerkship directors. Both projects will be completed and submitted to the IMS Subcommittee by October 1.

**Action:** None  
**Responsible:** Dr. Thurstin and Dr. Stoves

### STRATEGIC PLANNING PROJECT

**Purpose:** Update

**Info/Discussion:** The overall plan has been reviewed by a faculty member from the School of Business with experience in strategic planning. The process of obtaining information from a wide variety of groups with an interest in the quality of the product (MD) will be assisted by a faculty member from the School of Health-Related Professions who has extensive expertise in conducting focus groups.

**Action:** None at present  
**Responsible:** Drs. Nathan Smith, Peter Smith, and Dennis Boulware

Summary by Bill Weaver, PhD

### UPDATE IN LIEU OF A MEC MEETING

**DATE:** November 7, 2003

**TO:** Medical Education Committee

**FROM:** Nathan Smith, MD and Peter Smith, PhD, MEC Chair and Vice Chair, respectively and Dennis Boulware, MD, Senior Associate Dean for Education

**SUBJECT:** MEC Meeting Cancellation and Update

This message is being sent to you in lieu of the regular MEC meeting which would have occurred on November 18. Although we do not feel that we have a sufficient reason for a face-to-face meeting, we do want to bring you up to date on issues of interest.

**Genetics in Medicine Course.** This proposed course was submitted to and heartily approved by the IMS Subcommittee on September 8, 2003. At that time, there was some concern about the fullness of the schedule occasioned by that addition. With that issue still under investigation, the proposed course was presented for information only at the MEC meeting on September 16. Once the time commitment issue
was clarified, the proposed course was then submitted to the MEC voting members for electronic vote. It passed overwhelmingly and was sent to the Administration for final approval. The course began last week.

**Clinical Education Task Force.** This task force was charged to review the 3rd and 4th year clinical education program. Three meetings have been held in which the issues have been outlined, some questions that help to determine change parameters have been answered, and the Rural Medicine Clerkship advocates have presented their case. Other clinical disciplines that do not have a required clerkship will be invited to present their case. Then, the task force will review the collected information and make a recommendation to the IMS Subcommittee, with early January 2004 as the target date.

**Strategic Planning Process.** The UASOM undergraduate medical education program strategic planning process is underway. The first step involved identifying the various constituencies that need to provide input and how to elicit valuable information without channeling the input providers' thinking. A School of Health-Related Professions faculty member with expertise in conducting focus groups using a nominal group process has agreed to assist.

**Peer Review Process for Courses and Clerkships.** The course director representative on the Assessment Subcommittee (Dr. Hal Thurstin) was asked to assemble some course directors to develop review criteria and a review process for peer review of courses. He has done that, and a tentative process will be piloted using his own course in January 2004. Based on the pilot study, the process will be further refined by the course directors and submitted for review and comment by the Assessment Subcommittee. Final review and comment will be provided by the IMS Subcommittee and later the MEC.

The Birmingham clerkship director representative on the Assessment Subcommittee (Dr. Andree Stoves) was asked to do the same thing for peer review of tri-campus clerkships. That work has been completed, and it will be submitted for review and comment by the Assessment Subcommittee before being returned for final review by all clerkship directors and then submission to the IMS Subcommittee and later to the MEC.

### MEDICAL EDUCATION COMMITTEE
January 20, 2004, 3:30pm
3rd Floor Case Conference Room, Volker Hall

**PRESENT:** In Birmingham: Dennis Boulware, Siene Chiang, Stuart Frank, Craig Hoesley, Jim Leeper, Alex Leigh, Kathy Nelson, Scott Plutchak, Nathan Smith, Peter Smith, Dmetri Sychev, Julie Walsh, Bill Weaver, Philip Weems, Mike Wyss, and Mr. Plutchak's guest Nancy Alley from University of Michigan School of Public Health; In Huntsville: Lanita Carter, Ha Nguyen, and Tarak Vasavada; In Tuscaloosa: Daniel Avery (Jim Leeper was present in Birmingham)

**GRADING POLICY**

**Purpose:** Announcement

**Info/Discussion:** Dr. Boulware announced that the quartile grading policy which was approved by the MEC last year but tabled by the Medical School Executive Committee, in the light of further explanation, was reconsidered and approved today. It will apply only to students in the 2004-2005 Freshman class.
### INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE REPORT

**Purpose:** Update

**Info/Discussion:** As Chair of the IMS Subcommittee, Dr. Frank appointed a Clinical Education Task Force and asked Dr. Hoesley to chair it. The charge of the Task Force was to find a way to incorporate an additional week for the Neurology Clerkship, which had already been committed to the new Chair of Neurology. In doing that, the Task Force found it necessary to review the years 3 and 4 clinical education program. Changing Rural Medicine at the Birmingham campus only from a 3rd year requirement was favored by a majority of the Task Force members. The time thereby freed up in the 3rd year would provide an opportunity for Selectives in several disciplines to be part of the 3rd year program. The deadline for getting a decision made is very tight if any change is to be implemented in the 2004-05 academic year.

**Action:** None

**Responsible:** Drs. Frank and Hoesley made the report.

### COURSE PEER REVIEW CRITERIA AND PROCESS

**Purpose:** Update

**Info/Discussion:** The criteria and process were developed for the courses and reviewed and approved in December by the MEC Executive Committee (on behalf of the Assessment Subcommittee). A schedule for course reviews has been established, and the first review is currently underway. Dr. Hal Thurstin led the developmental process; the course directors approved the outcome. Each course director will compile information called for in the criteria; a course director who teaches in a different term will conduct the review and submit a report to the Course Directors as a group; any disagreements between the reviewer and the director of the course being reviewed will be addressed in a meeting involving the Senior Associate Dean for Education; the Course Directors group will summarize the findings and submit them to the IMS Subcommittee for discussion and approval.

**Action:** Implementation is underway

**Responsible:** Course Directors group

### CLERKSHIP PEER REVIEW CRITERIA AND PROCESS

**Purpose:** Update

**Info/Discussion:** The criteria and process were developed by a committee (Dr. Andree Stoves, Chair) for the tri-campus clerkships and reviewed in December by the MEC Executive Committee. While the criteria seemed very thorough, concern was expressed about the difficulty in obtaining some of the information. As a result, the tri-campus Clerkship Directors were asked to review the criteria and process again and agree that the information can be obtained and documented without an undue amount of difficulty.

**Action:** Tri-campus clerkship directors to agree on criteria and process and implement.

**Responsible:** Tri-campus Clerkship Directors group

### PRE-CLINICAL COMPETENCIES DOCUMENT

**Purpose:** Update

**Info/Discussion:** A large quantity of potential competencies have been obtained from the various
pre-clinical disciplines. A draft of a design will be developed for review and approval by the Course Directors group and possibly the IMS Subcommittee. Then, the competencies will be sorted into the various categories.

**Action:** Work is to begin immediately.

**Responsible:** Drs. Peter Smith and Bill Weaver

### STRATEGIC PLANNING

**Purpose:** Update

**Info/Discussion:** The process is underway, with a nominal group process to be used and information to be obtained from a range of categories within each of the following overall consumers of the physicians produced in our undergraduate medical education program: patients, residency program directors, and practicing physicians.

**Action:** The work is continuing.

**Responsible:** Dr. Boulware and MEC leadership

### COMMITTEE MEMBERSHIPS AND LEADERSHIP

**Purpose:** Update

**Info/Discussion:** January and July have been determined to be the two times curriculum committee memberships are reviewed and updated. That work is currently underway. In addition, there are leadership vacancies on the Assessment Subcommittee that need to be filled. That, too, is under consideration.

**Action:** Vacancies to be filled immediately.

**Responsible:** MEC Executive Committee

### POTENTIAL MEETING CHANGES

**Purpose:** Update

**Info/Discussion:** In recent months there has been a general lack of vigor among all of the curriculum committees. That is partly due to a dearth of urgent issues to address. However, it may also be partly due to other factors. Work is underway to adjust frequency of meetings (MEC from 6 to 4 per year; Assessment from 12 to 6 per year; and IMS from 12 to 6 per year); location of meetings (perhaps closer to clinical areas in Birmingham and with at least one meeting per year originating from Huntsville and one from Tuscaloosa); establishing and announcing a theme for each meeting; replacing audioconferencing with videoconferencing for most meetings; and giving more attention to electronic communication with members, especially sending materials to branch campuses if those materials are to be distributed in the meeting at the Birmingham campus.

**Action:** Details will be finalized and announced soon.

**Responsible:** MEC leadership and Dr. Boulware

### COURSE AND CLERKSHIP ADMINISTRATIVE WEBSITE

**Purpose:** Update

**Info/Discussion:** The purpose is to develop a one-stop shopping arrangement where information important to course and clerkship directors can be accessed and where policies can be accessed from the official url which will be included in this website.

**Action:** This work is currently underway.

**Responsible:** Course Directors, Tri-campus Clerkship Directors, MEC leadership, Dr. Boulware,
RECENT SUPREME COURT DECISION AND MEDICAL SCHOOL ADMISSIONS

**Purpose:** Update

**Info/Discussion:** The Supreme Court's decision in the University of Michigan Law School case has direct implications for our School of Medicine admissions process. The bottom line is that "protected categories" (including race) can be given credit in the admissions process. However, to do that each applicant with equal numerical qualifications (gpa, MCAT, etc.) must be reviewed.

**Action:** The decision is being followed, but it requires more time, effort, and paperwork.

**Responsible:** Dr. Nathan Smith

Summary by Bill Weaver, PhD

MEDICAL EDUCATION COMMITTEE

March 3, 2004, 5:00pm

3rd Floor Case Conference Room, Volker Hall

**PRESENT:** In Birmingham: Peter Anderson, Roger Berkow, Dennis Boulware, Fred Burg, Cheri Canon, Lanita Carter, Phillip Chang, Jennifer Clem, Bill Curry, Stuart Frank, Brian Geary, English Gonzalez, Mike Harrington, Craig Hoesley, Chris Lorish, Stan Massie, Kethe Nelson, Ha Nguyen, Scott Plutchak, Robert Robichaux, Nathan Smith, Peter Smith, Tamela Turner, Julie Walsh, Bill Weaver, and Philip Weems; **In Huntsville:** May Jennings and Tarak Vasavada; **In Tuscaloosa:** Michael Bindon

CLINICAL EDUCATION TASK FORCE RECOMMENDATIONS

**Purpose:** To consider the recommendations

**Info/Discussion:** The Chair, Dr. Nathan Smith, outlined the purpose of the medical education program and the oversight role of the Medical Education Committee. He reminded the audience that the purpose is to do whatever is best to educate students to become the best physicians they can be. He outlined the reasons for a review of the clinical education program and the charge issued to the Integrated Medical Sciences (IMS) Subcommittee to review the clinical education program. Dr. Hoesley, Chair of the Clinical Education Task Force that had been appointed by the Chair of the IMS Subcommittee (Dr. Frank), outlined the deliberative process by which information was gathered from other medical schools and from local stakeholders. He pointed out that after information had been gathered, 16 different curriculum schematics were reviewed. The outcome that the Task Force is recommending is one that limits the change while it addresses at least the most immediate Birmingham issues: an additional week for the Neurology Clerkship and a presence by some non-clerkship disciplines in the Junior year. The changes apply to the Birmingham campus, only, and they are as follows: (1) increase the Neurology Clerkship to 4 weeks, which will share an 8-week block with Family Medicine; (2) replace the 4-week Rural Medicine clerkship with 3-week block devoted to Selectives (from various non-clerkship disciplines and Rural Medicine), which will share an 8-week block with the 5-week Psychiatry Clerkship; (3) eliminate the Rural Medicine requirement in the Junior year; (4) permit the required 4-week Ambulatory Acting Internship in the Senior year to be completed in a rural or other underserved area. A lengthy discussion ensued, with an amendment being proposed by Dr.
Jennings to require all Birmingham students to complete a minimum of 3 weeks in either the Junior or Senior year in a rural or other underserved area. The amendment was approved by a vote of 9 to 0, and the Task Force recommendations, as amended, were approved by a vote of 9 to 0.

**Action:** The recommendations will be sent to the Dean for his consideration; if they are approved, they will be implemented in July 2004 with the class of 2005.

**Responsible:** Nathan Smith

Summary by Bill Weaver, PhD

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### MEDICAL EDUCATION COMMITTEE

**April 20, 2004, 4:00pm**  
**3rd Floor Case Conference Room, Volker Hall**

**PRESENT:** In Birmingham: Roger Berkow, Dennis Boulware, Steven Carroll, Seine Chiang, Jeff Engler, Ashley Evans, Julie Harper, Craig Hoesley, Chris Lorish, Kathy Nelson, Scott Plutchak, Nathan Smith, Julie Walsh, Bill Weaver, and Philip Weems; In Huntsville: Lanita Carter, May Jennings, Ha Nguyen, and Tarak Vasavada

**MINUTES (March 3, 2004 meeting)**

The minutes have been posted on the web. If no response is received in 5 days, the Minutes will be considered to be approved as is.

### PRE-CLINICAL COMPETENCIES

**Purpose:** Update

**Info/Discussion:** In Dr. Peter Smith's absence, Dr. Weaver reported that the project is underway and that collection of information on each course is being carried out by way of a survey being administered to course directors.

**Action:** The work will continue, and the information from all course directors should be completed within a month.

**Responsible:** Drs. Peter Smith

### STRATEGIC PLANNING

**Purpose:** Update

**Info/Discussion:** Dr. Boulware reported that the work is behind schedule but that the various constituencies of the medical education program are going to be queried. The first such session, involving directors of residency programs that have over the years taken several of our graduates and using a nominal group technique involving both a telephone conference call and sending of responses via the Internet, is scheduled for April 28.

**Action:** Once the information is compiled from the residency directors, the process will continue by querying other constituency groups.

**Responsible:** Dr. Boulware and Dr. Richard Shewchuk of the School of Health Related Professions

### ORGANIZATIONAL ISSUES
### Purpose: To consider how to facilitate success by new committee leadership

**Info/Discussion:** Dr. Smith noted that the current and near-future leadership of the MEC and its subcommittees includes individuals who were not a part of the development of our last strategic plan (Curriculum 2000). As we are moving into a new Strategic Planning process, there is a need for us to work to help develop this new leadership. The discussion included a suggestion that we develop plans for a retreat, possibly in the late summer/early fall.

**Action:** None at present

**Responsible:** Drs. Nathan Smith, Peter Smith, and Dennis Boulware

### RESIDENCY MATCH RESULTS

**Purpose:** Update

**Info/Discussion:** Dr. Nelson reported that the match results turned out well but that 14 students needed assistance on Scramble Day. This number was occasioned by various factors, including unrealistic expectations about one's competitive position, difficulty of husband/wife matching in the same locale, and not listing enough choices of places for doing a transition year prior to entering a residency at the second year level. Only 46% entered primary care (counting Ob/Gyn as primary care), 25% entered Surgery or a Surgical subspecialty, 76% remained in the Southeast, 42% remained in Alabama, and 6 students have deferred their residency for a year, mostly for family issues or to engage in research. The residency match process has been under judicial concern, but a law has been passed to exempt it from antitrust litigation.

**Action:** None

**Responsible:** Dr. Nelson

### CHARGE TO BRANCH CAMPUSES

**Purpose:** Update

**Info/Discussion:** Dr. Boulware reported that the recent curriculum changes at the Birmingham campus prompted an offer to be made to the branch campuses to each review its own program and determine if there are changes that would better enable students to benefit from that campus' mission, expertise, and facilities.

**Action:** Each campus needs to notify Dr. Boulware by April 30 if it intends to develop a proposal for consideration. A draft of the proposal is due by July 30.

**Responsible:** Dr. Tarak Vasavada in Huntsville and Dr. Eugene Marsh in Tuscaloosa (or their successors) will chair the process on their respective campus.

### ASSESSMENT SUBCOMMITTEE REPORT

**Purpose:** Update

**Info/Discussion:** Drs. Steven Carroll and Ashley Evans, the new Chair and Vice Chair, respectively of the Assessment Subcommittee reported that at the last Executive Committee meeting it was agreed that curricular decisions should not be made without consideration of current and historical student performance.

**Action:** Drs. Carroll and Evans will meet soon with Dr. Boulware and Dr. James Jackson to determine what data on student performance are available and from there will identify some areas for the Assessment Subcommittee to investigate.

**Responsible:** Drs. Carroll and Evans
INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE REPORT

Purpose: Update
Info/Discussion: In the absence of the Chairman, Dr. Stuart Frank, Dr. Hoesley reported that the IMS Subcommittee is in the process of defining what is meant by "underserved" and therefore what will be considered acceptable as a means of students meeting the "rural or other underserved" requirement. That discussion was a lively and informative one.
Action: The decision will be finalized at the next meeting of the IMS Subcommittee; so as not to delay the decision, the next meeting has been moved to May 10 from its scheduled meeting date of June 14.
Responsible: Dr. Frank

COURSE DIRECTORS REPORT

Purpose: Update
Info/Discussion: Dr. Boulware reported that (1) the Volker Hall medical student computer facility has been expanded from 48 to 77 computer and upgraded from Windows 98 to Windows XP, (2) compiling of pre-clinical competencies is underway (as reported above), and (3) the revised course peer review process has been inaugurated with the Behavioral Science and Human Sexuality course being the first to be reviewed under the new methodology.
Action: The course directors and Dr. Boulware work together each month to set an agenda that addresses issues of importance to the pre-clinical courses and their students and faculty.
Responsible: Dr. Boulware chairs the group.

CLERKSHIP DIRECTORS REPORT

Purpose: Update
Info/Discussion: Dr. Berkow reported that (1) a new electronic evaluation system is being implemented, one that will provide a myriad of opportunities, including logging patient information, etc., (2) the new Clinical Skills Lab is increasing its capabilities and is looking for additional instructional uses that can be made of the facility in addition to the assessment uses which it is already fulfilling, (3) a course and clerkship director administrative website is being designed and developed as a one-stop shopping center for information of value to course and clerkship directors, and (4) a discussion among the clerkship directors about student absences resulted in a general consensus of no more than two days absence without having to make up the time.
Action: The clerkship directors and Dr. Berkow work together each quarter to set an agenda that addresses issues of importance to the clerkships and their students and faculty.
Responsible: Dr. Berkow chairs the group.

Summary by Bill Weaver, PhD
### ASSESSMENT SUBCOMMITTEE
#### Membership (as of June 30, 2004)

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<th>Category</th>
<th>Name</th>
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<td>Hal Thurstin, PhD</td>
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### ASSESSMENT SUBCOMMITTEE MINUTES

The Assessment Subcommittee had only one meeting scheduled during this reporting period, but it was postponed to a week just beyond this reporting period.
INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE
Membership (as of June 30, 2004)

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INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE
July 14, 2003, 8am, Volker L203

PARTICIPANTS in Birmingham: Dr. Gary Abrams, Dr. Roger Berkow, Ms. Dawn Bryant, Dr. Cheri Canon, Dr. Stephen Carroll, Dr. Stuart Cohen, Dr. Jeff Engler, Dr. Stuart Frank, Mr. Brian Geary, Dr. Craig Hoesley, Dr. Chris Lorish, Dr. Kathy Nelson, Dr. Tony Nicholas, Dr. Dennis Pillion, Mr. Amish Shah, Dr. John Shuster, Dr. Peter Smith, and Dr. Bill Weaver; In Tuscaloosa: Dr. Laura Satcher

SCHOLARS' WEEK UPDATE

Purpose: To address concerns about uneven student time and effort requirements

Info/Discussion: This concern prompted two actions by Dr. Frank. Because of rumors about some Scholars' Week courses being much more lax than others in their time commitment requirements of students, Dr. Frank sent a message on June 10 to all Scholars' Week course directors. In that message, he reminded them of the need to consider the Scholars' Week experience as expecting the same level of student time commitment as would be the case in a week of a regular clerkship. In addition, having learned that the ACLS course required only two full days of activities, Dr. Frank sent a letter on June 12 to the person responsible for the ACLS course and to the Chair of Emergency Medicine, the course's home department. They were told that after the July Scholars' Week session the ACLS course will no longer be included as an option unless they are able to expand the course by linkage with other topics in emergency medicine to make it a full-week experience. No response has been received as yet.

Action: No further action to be taken unless a revised ACLS course proposal is received.
CLINICAL EDUCATION PROGRAM

Purpose: To begin a discussion of the clinical education program in terms accommodating an additional week for the Neurology Clerkship

Info/Discussion: A commitment made by the Dean at the time of the appointment of the new Chair of the Neurology Department requires a reconsideration of the clinical education program. This session begins that effort. In the spring and summer of 2000 in compliance with the recently-approved Curriculum 2000 Task Force report, the MEC Executive Committee began a review and discussion of the clinical education program. By summer of that year with the pre-clinical program occupying much of the time, the clinical program consideration was postponed until later. The recent request by the Dean that the Neurology Clerkship be increased from 3 to 4 weeks requires that a decision be made by this subcommittee: either find a one-year temporary fix while the curriculum strategic planning process is completed or review the issue more broadly and devise a revision that would likely be consistent with the outcomes of the strategic planning process. To begin the review, it was decided to raise issues that have been considered as a part of the mix before to determine what direction seems to be best. Dr. Nicholas pointed out that the national neurology society favors a clerkship of at least 4 weeks and indicated that surveys of students over the last few years indicates that they would like an additional week of neurology experience. Information concerning the length of required clerkships and whether they are offered in the 3rd or 4th year at other U.S. allopathic medical schools is included in the table below. In the discussion that followed, several suggestions were made. Those points and others will be compiled and sent to the members of this subcommittee soon. In addition, Dr. Frank will appoint a task force to review the various issues and develop some possible modifications for submission to this subcommittee before its August 11 meeting.

Action: A task force to review requests and identify possible changes will be appointed and to report back at next IMS meeting.

Summary by Bill Weaver, PhD

INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE
September 8, 2003, 8am, Volker L203

PARTICIPANTS in Birmingham: Dr. Gary Abrams, Dr. Roger Berkow, Dr. Dennis Boulware, Dr. Stephen Carroll, Dr. Stuart Cohen, Ms. Anna Laura Cook, Dr. Stuart Frank, Mr. Brian Geary, Dr. Craig Hoesley, Dr. Bruce Korf, Ms. Theresa Logan, Dr. Chris Lorish, Dr. Kathy Nelson, Dr. Tony Nicholas, Dr. Dennis Pillion, Mr. Scott Plutchak, Mr. Amish Shah, Dr. Jim Sheetz, Dr. Nathan Smith, Dr. Peter Smith, Dr. Julie Walsh, and Dr. Bill Weaver; In Tuscaloosa: Dr. Cathy Gresham; In Huntsville, Dr. Marcia Chesebro was present but unable to connect.

PROPOSED GENETICS IN MEDICINE COURSE

Purpose: To review the course description and the overall plans of the new Chair and course director of the proposed course in Genetics

Info/Discussion: The meeting was called to order by Dr. Frank, Chair, who introduced Dr. Bruce Korf, the Chair of Genetics and Course Director of a course being proposed in Genetics. At Dr. Frank's request, Dr. Weaver explained the process of identifying time in the Fall term of the Freshman year for the proposed course. Dr. Korf distributed a written description of the proposed course and reviewed it for the Subcommittee. The proposed course is a circumscribed experience in the Freshman year, but he pointed out that his overall goal is to integrate Genetics content in appropriate settings in other pre-
clinical courses and in the clinical clerkships, as well. He expressed an interest in teaching the fundamental principles of Genetics but also integrate Genetics into all of medical education. In fact, he expressed an interest in creating a total Genetics instructional program that would become a national model. As he envisions it, the program would be a three-step process: (1) intensive, brief exposure to Genetics, (2) include Genetics embedded in other courses in the first two years, and (3) integrate Genetics into clinical teaching, which is done virtually nowhere. As to teaching methodology, Dr. Korf favors the small-group active learning format, but, because of limited faculty at the present time and a local climate that has not embraced such methodology, the course will be a hybrid of some semi-small group activities and some large-group lectures. The written description is attached below. Following a brief discussion, the course was approved without objection, and Dr. Korf was authorized to proceed with its introduction into the current Fall term Freshman year.

Approval of the new course prompted a discussion about what addition of contact hours would do to the already-crowded schedule of the Fall term. When it was learned that the former Genetics time in the Biochemistry course had been back-filled by additional Biochemistry content, several members were concerned. Questions were raised about whether the MEC and/or its subcommittees or an administrator had the authority to address this and any other curriculum change that appears to be moving in the opposite direction from that sought by the MEC over the last few years. It is not clear who has the authority, and, if there is such authority, where that authority ends. Dr. Nathan Smith suggested that the issue be taken up for discussion at the MEC Executive Committee, which was scheduled to meet later that day.

Action: The course was approved enthusiastically and without objection.

Summary by Bill Weaver, PhD
of the changes that are under consideration. The work of the Task Force was occasioned by a department chair recruitment offer of an additional week for the Neurology Clerkship. The need to make adjustments in the Junior year in order to accommodate this offer, combined with requests over the last few years by several disciplines for an opportunity to be involved in students' Junior year clerkships, prompted appointment of the Task Force to review the entire clinical education program. Obtaining an extra week in the Junior year will require some changes in the current clerkship arrangement. Because the Rural Medicine Clerkship is viewed—in Birmingham, at least—as more of a practice location than as a discipline and because Rural Medicine is not the strength at the Birmingham campus, Birmingham is considering eliminating Rural Medicine as a required clerkship in the Junior year. If done, that would occur only in Birmingham, as Rural Medicine is a strength in Huntsville and particularly in Tuscaloosa. Thus, a key issue has been how to enable each campus to play to its strength while still providing all of the basic training that students need and at the same time determine how the logistics of such an arrangement could be handled.

To determine what disciplines might be interested in a presence as a Selective in the Junior year, 12 disciplines were offered an opportunity to submit a proposed educational activity for the Junior year. Eight disciplines submitted a description of the value of their discipline to medical students at this stage in their undergraduate medical education program. A vote is being taken on those requests. If that vote passes, work will begin on how such Selectives might be incorporated into the Junior year at Birmingham and, at the same time, how Rural Medicine opportunities could be offered as an elective to Birmingham students.

If a long-term solution to the Junior-Senior year program cannot be achieved by the end of February, a quick fix consisting of a one-year reduction of the Psychiatry clerkship will be utilized, with a commitment to replacing that Psychiatry week and more in the following year.

**Action:** The Task Force will be working to try to develop a long-term solution for approval and implementation by the end of February. Failing that, a quick fix for one year will be adopted.

**Responsible:** The Task Force

Summary by Bill Weaver, PhD
# Developing an Operational Definition for "Underserved"

**Purpose:** To identify the criteria which will be used to determine what experiences will meet the requirement that Birmingham students obtain a minimum of 3 weeks of experience in a rural or other underserved setting.

**Info/Discussion:** The following ideas were suggested as possible criteria to be reviewed as part of an educational experience being determined to be acceptable for meeting the requirement of "underserved". Only as a "new" experience above and beyond any that currently exist OR as a specific requirement that can be met through existing required clinical activities (e.g., clerkship in an underserved setting) if those activities meet the other criteria.

- In a facility that is located in an underserved area (regardless of the nature of the patient population) OR in a facility that has a substantial underserved patient population (regardless of whether the facility is located in an underserved area).

- In a UAB facility if that facility meets a predetermined level of underserved patient population OR only outside UAB in facilities that meet a predetermined level of underserved patient population.

- Only in a primary care setting OR in both a primary care setting and a subspecialty setting if it meets the other criteria.

Factors in determining underserved might be Medicaid and uninsured. Perhaps some, but not all UAB clinics that might meet the requirement would actually not meet the spirit of the intent. Primary care clinics, not subspecialty clinics. Perhaps emergency department at Children's could be equivalent as primary care; maybe same for UAB emergency department. Health department might be a possibility. Don't ignore location as a part of the overall decision. Experience at rural settings can be different because of non-availability of some services. Singh: Probably few students will take Rural as a Selective. Most students rotate through Cooper Green in their 3rd year clerkship. Yoon: Work in Huntsville Hospital and rural clinics is very different. Community mental health centers would potentially qualify. Question of whether any local program can adequately meet the requirement. Inpatient or ambulatory? Subspecialty or primary care?

**Action:** To be considered by IMS members and discussed at the next meeting of the IMS, which is being moved from June 14 to May 10. In the meantime, anyone with ideas on the subject may send them to Bill Weaver, who will send them to the entire IMS.

Summary by Bill Weaver, PhD

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### Integrated Medical Sciences Subcommittee

**May 10, 2004, 8am, Volker 301A**

**Participants in Birmingham:** Dr. Gary Abrams, Dr. Roger Berkow, Dr. Dennis Boulware, Dr. Cheri Canon, Dr. Jeff Engler, Dr. Stuart Frank, Dr. Craig Hoesley, Dr. Lou Justement, Dr. Chris Lorish, Dr. Kathe Nelson, Dr. Tony Nicholas, Dr. Nathan Smith, Dr. Tamela Turner, Dr. Julie Walsh, and Dr. Bill Weaver; **In Huntsville:** Dr. Lanita Carter; **In Tuscaloosa:** Dr. Cathy Gresham

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**Developing an Operational Definition of "Underserved"**
Purpose: To make a decision on what should be allowed to meet the requirement for Birmingham students that they complete a minimum of 3 weeks in a rural or other underserved setting.

Info/Discussion: Dr. Frank described the one agenda item for this meeting and reviewed the four sets of either/or choices derived from the discussion at the April meeting and that was sent to the voting members to obtain information as a guide for the deliberations at this meeting. The sets of choices were as follows, with the vote on each choice being in parentheses:

To meet the requirement of an experience in an underserved setting, the experience must be:
Set 1: Only as a "new" experience above and beyond any that currently exist (3) OR as a specific requirement that can be met through existing required clinical activities (e.g., clerkship in an underserved setting) if those activities meet the other criteria (5)

To meet the requirement of an experience in an underserved setting, the experience must be:
Set 2: In a facility that is located in an underserved area, regardless of the nature of the patient population (0) OR in a facility that has a substantial underserved patient population, regardless of whether the facility is located in an underserved area (7)

To meet the requirement of an experience in an underserved setting, the experience must be:
Set 3: In a UAB facility if that facility meets a predetermined level of underserved patient population (6) OR only outside UAB in facilities that meet a predetermined level of underserved patient population (1)

To meet the requirement of an experience in an underserved setting, the experience must be:
Set 4: Only in a primary care setting (3) OR in both a primary care setting and a subspecialty setting if it meets the other criteria (4)

It was clarified that the requirement could be met in either the Junior or Senior year. Dr. Turner described the Rural Medicine Clerkship curriculum and urged that there be more to meeting the requirement than merely completing a period of time in a setting considered to be underserved. Dr. Frank pointed out that the rural medicine experience is not being eliminated but only being reduced from 4 weeks to 3 weeks in the MS3 year and no longer required of all students. Dr. Smith argued that we need to know the goals and objectives of such an experience before we can determine how it can be met. Dr. Berkow noted that the core clinical competencies contain some that such an experience could help students meet, though Dr. Hoesley argued that all such competencies are already being addressed through students' regular experiences. Contrary to the understanding of others, Dr. Smith stated that Dr. May Jennings, the author of the amendment, did not favor the requirement being met as a part of a required clerkship. In short, it is not clear what Dr. Jennings' preference is, but some felt that since Dr. Jennings' wording of the amendment was general and the MEC voted on that wording, it is the responsibility of this subcommittee to develop a more precise wording. Dr. Canon thought it would be useful to know what the MEC understood the amendment to be at the time it was voted on by that body. Dr. Hoesley pointed out that if the requirement cannot be met through a required MS3 clerkship, students have at least two other opportunities to meet the requirement: Rural Medicine Selective and Ambulatory AI. Dr. Turner pointed out that one should not count on many students taking the Rural Medicine Selective, as it would be very difficult to compete with other Selectives and that in so doing the Rural Medicine experience will die. In response to a question of whether the requirement of "rural or other underserved" could be met in the Family Medicine Clerkship when students are in fact assigned to preceptors in the rural community, Dr. Turner indicated that that might be possible but that only 40% or so of the students do their Family Medicine Clerkship in a rural setting.

Dr. Frank made and Dr. Engler seconded a motion to vote on whether the eligibility of a site to meet the underserved requirement should be based on the nature of the patient population, regardless of the nature of the geographic area, or the nature of the geographic area, regardless of the nature of the specific
facility's patient population. By a vote of 5 to 2, it was decided that eligibility should be based on the nature of the patient population instead of the geographical location.

Dr. Frank made and Dr. Abrams seconded a motion to vote on whether the experience could be offered in UAB and outside facilities or only in outside facilities. By a vote of 5 to 0, it was decided that it should be offered in UAB and outside facilities.

Dr. Nicholas made a motion that the experience cannot be met in any required clerkship. The motion died for lack of a second. Dr. Frank concluded that there are some questions that need to be addressed before the subcommittee can make a decision on whether the experience can be provided acceptably in existing required clerkships. Because of the need to get the issue resolved, there will either be another meeting before the next regular meeting (which would be in August) or the issue will be laid out and members will be asked to vote electronically.

Summary by Bill Weaver

INTEGRATED MEDICAL SCIENCES SUBCOMMITTEE  
June 7, 2004, 8am, Volker 301A

PARTICIPANTS in Birmingham: Dr. Gary Abrams, Dr. Roger Berkow, Dr. Dennis Boulware, Dr. Steven Carroll, Ms. Elaine Cox, Dr. Stuart Frank, Dr. Michael Harrington, Dr. Lou Justement, Dr. Chris Lorish, Dr. Kathe Nelson, Dr. Tony Nicholas, Mr. Scott Plutchak, Dr. Tamela Turner, Dr. Julie Walsh, and Dr. Bill Weaver

DEVELOPING AN OPERATIONAL DEFINITION OF "UNDERSERVED"

Purpose: To make a decision on what should be allowed to meet the requirement for Birmingham students that they complete a minimum of 3 weeks in a rural or other underserved setting.

Info/Discussion: The Chair, Dr. Frank, outlined the work of the IMS Subcommittee on fleshing out the approved requirement that Birmingham students have a minimum of three weeks in a rural or other underserved setting. He pointed out that it had been determined at the last IMS Subcommittee meeting that the requirement could be met (1) in either the Junior or the Senior year, (2) that the key factor is the nature of the patient population rather than the nature of the geographical area in which the activity was offered, and (3) that it could be offered in a UAB facility if it met the criteria regarding the appropriate percentage of underserved patients.

The purpose of this meeting is to determine:
(1) whether the requirement can be met in within an existing required 3rd year clerkship if the patient population meets the "rural or other underserved" criteria, and, if so,

(1a) what the minimum percentage of rural or other underserved in the patient population for a setting to meet the requirement, and

(1b) what criteria should be used to determine "underserved".

As regards #1, Dr. Berkow said that Pediatrics would not meet the requirement, as that clerkship was not designed to meet that requirement, to which Dr. Nelson added that case managers and social workers handle many of the social issues. Dr. Nicholas agreed that the same was true in Neurology.
Boulware pointed out that having case managers and social workers to address issues of underserved patients is an example of the system working well and one that students can learn from by seeing it in operation. Dr. Abrams questioned whether learning about underserved issues can be achieved in a clerkship focused on other issues. Dr. Harrington pointed out that the Rural Medicine clerkship teaches more than the discipline, as it reviews overall social issues of importance in the community. Dr. Frank pointed out that in taking a history, students and physicians encounter social issues when dealing with underserved patients. Dr. Harrington noted that many services are not available in rural settings but are available in urban settings. Dr. Boulware pointed out that these services Dr. Harrington has mentioned are not available for patients at Cooper Green Hospital.

Dr. Harrington argued that we need a curriculum that is focused on underserved issues instead of the underserved issues being an aside to the main issue of learning a clinical discipline. Dr. Berkow asserted that while not all disciplines might be appropriate for meeting the underserved learning requirement, Cooper Green Hospital's patient population would seem to be appropriate for meeting the criteria of underserved. Dr. Berkow suggested polling clerkship directors regarding the percentage of underserved patients in their respective clerkship. Dr. Nelson suggested delaying approval of any current clerkship as meeting this requirement for one year in order for the questions to be clarified. Dr. Nicholas questioned whether there might be external funding to support development of an underserved curriculum, and Dr. Harrington suggested that an RFP could be made available to clerkship directors to develop an underserved experience.

It was pointed out that while the current discussion concerns what happens in the 3rd year required clerkships, there is another opportunity for meeting the requirement in the 3rd year (Rural Medicine Selective) and one or more in the 4th year (Ambulatory AI or Elective if done in a rural or other underserved setting).

Although the original amendment that called for a rural or other underserved experience only called for a minimum of 3 weeks in a rural or other underserved setting, some believe that a specific underserved curriculum—similar to that already used in the rural medicine clerkship—should be developed. Others believe that it is not necessary or appropriate to go beyond the level of exposing students to issues of underserved patients as those students go about their clinical activities.

**Action:** A motion was made by Dr. Abrams and seconded by Dr. Justement that a required clerkship be considered eligible to meet the requirement if it meets the necessary criteria regarding the percentage of underserved patients. Motion carried by a vote of 6 to 2. As a follow-up, by a vote of 5 to 0 it was determined that Cooper Green Hospital met the percentage requirement and that any clerkship that has at least 3 weeks of experience at Cooper Green will be eligible for its students assigned there to have met the requirement.

The issue will be addressed further at the next IMS Subcommittee, under the leadership of the new chair, Dr. Justement. The issues voted on at this meeting will be submitted as part of the overall package for MEC consideration at its next meeting.

**Responsible:** Dr. Justement

Summary by Bill Weaver
Clinical Education Ad Hoc Task Force

Membership
- Craig Hoesley, MD, Medicine, Birmingham (Chair)
- Cheri Canon, MD, Radiology, Birmingham
- Roger Berkow, MD, Pediatrics, Birmingham
- Stuart Frank, MD, Medicine, Birmingham
- Brian Geary, MS4, Birmingham
- Alice Goepfert, MD, Ob/Gyn, Birmingham
- Eugene Marsh, MD, Neurology, Tuscaloosa
- John Shuster, MD, Psychiatry, Birmingham
- Tarak Vasavada, MD, Psychiatry, Huntsville

Minutes (August 6, 2003 - February 4, 2004)

CLINICAL EDUCATION TASK FORCE MEETING
August 6, 2003

PARTICIPANTS: In Birmingham: Craig Hoesley, MD, Stuart Frank, MD, Alice Goepfert, MD, Cheri Canon, MD, John Shuster, MD, Eugene Marsh, MD, Roger Berkow, MD, Brian Geary (MS4), and Bill Weaver, PhD; In Huntsville; Tarak Vasavada, MD

Dr. Hoesley explained that the reason for reviewing the clinical education program is in the short-run to identify how to increase the Neurology Clerkship from 3 to 4 weeks. And some time was spent at the beginning of the meeting in reviewing the current requirements for the MS3 and MS4 curriculum at the UASOM. In addition, as was begun once before, it has been decided that a more comprehensive review of the clinical education program should be conducted. The short-run work must be completed in time for the registration process to be carried out in January. The more comprehensive review will not have that deadline, though it might be completed by that time. He reviewed the formal charge which Dr. Nathan Smith, MEC Chair, had sent.

Charge to the Task Force for the Clinical Curriculum

This task force will review the clinical curriculum for students at the University of Alabama School of Medicine. The review will consider the strengths, weaknesses, opportunities, and potential threats to the current curriculum.

Other specific questions to address include:
(1) Given the current state of medical clinical education, what would be the optimal length for each clerkship and Acting Internship? Are there current clerkships or acting internships that should be added or deleted?
(2) What is the best way to expand the clinical rotation in Neurology to four weeks?
(3) Is it possible to offer opportunities for limited elective activities prior to completing the 3rd year? If so, what would be the best way to achieve this?
(4) The School of Medicine requires 16 weeks of electives to meet the graduation requirement. Should these required graduation electives be restricted to the senior
level electives, or can that graduation requirement be met with electives taken prior to completing the required junior clerkships?

The task force should seek input from key stakeholders including representative clerkship directors and departments that do not currently have required clerkships.

Chair: Craig Hoesley, M.D.
Task force members: To be selected by Stuart Frank, M.D. and Craig Hoesley, M.D.
Report Due: October 15, 2003

There are a variety of issues that will need to be considered as a part of the mix. For example, here are a few:

**Can the curriculum be done differently at the three campuses?**
The LCME always asks questions about the comparability of educational experiences at the 3 campuses, and probably always will. The LCME has never said the programs have to be identical—indeed, the programs are not identical now. However, the LCME implications need to be kept in mind in making a decision (Weaver). Psychiatry/Neurology integrated experience works well in Tuscaloosa, with overlaps being handled well (Marsh).

**Can the third year be extended to include an additional clerkship block?**
This is dependent on how late students can take the Step 2 exam and, but perhaps less importantly, how early they need to get their residency application in.

With regard to taking Step 2, the UASOM policy as provided by Dr. Boulware is as follows: (1) Effective for the graduation class of 2005 and subsequent classes, an attempt to pass the USMLE Step 2 and the CSE must be no less than three months before the anticipated diploma date. Failure to meet this deadline will subject the M.D. candidate to a possible delay in their diploma date. Failure to record a passing score on the USMLE Step 2 by this deadline will be grounds for academic dismissal from the School of Medicine. (3) Effective for the graduation class of 2005 through 2007, graduates will be required to take, but not pass, the USMLE CSE. This policy will be revised or renewed in 2007 for subsequent graduates.

With regard to when students' residency applications need to be in, consistent with Dr. Canon's understanding, ERAS sends out revised information daily to the programs and the sending of information is dependent on the applicant. So the quicker the applicant gets the application completed and authorizes sending it, then the quicker the program can schedule an interview. See [http://www.aamc.org/students/eras/steps/start.htm](http://www.aamc.org/students/eras/steps/start.htm) for details.

**Should any of the current clerkships be increased in length?**
Adding a week for Neurology is appropriate because the USMLE's Clinical Skills Exam will cover students' ability to assess neurologic function, thus our students must be ready for that. (Geary)

**Can any of our current clerkships be reduced in length?**
Please don't plan to reduce Psychiatry (Vasavada). Pediatrics could be reduced if necessary (Berkow). Reducing the Ob/Gyn clerkship is not appropriate. This most often the only clinical exposure our students get to women's reproductive and general health issues. Although most of our students do not choose Ob/Gyn as a career, half of their patients will be female, and they should have adequate exposure to women's health issues during medical school (Goepfert).
Can any of our current third-year clerkships be abolished or merged or moved to the fourth year?
We should at least be aware of how our curriculum matches up with those at other institutions and in what respects ours is different. One example is the fact that we are almost totally unique in having a clerkship designated as Rural Medicine (Frank). What evidence do we have about the success of the Rural Medicine Clerkship in attracting physicians to rural communities (Goepfert)? Note: This is being investigated in Birmingham and from information from Dr. Wheat in Tuscaloosa (Weaver). Maybe we should survey students re their perception of the value of the Rural Medicine Clerkship experience (Geary). Student input is fine but not always fully informed about the long-term value of an experience---must continue to be somewhat paternalistic on such issues (Canon). Is the Rural Medicine Clerkship evaluated in the same way as other clerkships (Hoesley)? Note: Yes it is, and we have data for the last few years (Weaver). Not sure what the data are about rural medicine practice location but will ask John Wheat, who is most likely to have such data (Marsh). The combined curriculum (3rd and 4th year) should be considered when we look at possible changes----some clerkship experiences are augmented by required fourth year AIs. If we must reduce time spent in the third year in a certain area then we should consider requiring exposure in the fourth year in an elective (Goepfert).

Can some required clerkships be completed in the fourth year?
This is done at some schools. Students would have to take responsibility for making sure their field of knowledge covered all areas that might be on the Step 2 exam if they take that exam before completing all of their required clerkships (Berkow).

Can time be made available in the third year for an elective (especially in disciplines that will enable students to make better informed career choices)?
Some disciplines need a presence with students in the third year, even though for some at least it is not necessary to "teach" students that discipline (Canon).

Can time be made available in the third year for a research experience?

Can Senior AIs be adjusted to address third-year needs?
Maybe the Ambulatory AI could be required to be taken in a rural setting.

In addition, there was a brief discussion of some time allocation suggestions made by Brian Geary. Summary by Bill Weaver, PhD

CLINICAL EDUCATION TASK FORCE MEETING
September 3, 2003

PARTICIPANTS: In Birmingham: Craig Hoesley, MD, Stuart Frank, MD, Alice Goepfert, MD, Cheri Canon, MD, John Shuster, MD, Roger Berkow, MD, Brian Geary (MS4), and Bill Weaver, PhD; In Huntsville; Tarak Vasavada, MD; In Tuscaloosa: Eugene Marsh, MD

Weaver briefly summarized the answers provided by the Task Force members and tri-campus clerkship directors to the series of questions and apologized for not having the collected responses ready for distribution before the meeting. In general, the respondents seemed to think that:

- Using 8-week blocks (with some comprised of 2-week units) is advisable.
- The 3rd and 4th years could be thought of as one block for educational purposes.
• The 3rd year might be lengthened and the 4th year shortened in order to accommodate educational needs, though completing a clerkship in the extension period of the 3rd year might pose a problem for students hoping to match in highly competitive residency disciplines.

• Because expertise differs from campus to campus, the educational offerings should take advantage of that expertise while assuring coverage of the basics at all campuses. For example, a clerkship that is required in the 3rd year on one campus might be a 4th year requirement (or an elective) at another campus. For example, in Birmingham the Rural Medicine Clerkship might be changed to Urban Underserved Clerkship or left as Rural Medicine and shifted to the 4th year as a requirement (maybe even Ambulatory AI) or an elective.

• Some current 3rd year clerkships could be allowed to be completed in the 4th year.

• Some clerkships may need to be lengthened; Neurology and Psychiatry were mentioned as each benefiting from one additional week.

• Some clerkships might be shortened, but only Pediatrics volunteered to consider it.

• As to clerkships that might be abolished, Rural Medicine was mentioned most often, especially at some campuses and if there is not compelling evidence to do otherwise. The data that James Jackson was able to provide on the relationship between the Rural Medicine Clerkship and selecting a practice in a rural community was sketchy and seemed to indicate that some of those who had not reported their practice location may actually still be in subspecialty training and thus less likely to settle in a rural community. Apparently, several students have direct loans from rural communities, and their establishing a medical practice in those communities may be a part of the pay-back on those loans. Weaver and Jackson are obtaining more information. Drs. Leeper and Higginbotham in Tuscaloosa are also developing a report. The next meeting of the Task Force will not be scheduled until those reports are ready. A department's attitude toward giving up or shortening the Rural Medicine Clerkship may be heavily influenced by the potential loss of money from the School for administering the clerkship.

• Some medical disciplines would welcome a presence in the clerkship list, even if only 2 weeks, with most preferring to be in the 3rd year.

• Elective opportunities should be provided to students, again preferably in the 3rd year, if they are to be instructive in career choice decisions.

The meeting was adjourned. Summary by Bill Weaver, PhD

CLINICAL EDUCATION TASK FORCE MEETING
September 24, 2003

PRESENT in Birmingham: Drs. Craig Hoesley, Roger Berkow, Stuart Frank, Eugene Marsh, Jim Leeper, Mike Harrington, Bill Curry, Dennis Boulware, James Jackson, and Bill Weaver;
PARTICIPATING BY TELEPHONE IN HUNTSVILLE: Drs. Tarak Vasavada and Alan Maxwell

Dr. Hoesley called the meeting to order and explained that this meeting would be mostly a fact-finding session related to the Rural Medicine Clerkship, as that clerkship has been mentioned as at least one of the clerkships that might be involved as a part of the search for an additional week for the Neurology
Clerkship. He announced that Drs. Leeper, Harrington, and Curry in Birmingham and Dr. Maxwell in Huntsville were present to discuss the Rural Medicine Clerkship. Letters from the following individuals and entities opposing change to the Rural Medicine Clerkship were distributed:

- Bill Curry, MD (Dean of College of Community Health Sciences and Associate Dean for Tuscaloosa and Rural Programs)
- John Wheat, MD, MPH (Professor and Director of Rural Medical Scholars Program)
- Miranda Andrus, PharmD (Assistant Clinical Professor of Pharmacy Practice, Auburn University)
- Sam Wiggins (County Extension Coordinator, Pickens County)
- Beverly Flowers Jordan, MD, ATC (Resident, Tuscaloosa Family Practice Program)
- Michael McBrearty, MD (Chairman of the Alabama Family Practice Rural Health Board)
- Tom Kincer, MD (Associate Director, Montgomery Family Medicine Residency Program)
- Garry Magouirk, MD (Vice President, Rural Alabama Health Alliance)
- Claude Ouimet, MD, Melissa Behringer, MD, and Jimmie Denise Clark, MD (Chairman, President, and President-elect of the Alabama Academy of Family Physicians)
- Dale Quinney (Program Manager, Alabama Rural Health Association)
- Clyde Bargainier, DrPH (Director, Office of Primary Care and Rural Health Development, Alabama Department of Public Health)

The discussion that followed has been organized under the following categories:

**School of Medicine Mission.** Dr. Boulware explained that the LCME has always been a major factor in deciding what can and cannot be done in the curriculum and added that capitalizing on each campus' strengths, even if that means different campuses operate differently, can easily be justified to the LCME. Since Tuscaloosa has strength in rural medicine, that campus should not only continue its rural medicine activities but also should look for ways of expanding them. The Birmingham campus, on the other hand, has a very different area of expertise and with heavy NIH funding and a large research and subspecialty enterprise should be given an opportunity to apply that expertise in its medical education program. For example, at present there is no opportunity for students to learn about Radiology, Pathology, Anesthesiology, Ophthalmology, Emergency Medicine, Physical Medicine and Rehabilitation, etc. in the third year. Thus, the UASOM has several goals, with providing educational experiences that may help to meet Alabama's rural health care needs being but one of them.

**Rural Medicine Clerkship and Its Effect on the Rural Physician Workforce.** Dr. Leeper presented a report that included a history of the Rural Medicine Clerkship and an explanation of how that clerkship is organized and operated in Tuscaloosa. With regard to the latter, he indicated that even though the Rural Medicine Clerkship is currently Pass/Fail, the Tuscaloosa campus would like to move to a letter grade and is set up to do that. In addition, he presented data by campus on the percentage of UASOM graduates who have entered practice in Alabama rural communities, though for some years admittedly the number of responses from which percentages were calculated was very small. Dr. Harrington also distributed a
description of some projects completed by the Birmingham students in their Rural Medicine Clerkship. Although all agreed that the data are soft and subject to wide interpretation, it appears that the UASOM for most years has been at the national average in the production of physicians who ultimately establish practices in rural communities. Drs. Harrington and Curry pointed out that meeting the deficit in rural physicians---taking attrition into consideration---would require a higher production of rural physicians in the future from both medical schools in Alabama.

**Why a Proposed Change is Being Considered.** Dr. Hoesley explained finding time for the promised additional week for the Neurology Clerkship was viewed as an opportunity to at least consider other long-standing requests concerning the clinical education program. Dr. Harrington asked what is to be expected as a result of a lengthened Neurology Clerkship in the third year and stated that Dr. Watts, the new Chair of the Neurology Department, had indicated that he was flexible about the Neurology Clerkship being in either the third or fourth year. As a result, Dr. Harrington suggested leaving Rural Medicine where it is and moving Neurology to the fourth year. Dr. Vasavada agreed that this might be workable but only on a short-term basis if a longer period of time was needed to work out a long-term solution. Various suggestions were made as to how to free up an extra week for the Neurology Clerkship. Although using the time allotted to Scholars' Week was suggested, that would provide only two weeks a year. Thus, it would not provide extra time to all clerkship blocks. Suggestions of simply removing a week from some other clerkship to give to Neurology would result in a fragmented Neurology experience and in some students taking the separated "extra" week in Neurology before having had the current 3 weeks of Neurology. Another suggestion was to have Psychiatry and Neurology share an 8-week block (4 and 4) and for 1 week of the Psychiatry Clerkship to be moved to the 4th year and have a week added to make a 2-week Psychiatry experience in the fourth year. It was pointed out that to do this it would be necessary to cover in the 3rd year portion the Psychiatry content that will be assessed on the Step 2 exam. It was also pointed out that no Rural Medicine content is covered on the Step 2 exam.

**Goal(s) of the Rural Medicine Clerkship.** Drs. Leeper, Curry, and Harrington pointed out that one goal of the Rural Medicine Clerkship is to increase the number of graduates who enter rural practice in Alabama, but another goal is to help the vast majority of graduates who are not going to enter rural practice to obtain a better understanding of and appreciation for the rural health care environment from which they may later receive and send back patients. In response, it was pointed out that since rural medicine is not an academic discipline, both of these goals could be achieved in the fourth year as well as in the third year.

**Information About the State's Health Care Needs.** Although it is generally known that Alabama has unmet physician needs, it is difficult to quantify the extent of the need. For example, Dr. Harrington said that he found 15 different ways to measure manpower shortage, and others have been frustrated by multiple ways of defining "rural".

**How to Increase the Number of Physicians Who Practice in Rural Settings.** The literature seems to indicate that physicians' decision to practice in a rural community is a result of several factors, with no single factor being strongly influential. The decision involves a balancing of the positive and negative factors: (1) personal (physician and/or spouse from rural area, service commitment to pay off a loan, instant patient population, instant recognition in the community, availability of other medical professionals and high-tech services, quality of the local public and private educational systems, cultural opportunities, reimbursement issues, etc.), (2) community (cost to establish and staff a practice, amount of living space and working space, etc.), and (3) encouragement (identification and nurturing in rural medicine prior to college, in pre-med, undergraduate medical education, and graduate medical education, etc.). Acknowledging that several factors enter in the practice location decisions, Drs. Curry, Harrington, and Leeper contend that the Rural Medicine Clerkship can be most effective only if it remains in the third year and is required for all students at all three campuses. The Task Force members in attendance felt that
the most reliable indicator that a student would ultimately practice in a rural setting is a student being raised in a rural environment. Thus, the clinical curriculum may be less influential in increasing the number of rural physicians than the medical school admissions process of identifying and providing early enhancements (e.g., money) to students from a rural background.

Dr. Hoesley thanked the guests for their input, indicated that the information presented in writing and shared orally at this meeting would be shared with the Task Force members who were not present as a part of the future deliberations.

The meeting was adjourned. Summary by Bill Weaver, PhD
LETTER EXTENDING OFFER FOR SELECTIVES TO BE DEVELOPED

DATE: October 31, 2003

TO: Chair, Department of _________________________

FROM: Craig Hoesley, MD, Chair, Clinical Education Task Force

RE: Interest in a Junior-Year Clinical Clerkship

The Medical Education Committee has charged this Clinical Education Task Force to review the clinical education program (Junior and Senior years) to identify improvements that might be made. One possibility is to see if disciplines that currently do not have a clinical clerkship in the Junior year would be interested in developing one. The preliminary thought is that these clerkships would be called "Selectives" and would be either 4 weeks or 2 weeks in length. All students would be required to complete a certain number of Selectives (probably one 4-week Selective or two 2-week Selectives) during their Junior year. Obviously, only a portion of the class would be able to take a Selective in any department.

To assist you in making a decision about your department's interest in participating, I have provided information about what would be expected.

(1) Each proposed Selective would be reviewed by the UASOM curriculum committee structure, with each successful proposal requiring that each Selective to have a: (a) faculty member designated as Selective Director; (b) set of goals and objectives for the Selective; (c) firm outline of academic work to be accomplished by the student; (d) meaningful means of assessing student performance that enables providing a letter grade to the student; (e) method of student assessment of the Selective (just as is done by current clerkships); and (f) method of student assessment of faculty performance (just as is done by current clerkships).

(2) Each Selective must be available throughout the academic year. However, it might be possible for two or more Selectives to combine efforts to meet this requirement.

If your department is interested in being considered for a Selectives in the Junior year, please click REPLY and explain briefly

(a) students' need for your discipline at this point in their education,

(b) that you would be able to meet all of the requirements listed above,

(c) the maximum number of students you could accommodate in each clerkship block (2-week or 4-week), and

(d) whether you would be interested in being considered if only 2-week blocks are available.

PLEASE SEND YOUR REPLY BY NOVEMBER 18, 2003.

Thanks. The Task Force looks forward to hearing from you.
CLINICAL EDUCATION TASK FORCE MEETING
December 11, 2003, 5pm

PRESENT in Birmingham: Craig Hoesley, Cheri Canon, John Shuster, Nathan Smith, Stuart Frank, Eugene Marsh, Kathy Nelson, Alice Goepfert, Roger Berkow, and Bill Weaver; BY TELEPHONE in Huntsville: Tarak Vasavada

Dr. Hoesley summarized the work that has been done to date. This summary includes bulleted points listed under some organizing issues/questions. While this does not capture the discussion, maybe it will be useful in identifying the next step.

Value of the Rural Medicine Clerkship

The value of the Rural Medicine experience is more than potentially leading to selecting a rural location for career practice. It is an important way of finding out what it is like in the rural community. Many students who enter specialties may receive referrals from rural communities and return patients to rural communities. It is a valuable way for them to learn the kinds of settings from which they may receive or send patients. The Rural Medicine contingent who came to the last Task Force meeting seemed to be intransigent on the issue of eliminating Rural Medicine as a requirement, even if only in Birmingham. And the thrust of their argument was the desire to increase the number of graduates who ultimately practice in rural areas of Alabama.

Comparability of Educational Experiences Across Campuses

UASOM reports to the LCME have always indicated our attempt to achieve comparability of educational experience across campuses while capitalizing on the unique expertise that is available at each campus. Thus, probably the educational program can differ from campus to campus, but it is not clear how much variation would be acceptable to the LCME, and the students. For example, the Psychiatry/Neurology arrangement is done differently in Tuscaloosa than at either of the other campuses. They have never questioned that. Since Rural Medicine is not a discipline, it might possibly be required at some campuses and not at others without any major concern from the LCME. However, the LCME might view differently a discipline clerkship being made an elective at one campus or made a different length from campus to campus. In addition to the opinions of the LCME, student attitudes would also be important. For example, do they perceive themselves as being shortchanged by being forced to a campus that they perceive as offering them fewer options and, even worse for students already admitted, doing all of this AFTER they were admitted and made their clinical campus selection. Even explaining the differences at the time of admission may make it more difficult for some campuses to attract the required number of students. Also, if the Birmingham department chair is in fact responsible for that department's activities at the branch campus, it would be necessary to obtain the agreement of the Birmingham department chair for any variation that occurred at any campus.

Long-term Solution or Quick Fix or One-year Delay?

Long-term solution: Any solution, long-term or quick fix, will need to be completed, submitted to the IMS Subcommittee, MEC, and Dean and ready for listing in the scheduling system by the end of February 2004 if it is to be implemented for the 2004-2005 academic year. The number of complicated issues that would need to be implemented makes it appear that arriving at a long-term review and solution would not be possible in that short span of time. So, a one-year quick fix or a one-year delay seem to be the only alternatives.
Quick fix: This approach would involve adjustments for one year with the understanding that by the next year the long-term solution would be readied for implementation. Maybe a quick fix can serve as a transition from the current curriculum to the newer one.

The imperative is to provide an extra week for the Neurology Clerkship. Doing that will require some adjustments in the overall curriculum schedule. We need to consider both the Junior and Senior years.

Some possibilities re the Neurology Clerkship (especially in Birmingham) are as follows: (1) add a 4th week and leave the clerkship like it is, either matched up with Psychiatry reduced to 4 weeks or perhaps with Family Medicine of 4 weeks, (2) offer the entire Neurology clerkship in the Senior year, (3) offer 3 weeks as is and the 4th week in the Senior year, and (4) give students an option of taking the entire clerkship in the Junior or Senior year. Note: Because Neurology content is on the Step 2a and 2b exams, moving the clerkship to the Senior year would require students to be responsible for their own Neurology preparation for those exams. (See Junior and Senior years schematics below.)

Some possibilities re the Rural Medicine Clerkship (especially in Birmingham) are as follows: (1) move the clerkship to the Senior year and leave it as a requirement, perhaps serving as the required Ambulatory Clerkship, which might be renamed Primary Care, (2) leave the clerkship in the Junior year but make it a selective, (3) whether the clerkship remains in the Junior year or moves to the Senior year, expand it to include underserved urban, and (4) make it one of the 4-week Selectives that are available to students in the 3rd year. Note: If Selectives are provided in the Junior year, faculty advisors should be available to assist students in choosing selectives wisely. (See Junior and Senior years schematics below.)

One-Year Delay: A possible option would be to request a one-year delay on implementation of the extra week in the Neurology Clerkship by explaining to the Dean and Neurology Chair that the process is much more complicated than originally thought (LCME issues, tri-campus issues, etc.) and that a quick fix would be disruptive and for only one year. Assurance would be given that the full review and long-term solution would be implemented for 2005-2006.

Next step: Review several possible schematics, with primary attention to a quick fix.

Summary by Bill Weaver, PhD

CLINICAL EDUCATION TASK FORCE MEETING
February 4, 2004

PARTICIPANTS in Birmingham: Members: Shuster, Hoesley, Geary, Canon, Berkow, and Eugene Marsh; Visitors: Peter Smith, Nathan Smith, Bill Weaver; BY TELEPHONE in Huntsville: Tarak Vasavada

Dr. Hoesley pointed out that in a conversation with Dr. Cleveland Kinney, Interim Chair of Psychiatry, Option 1 (one that would involve Psychiatry reducing to 4 weeks in the Junior year and receiving in return 2 weeks in the Senior year) was not doable from an administrative standpoint.

As a part of the deliberations, the following issues were reviewed:

Can the curriculum be done differently at the three campuses?
The LCME always asks questions about the comparability of educational experiences at the 3 campuses, and probably always will. The LCME has never said the programs have to be identical---indeed, the programs are not identical now. However, the LCME implications need to be kept in mind in making a
decision (Weaver). Psychiatry/Neurology integrated experience works well in Tuscaloosa, with overlaps being handled well (Marsh).

**Can the third year be extended to include an additional clerkship block?**

This is dependent on how late students can take the Step 2 exam and, but perhaps less importantly, how early they need to get their residency application in.

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With regard to when students' residency applications need to be in, consistent with Dr. Canon's understanding, ERAS sends out revised information daily to the programs and the sending of information is dependent on the applicant. So the quicker the applicant gets the application completed and authorizes sending it, then the quicker the program can schedule an interview. See http://www.aamc.org/students/eras/steps/start.htm for details.

**Should any of the current clerkships be increased in length?**

Adding a week for Neurology is appropriate because the USMLE's Clinical Skills Exam will cover students' ability to assess neurologic function, thus our students must be ready for that. (Geary)

**Can any of our current clerkships be reduced in length?**

Please don't plan to reduce Psychiatry (Vasavada). Pediatrics could be reduced if necessary (Berkow). Reducing the Ob/Gyn clerkship is not appropriate. This most often the only clinical exposure our students get to women's reproductive and general health issues. Although most of our students do not choose Ob/Gyn as a career, half of their patients will be female, and they should have adequate exposure to women's health issues during medical school (Goepfert).

**Can any of our current clerkships be abolished or merged or moved to the fourth year?**

We should at least be aware of how our curriculum matches up with those at other institutions and in what respects ours is different. One example is the fact that we are almost totally unique in having a clerkship designated as Rural Medicine (Frank). What evidence do we have about the success of the Rural Medicine Clerkship in attracting physicians to rural communities (Goepfert)? Note: This is being investigated in Birmingham and from information from Dr. Wheat in Tuscaloosa (Weaver). Maybe we should survey students re their perception of the value of the Rural Medicine Clerkship experience (Geary). Student input is fine but not always fully informed about the long-term value of an experience---must continue to be somewhat paternalistic on such issues (Canon). Is the Rural Medicine Clerkship evaluated in the same way as other clerkships (Hoesley)? Note: Yes it is, and we have data for the last few years (Weaver). Not sure what the data are about rural medicine practice location but will ask John Wheat, who is most likely to have such data (Marsh). The combined curriculum (3rd and 4th year) should be considered when we look at possible changes----some clerkship experiences are augmented by required fourth year AIs. If we must reduce time spent in the third year in a certain area then we should consider requiring exposure in the fourth year in an elective (Goepfert).

**Can some required clerkships be completed in the fourth year?**
This is done at some schools. Students would have to take responsibility for making sure their field of knowledge covered all areas that might be on the Step 2 exam if they take that exam before completing all of their required clerkships (Berkow).

*Can time be made available in the third year for an elective (especially in disciplines that will enable students to make better informed career choices)?*

Some disciplines need a presence with students in the third year, even though for some at least it is not necessary to "teach" students that discipline (Canon).

*Can time be made available in the third year for a research experience?*

*Can Senior AIs be adjusted to address third-year needs?*

Maybe the Ambulatory AI could be required to be taken in a rural setting.

In addition, there was a brief discussion of some time allocation suggestions made by Brian Geary.

In response to the question of whether Psychiatry could benefit more by sharing an 8-week block with Neurology rather than Selectives, Dr. Nathan Smith said that presently there is so little overlap that it would make no difference which discipline Psychiatry shares a block with.

Shuster: Option 3 (quick fix) is a punt and should be considered only if all else fails.

Problem of Family Medicine shelf exam is that students who take the Family Medicine clerkship first have a difficult time, as it contains much information that would be learned on other clerkships. Similarly, taking a Selective in the first block is a problem because the student will have a lack of clinical knowledge in general at that point.

Marsh: Option 2 would seem best from the Tuscaloosa campus standpoint re comparability. Tuscaloosa will consider developing some Selectives, as having them available will be important in student campus selection recruitment. Also, at the branch campuses some Selectives discipline content could be incorporated into existing clerkships.

The Birmingham experience could be a good pilot for use by other campuses in selecting Selectives, etc.

Berkow: In Option 2, we could change Ambulatory AI to Primary Care AI, which could be like a Senior Rural Medicine AI. Emergency Medicine might also be included in this AI.

It was agreed that Option 2 should be proposed as a recommendation to the IMS Subcommittee which should be encouraged to take it up via electronic vote. This suggestion was approved with but two "no" (Vasavada and Marsh).

Meeting adjourned. Summary by Bill Weaver, PhD
Date: March 4, 2004

To: William B. Deal, Dean

CC: Dennis W. Boulware, MD, Senior Associate Dean for Medical Education

From: Nathan B. Smith, MD, Chair of the Medical Education Committee

Re: Recommendations on Modification of the Clinical Education Program, Birmingham Campus

The Medical Education Committee met yesterday in a special meeting to consider recommendations on the UASOM clinical education program developed by the Clinical Education Task Force and approved by the Integrated Medical Sciences Subcommittee. The Task Force had gathered information from various sources and had deliberated in five meetings. (For details, see attachment) It was determined that the current clinical education program does not allow students on the Birmingham campus with its tertiary care medical environment to take full advantage of that expertise in the same way that the students at Huntsville and Tuscaloosa are being able to take advantage of the rural medicine expertise at those campuses.

As a result the following recommendations were discussed yesterday and approved by a vote of 9 to 0. We submit them for your consideration and urge you to provide your decision as quickly as possible, as we are already past the most desirable point for making changes for implementation in July of 2004.

The following modifications would apply only to the students completing their clinical education program at the Birmingham campus, would apply to the students beginning their Junior year in July 2004, and would be implemented in July 2004.

In the Junior year:
- The Medicine, Surgery, Pediatrics, and Ob/Gyn clerkships will remain at 8 weeks each.
- The Psychiatry Clerkship will remain at 5 weeks, and will share an 8-week block with a new 3-week entity called Selectives (Areas to date that have requested and have been tentatively approved include the following: Anesthesiology, Emergency Medicine, Human Genetics, Ophthalmology, Pathology, Radiation Oncology, Radiology, and Urology).
- The Family Medicine Clerkship will remain at 4 weeks, and will share an 8-week block with Neurology, which will be increased from 3 weeks to 4 weeks.
- The 4-week Rural Medicine Clerkship will be eliminated as a requirement in Birmingham (but only in Birmingham). However, Rural Medicine will be invited to become one of the 3-week Selectives and also all graduates completing their clinical education program at the Birmingham campus will be required to complete a minimum of 3 weeks of experience in a rural or other underserved setting at some point in either the Junior or Senior year.

In the Senior year:
The Medicine AI, Surgery AI, Inpatient AI, and Ambulatory AI will remain 4 weeks.
The Ambulatory AI requirement and the requirement for a rural/underserved experience can both be met by the formerly required Rural Medicine clerkship.
Description of the Deliberative Process

At the Integrated Medical Sciences (IMS) Subcommittee meeting on July 14, 2003, it was announced that a task force would be appointed to review the clinical education program in order to accommodate an additional week for the Neurology Clerkship which the Dean had committed to the new Neurology Department Chair. As Chair of the IMS Subcommittee, Dr. Frank appointed the following members to the Task Force:

- Craig Hoesley, MD, Medicine, Birmingham (Chair)
- Cheri Canon, MD, Radiology, Birmingham
- Roger Berkow, MD, Pediatrics, Birmingham
- Stuart Frank, MD, Medicine, Birmingham
- Brian Geary, MS4, Birmingham
- Alice Goepfert, MD, Ob/Gyn, Birmingham
- Eugene Marsh, MD, Neurology, Tuscaloosa
- John Shuster, MD, Psychiatry, Birmingham
- Tarak Vasavada, MD, Psychiatry, Huntsville

The Task Force was charged to review the clinical curriculum for students at the University of Alabama School of Medicine and to consider the strengths, weaknesses, opportunities, and potential threats to the current curriculum.

Early on, it was agreed that the goals of the clinical education program are to:

- give students a solid foundation in all disciplines for residency;
- expose students to all clinical disciplines before residency application;
- expose students to activities (particularly research) that acquaints them with academic medicine;
- expose students to activities that acquaint them with the need for primary care (particularly in underserved areas); and
- help students develop clinical thinking/problem-solving skills.

With these goals in mind and recognizing the need to assure a quality clinical education to all students, the Task Force reviewed information on the clinical education program of other medical schools, obtained information from the Task Force members themselves and from various stakeholders (clerkship directors, rural medicine advocates, and non-clerkship discipline faculty), and engaged in lengthy discussion at 5 in-person meetings.

The deliberations included a review of the following issues: clerkship length, location, additions, and deletions, whether and, if so, how to add electives in the Junior year, etc.

Key questions that were necessary to address in the deliberations:

- Can the curriculum be done differently at the three campuses?
- Can the third year be extended to include an additional clerkship block?
- Should any of the current clerkships be increased in length?
- Can any of the current clerkships be reduced in length?
- Can any of our current clerkships be abolished or merged or moved to the fourth year?
- Can some required clerkships be completed in the fourth year?
- Can time be made available in the third year for an elective (especially in disciplines that will enable students to make better informed career choices)?
- Can time be made available in the third year for a research experience?
- Can Senior AIs be adjusted to address third-year needs?
Rationale:

- The LCME requires the program at all campuses to be "comparable," but they need not be "identical".
- The LCME has accepted campus-to-campus differences that capitalize on campus strengths once the essential knowledge, skills, and experiences are met at "all" campuses.
- The strengths at Huntsville and Tuscaloosa (primary care/rural medicine) differ from those at Birmingham (subspecialty training). Thus the Rural Medicine Clerkship would not be changed at Huntsville and Tuscaloosa.
- Because Rural Medicine is a "location" and not a medical discipline, the students at Birmingham should be given an opportunity to follow the Birmingham campus strength (and obtain experience in other non-clerkship clinical disciplines), just as the students are doing in Rural Medicine at Huntsville and Tuscaloosa.
- Even at Birmingham, Rural Medicine would be included as a Selectives option in the Junior year.
- Also at Birmingham, the Ambulatory Acting Internship in the Senior year would be strongly encouraged to be taken in a rural setting.

All of this was done with full knowledge of the end-of-February deadline for implementation in the 2004-05 academic year. Although all of the above questions were discussed, the time constraints simply precluded possibilities that would create complicated scheduling from being endorsed. In the process of looking at scheduling issues, 16 Junior year schematics were reviewed. Ultimately, the plan that seems to meet some of the needs while being least disruptive is the one described above. No plan was most suitable to everyone, but this one was approved by the Task Force by a vote of 7 to 2. It is expected that the experience in Birmingham can serve as a pilot for helping branch campuses identify Selectives areas that they may wish to develop at some point.
APPENDIX 1: PRE-CLINICAL COURSE INTERNAL REVIEW PROTOCOL

Purpose of Review: To assess the extent of congruence with UASOM Undergraduate Medical Education Policies and Goals, of concordance with LCME educational standards for undergraduate Medical Education, and of achievement of course specific objectives and competencies by each basic science course.

Review Team: Two basic science course directors will serve as the review team. The Senior Associate Dean for Medical Education will select the review team members in a rotating manner.

Schedule of Reviews: A review of each course will occur once every four years, allowing for each course to have been reviewed between LCME accreditation visits. The Senior Associate Dean for Medical Education, following consultation with basic science course directors, will establish a schedule of review of basic science courses.

Materials to be utilized:
- LCME Standards for Accreditation as related to Educational Program
- UASOM MEC Curriculum 2000, especially Part I
- Previous LCME Accreditation Report information relevant to the course
- Course Director's Self-Study Report
- Prior course review, if available
- Summary of student course evaluations
- Measures of student performance (e.g., grades, USMLE Step 1 results)

Procedure

Self-study: At the time designated by the Senior Associate Dean for Medical Education, the Course Director will prepare a self-study course review for submission to the review team. Using the materials and information delineated above, the Course Director will assess the course with reference to LCME standards, to UASOM goals, to stated course objectives and competencies, to prior course reviews, to student evaluations, and to measures of student performance. In creating the self-study report, the Course Director will address the following areas: aims/goals of the course, methods of instruction/learning, assessment of success in achieving aims/goals, and course revisions both recent and future. Once completed, the Course Director will submit the self-study to the review team.

Review Team: The review team will evaluate the success of the course in meeting LCME and UASOM standards and goals, as well as the course's success in meeting its stated aims. After the review team completes a preliminary evaluation of the course, the review team and course director will meet to discuss concerns and to clarify issues. Following the meeting, the review team will prepare a report, including input from the course director, for submission to the Senior Associate Dean. The report will detail the strengths of the course, identify areas of relative weakness, list recommendations, and outline barriers that interfere with a course's optimal functioning. If there are serious disagreements between the review team and the course director regarding the review, a meeting of the review team, course director, and Senior Associate Dean will be scheduled to seek consensus.

Review by Course Directors: After the review team has completed its review and any issues have been addressed, the review team will present its report with the course director's response during a meeting of Pre-clinical Course Directors for comment and input.
Report to MEC: A brief summary of the review will be sent to the MEC as confirmation that the review has been completed.

Outline for Self-Study

- **Aims/goals:** Submitting a recent syllabus, statement of goals and objectives, and indicating how these are communicated to students can satisfy this section.

- **Methods:** If the syllabus is specific about the types of learning activities employed, the course director can reference the syllabus to identify lecture time, small group experiences, or independent learning activity.

- **Assessment:** Frequency of "testing" and outcomes, how students "learn" from assessment, and external measures of success (USMLE scores or clerkship feedback) are important elements.

- **Plans:** Address expected changes in the three areas noted above and discuss blocks to change or why change would be harmful, if appropriate.

- **General Assessment:** The course director should comment upon his/her perception of meeting LCME and UASOM standards and goals. If there are differences between the course structure and said standards, discuss the importance of managing the course as is or the impediments to meeting the standards.
APPENDIX 2: CLERKSHIP GOALS AND REVIEW PROCESS

This review process for clerkships shall be based on the stated goals of the UASOM as presented to the MEC by the Assessment Subcommittee in September, 2002.

The Clerkships shall be responsible for assisting students to meet the educational goals as set forth in this document. While the specifics of scientific and clinical information will be of necessity vary from discipline to discipline, provision should be made within the appropriate context for the student to experience by didactic presentation, observation of faculty/resident clinicians, by case discussions, and by clinical experience with patients, the basic knowledge and skills related to the particular discipline of medicine represented in the individual clerkships. The clerkships shall be evaluated and monitored according to their efforts and success in facilitating the development of the knowledge, skills, attitudes and behaviors commensurate with these goals.

Area I: Scientific and Clinical Knowledge//Education

1. Present to the student at the beginning of the clerkship a list of the topics/clinical skills to be covered and mastered over the clerkship

2. Provide the student with opportunity to use the medical literature to improve his/her knowledge base and critically appraise information

3. Provide a uniform grading and assessment system across campuses to assess acquired knowledge and skills

Area II: Information Gathering, Retrieval, and Management Skills

1. Provide by instruction, example, and practice the basis for performance of both comprehensive and focused clinical history and physical/mental examination

2. Provide clinical/didactic/observational instruction and practice in using diagnostic tests pertinent to the discipline, including laboratory, radiographic, pathological, or psychological testing

3. Provide didactic/observational/clinical experience in obtaining, organizing, and using information derived from patient charts, digital databases, and paper records for diagnostic and management decisions

Area III: Interpersonal and Communication Skills

1. Provide by instruction, example, and practice the opportunity to acquire information from the patient/his family/his friends, colleagues, and other members of the care team, or others

2. Provide opportunities for experience in organizing, synthesizing and reporting both orally and in writing, patient information derived from the history, physical exam, diagnostic tests, and medical literature to patients, family/friends, colleagues, the care team, and others

3. Provide opportunities to teach and counsel patients/family especially on difficult topics and behavioral issues
4. Provide opportunities to engage/build relationships that are culturally sensitive and age appropriate

5. Provide opportunities to work effectively as a member of a coordinated healthcare team

**Area IV: Clinical Decision-Making**

1. Provide opportunities to develop a differential diagnosis using multiple sources of patient data

2. Provide opportunities to use evidence-based medicine techniques for data interpretation and critical analysis of history, exam, and test data to make treatment and management decisions, to predict outcome, and to plan for follow-up

3. Provide opportunities for the student to acquire and demonstrate knowledge and skills necessary for the prevention of illness and disease, treatment involving behavioral change, and the appropriate use of health care system resources for these interventions.

**Area V: Professionalism**

1. Provide opportunities for students to learn conscientious attention to tasks and patient advocacy

2. Provide opportunities for students to practice demonstrating respect, compassion, and empathy for others

3. Provide opportunities for students to demonstrate professional behavior that is consistently ethical and moral in a variety of contexts:
   a. Patient/physician relationship
   b. Physician/physician relationship
   c. Relationship with professional organizations
   d. Relationship with the greater Healthcare community

4. Provide opportunities for the student to demonstrate critical self-assessment of clinical knowledge, performance, and interaction skills and commitment to their improvement

5. Provide opportunities to demonstrate understanding of federal/state regulations regarding issues of patients’ rights/confidentiality

6. Provide instruction on issues of the context of medical care, including patient care, illness, prevention of illness in the context of:
   a. Family
   b. Epidemiology of processes
   c. Societal/political/cultural influences
   d. Economic concerns
   e. Ethical and historical issues
CLERKSHIP REVIEW CRITERIA

The Clerkship Review Criteria shall be based on efforts/progress in meeting the educational goals as outlined in the specified areas.

Respective Clerkship Directors shall address each individual aspect and item listed, and maintain a file listing the current efforts/plans to meet each goal, and shall provide to the committee at its request, an updated portfolio of ongoing efforts to meet the stated educational goals, and to monitor the clerkship activities.

PORTFOLIO CONTENTS

Page I: Basic Information about the Clerkship

1. Length in weeks
2. Clinical service opportunities (include patient demographics for the various clinical services)
3. Medical Student Education Committee - Makeup/Duties
4. Grading system for the clerkship across the 3 clinical campuses
5. Methods by which the 3 campuses coordinate efforts to provide comparable educational experiences to students
6. Method by which students’ progress is monitored throughout the clerkship
7. Process by which students are given feedback
8. Provisions for remediation in the event of poor performance

Page II: Scientific and Clinical Knowledge/Education

1. Include schedules of didactics, case conferences, clinical case discussions, orientation materials, examples of assigned readings, list of topics to be learned and goals to be achieved
2. Include documentation of assignments for evaluation of literature pertinent to topics taught/discussed in the clerkship
3. Include documentation of the students’ performance on the clerkship for the past 4 years:
   a. Grade distribution for the clerkship including class mean
   b. Standard deviation on the 3-digit Standard Score, and on the 2-digit Subject Test Score of the NBME Subject Test
   c. Median percentile rank on the Standard Score and on the Subject Test Score of the NBME Subject Test
   d. Mean and standard deviation on any related station from the third-year OSCE.
   e. Average of oral exam (if given)
Page III: Information Gathering, Retrieval, and Management Skills

1. Include documentation of the average time daily which students:
   a. Spend on clinical rounds
   b. Are directly observed by a supervisor interacting with patients in the
      clinical setting, either taking the history or doing an exam
   c. Interview/examine patient independently and then discuss their findings
      with their clinical supervisor

2. Include documentation of the average time daily, and the methods by which students spend:
   a. Being instructed regarding how to evaluate a patient problem using
      diagnostic tests
   b. Using the skills to independently formulate a diagnostic plan which is
      reviewed with a clinical supervisor

3. Include documentation that students receive instruction/practice in obtaining and using patient
   charts, digital databases, and paper records for documentation and management decisions

Page IV: Interpersonal and Communication Skills

1. Include documentation on the methods by which the clerkship provides
   opportunity for the student to learn/practice acquiring history from a
   patient/family/friends, colleagues, care team, or others

2. Include documentation that students are given opportunity to learn/acquire
   skills in organizing, synthesizing, and reporting orally, electronically, and
   in writing, information derived from the history, physical exam, diagnostic
   tests, and the medical literature to patients, family/friends, care team,
   others

3. Include documentation that students are given opportunity to teach and
   counsel patients and family members, especially regarding difficult topics
   and behavioral issues

4. Include documentation that students are given instruction/opportunity to engage in and build
   relationships that are culturally sensitive and appropriate

5. Include documentation that students receive instruction/opportunity to work effectively in a
   coordinated healthcare team

Page V: Professionalism

1. Include documentation that students receive instruction on, and are given opportunity to
   demonstrate:
   a. Conscientious attention to tasks and patient advocacy
   b. Respect, compassion, and empathy for others
   c. Professional behavior that is consistently ethical and moral in the
      following contexts:
      1. Patient/physician relationship
      2. Physician/physician relationship
2. Include documentation of how the clerkship provides opportunities for the student to demonstrate critical self-assessment of clinical knowledge, performance, and interaction skills and commitment to their improvement.

3. Include documentation of how the clerkship provides opportunity to demonstrate understanding of federal/state regulations regarding issues of patients’ rights/confidentiality.

4. Include documentation of how the clerkship provides instruction on issues of the context of medical care, including patient care, illness, prevention of illness in the context of:
   a. Family
   b. Epidemiology of processes
   c. Societal/political/cultural influences
   d. Economic concerns
   e. Ethical and historical issues