STARTING WITH THE END IN MIND

SMALL GROUP ONE: Essential Characteristics of the “physician of the future”

1. Build trust with patient, competent enough to create a dialogue, and be empathetic and self-aware
2. Capability of applying knowledge to problem solving and highest ethical standards
3. Effective communicator (involves teamwork, education of the patient, and leadership qualities) and knowledgeable and able to navigate the health care system
4. Learn how to learn (ton of information to acquire, with many changes) and communicate between departments, with patients and educators
5. Accessibility to patients (providing proper access to clinical care) and navigation of the health care system (including electronic information systems)
6. Weed out the weird ones (e.g., residents that can't perform)- get rid of these potential challenges and reverse engineering (e.g., residents have poor work ethic - find ways to train medical students to be the opposites)
7. Appropriate knowledge basis for practice (and self-assessment/self-improvement) and professional communication skills
8. Be a good team player (not have an ego), adept at inter-professional team work and effectively use the health care system
9. Acquire/synthesize basic and ongoing knowledge, and communicate on all levels – and across disciplines in a team-based environment, maintaining empathy and context of medical care
10. Effective communicator, goal seeker and continual learner, and receptive to continual change and evolution of knowledge.

ACTION ITEM FOR CEWG: Are our competencies and ILOs adequately addressing these characteristics? (assignment: Competency Working Group/ Daroowalla)
Missing concepts:

1. Empathy/Compassion
2. Team-based player in multidisciplinary team environment
3. Experts in getting people through the health care system
4. Social contract to fulfill
5. Culturally sensitive and/or culturally competent and/or diverse populations
6. Families/communities (add terms)
7. First sentence – still need to teach medical knowledge, where still provide an emphasis on tools for obtaining medical information
8. Professionalism is integral to the concepts noted
9. Provide the skills for life-long learning (e.g. research skills)
10. Societal pressures, industry pressures, legal issues, payment issues, and other pressures – which can be important. Need to introduce these concepts, such that MDs feel empowered to address these pressures.
11. Life-long improving – includes but goes beyond life-long learning.

**ACTION ITEM FOR CEWG: Finalize the Vision Statement including some of the ideas above.**

(assignment: Stephanie Brown)
SMALL GROUP 3A: Practices That **Hinder** Development of the Physician of the Future

- Distribution of time available
- The large didactic lecture is virtually useless
- Teaching to the exam
- What to learn precedes how to learn
- Collaboration of clinical knowledge into classroom learning
- Lectures that discuss compassionate behavior (may not be easily taught – but rather practiced and evaluated)
- Cut down on redundancy
- Evaluation focus – examinations cause studying for the test
- Learning the information at the wrong time
- Board exams provide something simple to focus on
- No clearly identified resources for learning
- Multiple choice reality which fosters memorization to the exam
- Too much separation of basic sciences and clinical sciences
- Lack of structure to assure that people that are more introverted can participate actively
- Too much emphasis on the step 1 board exam medical knowledge
- Frustrations related to time available related to material needed to be covered
- Lack of buy-in from basic scientists/ clinical rotations
- Lack of competent faculty/specimens/resources
- Lack of incentives for clinical faculty
- Departmental structure for teaching must be eliminated
- Limitation of Space/Money
- Faculty Inertia/Small Faculty
- Funding of resources needs to be focused centrally
- Anticipate Step 1 changes & pro-actively change
- Distribution of time – clinical/education & resources
- Integrating into the clinical environment
- Evaluation methods: NBME alone w/ clinical assessment
- Learning info at wrong time & context of deep learning; no standard resources
- Too much emphasis on USMLE
- Clinical practice model
- Need integration
- Large lectures are not helpful
- Teaching to exam
- Separation of basic science and clinical sciences
- Evaluation on MCQ/NBME only
- Lack of champions
- Resources for learning identified

**ACTION ITEM FOR CEWG: Summarize the key themes- Discuss during meeting**

Latha’s summary list below

- **Time Management**: Efficient, minimum and planned redundancy, resources identified
- **Learner Assessment**: Move away from MCQ, NBME focus
- **Integration**: More integration between years/clinical and basic
- **Faculty Engagement**, Support and Incentives
SMALL GROUP 3 B: Practices that **Facilitate** Development of the Physician of the Future

1. More basic content preparation in advance of the class time
2. **Raise expectations** to prepare them for experience
3. Love working with patients (both simulated and/or standardized cases)
4. Close collaboration of course directors with maximal integration with “optimal redundancy”
5. Deep drilling in the basic science and the social, political, ethical, interactive dimensions of the disease
6. Be realistic of how interact with real clinical environment – teach resilience so the MD retain their purpose
7. Building on prior knowledge and/or **case discussions in groups to solve problems as a team**
8. Holistic approach to organize multi-media resources to represent “best practices”, describe more, rather than reinvent the wheel
9. Pay for teaching
10. Develop an **academy of educators**
11. Positively **integrate the clinical integrations** with hospital administrators, nursing administrators, and other staff (e.g., patient safety focus)
12. Apply quality data to clinical research, such there is not a disconnect between basic and clinical sciences
13. **Longitudinal integration** of materials that are course appropriate and builds upon prior materials
14. **Make students responsible** daily for coming prepared, facilitate peer evaluations
15. Repeated chances to master the material, opportunity to give it another “crack” until mastery
16. **Clearly defined resources** (books and people that students can rely on upon for knowledge)
17. Practical application of what is learned and/or **team-based learning approaches**
18. **New assessment tools** that test not only knowledge, but ability to problem solve and think critically, frequent formative assessments
19. Ideally, consider a **longitudinal patient experience** and/or simulation patients becoming more complex
20. OSCE experiences and Stony Brook HOME provide more “real” life experience
21. **Learning communities** that integrate students from all years and a broad group of individuals from other areas (e.g., administrators)
22. Team based/case based learning/ small groups- these work
23. People that are inspirational and support change- new leadership
**SMALL GROUP FOUR: ACTION IDEAS**

- **Provide FD for teaching**: Provide/require training opportunities in new techniques (TBL)
- Balance clinical/educational roles
- Use other health professionals/engaged faculty/students
- Realize the resources that we do have – to utilize them more fully
- Develop Integrated longitudinal approach – patient experience

- **Create NEW assessment methods**
  - Increase Team Simulations
  - Continue Early clinical exposure / OSCEs SB HOME
  - Provide frequent quizzes
- **Create Learning communities** across classes/faculty students
- Decrease Board style exams
- Increase Essay type and small group work

- **Increase Case-based teaching**
  - Develop Resident teaching skills
  - Review curricular content for redundancies/threads
  - Increase peer assessment
  - End pre-clinical years earlier
  - Pilot different ideas
  - Identify horizontal strands

- **Change current structure**

- **Identify clear resources**
  - Provide frequent formative assessments
  - Provide high quality E-lectures
  - Address quality concerns
  - Eliminate Departmental Silos: Organization-based? Eliminate decentralized curriculum
• Blow up the curriculum better than others
• Create thread of excellence
• Create horizontal threads for topics that don’t belong to one group
• Evolve: Must be continually evolving
• Provide teaching time
• Promote creation of new teaching spaces
• Facilitate cross-conversations across disciplines, professions
• Question lecture value - ↓ lectures
• Add to clinical years
• Move towards holistic evaluation of students- admissions/ in school

ACTION ITEM FOR CEWG: Develop a phased action plan based on above (Team, assignment Daroowalla, Chandran and Fleit).

SMALL GROUP FIVE: Evaluation Measures
• Standardized OSCES
• Team assessments
• EBM
• Student satisfaction
• Faculty satisfaction
• Program Directors Questionnaire
• Alumni Survey >1 year
• NBME scores
• # Publications & quality
• Clerkship directors survey – prepared for clerkships?
• Applicant pool ? MCAT
• % have academic positions
• Patient self-rated health
- Long-term retention
- Faculty turnover
- Course evaluations/Focus groups
- Script Concordance Test
- PGY1 surveys
- Healthcare utilization of grads
- 360 evaluation/self-evaluation
- OSCE Feedback
- Research success of graduates
- Community engagement
- Create MILESTONES & Assess Achievement
- Trained faculty for mentorship
- GQ trends/Surveys/Focus groups
- External Reviews
- PGY3 survey?
- Student narrative on progress/change
- SP feedback

**ACTION ITEM FOR CEWG: Review and decide on additional assessments (assignment: Wei Hsin Lu)**