ADMINISTRATION RESPONSE

TO THE

STATE OF THE SCHOOL REPORT

OF THE

BROWN MEDICAL STUDENT SENATE

(1999–2000)

PREFACE

On behalf of my colleagues in the medical school administration, I commend the Medical Student Senate for their very thoughtful and insightful report on the state of the school for the 1999–2000 academic year. The thoroughness with which the survey was conducted and the maturity with which it was reported speaks well of the quality and character of our student body. Brown University historically has encouraged its students to participate actively in the affairs of the university, both at the college and graduate and professional levels of education. We believe that this active engagement in the affairs of the institution play an important role in advancing its goal of educating men and women who will "discharge the offices of life with usefulness and reputation."

The report of the Medical Student Senate received serious attention by the administration. This response reflects a considerable effort by many individuals representing many offices and programs within the medical school. Each concern raised in the report was studied carefully. We noted with considerable satisfaction that many of the concerns expressed by students during the 1999–2000 academic year have already been addressed through actions initiated since the time the data was collected. This document reports on the progress made between then and now.

Each item of concern raised in the Medical Student Senate report is addressed in this response in the same order in which it appeared in the original report. General areas accorded the highest priority in the report are dealt with first. The ranking within each category is the same as listed in the report. The response restates the students' concern, provides an update on progress since the 1999–2000 academic year, discusses the issue, presents the administration's position and plans, and, when appropriate, offers a timetable for expected actions and outcomes.

I thank the following members of the medical school administration for their assistance in preparing this response: Debra Abeshaus, Kathleen Baer, Edward Beiser, Richard Dollase, Mercedes Domenech, Lynn Epstein, Faiza Estrup, Julianne Ip, Susan Luckel, Francis McCrossan, Alicia Monroe, Lois Monteiro, Alexandra Morang, Ann Paton, Tovah Reis, Peter Shank, Steve Smith and Terrie Wetle. I thank Adrian Gardner for his initiative in conceiving of the idea for the report and shepherding the process through to its culmination in the publication of the State of the School Report. On a personal note, I remarked to Dean Smith, who took the leadership in compiling initial responses, that I took great satisfaction from spending time on the writing and editing of this report. It helped me shape and hone my own thinking about the medical school's future direction and its responsibility to our excellent students. All of us in the administration will be challenged to do our jobs better as a result of this ongoing conversation, and for that I thank you all.

Sincerely,
Donald J. Marsh, M.D.
Dean of Medicine and Biological Sciences

ADMINISTRATION RESPONSE TO THE MEDICAL STUDENT SENATE STATE OF THE SCHOOL REPORT (1999–2000)

1) Educational Content

General Integration (3.0/9)
Student Concern: Students felt strongly that there should be more integration of subject material between courses, particularly for courses in the first two years of medical school. Specific suggestions for integration were in behavioral sciences; anatomy, physiology, and histology; neurology and psychiatry; and medical interviewing and physical diagnosis. The report also called for more collaboration between biochemistry and nutrition and microbiology and infectious diseases. Additionally, the report proposed an 8-year longitudinal patient visitation program.

Response: The Medical Curriculum Committee (MDCC) has as its primary goal the development of a well-integrated and comprehensive preclinical curriculum that is effectively taught and systematically evaluated. Since 1997, the MDCC has requested that first- and second-year course leaders meet with students annually to discuss curriculum coordination issues. Over the years, much unnecessary redundancy in topics addressed in preclinical courses has been eliminated and greater integration achieved. In addition, the MDCC preclinical subcommittee has recently undertaken substantive reviews of first-year courses to improve their overall quality, including recommending ways that first- or second-year courses may more closely coordinate with one another.

Effective coordination of our dynamic and evolving medical curriculum will necessarily be ongoing. Periodically, the Medical Curriculum Committee will need to consider more substantial ways of restructuring courses or sets of courses to promote better integration. As a part of this process, it will be necessary to keep in mind that excellence in education inevitably requires some redundancy. At curriculum coordination meetings this January, first- and second-year course leaders agreed to consider the following changes to achieve better course coordination:

- First-year, first-semester leaders agreed to study ways to integrate more closely Bio 117–*Mammalian Physiology*, Bio 184–*Human Morphology*, and Bio 189–*Human Histology*, including the possibility of developing an integrated cross-disciplinary course that encompasses the three basic science disciplines.
- At the end of the spring semester, first-year, second-semester course leaders will discuss more substantial ways to promote curriculum integration and coordination.
- Second-year leaders agreed to work toward better integration of Bio 279/280–*Systemic Pathology*, Bio 281/282–*Pathophysiology*, and Bio 273/274–*Organ System Pharmacology*. At the request of students, they will consider giving an examination in each course after each three weeks of instruction that coincides with the end of each pathophysiology section.

- Second-year course leaders have also agreed to share syllabi and to achieve better coordination. On a trial basis, during the spring semester in two sections of pathophysiology, two problem-based learning cases will deal with the pathological, the pathophysiological, and the pharmacological aspects of an illness. Also, patients with an illness currently being discussed in pathophysiology will be asked to come to a Bio 373/374–*Introduction of Clinical Medicine* (ICM) Thursday afternoon class to discuss the disease with his or her physician and to answer questions from students about the ongoing treatment.

Timeframe: By 2001–02, significant progress will be made at coordinating the preclinical curriculum as attested by its redesign. Specifically, a series of planning meetings will be held to develop a cross-disciplinary model in the first-year, first-semester courses. Planning meetings with second-year course leaders will also be held to explore designing a new examination schedule and to more closely coordinate course content as well as undertake interdisciplinary teaching when appropriate. If the interdisciplinary PBL cases and the patient classroom visit that are trial tested this academic year are rated as effective, new cases will be developed in each of the ten course sections of pathophysiology and more patients visits to ICM will be instituted.

The integration and coordination of courses in neurology and psychiatry suggested in the report will be discussed at course leaders meetings during the spring semester.

Timeframe: It is anticipated that better coordination of the medical curriculum will be achieved during academic year 2001–02. A review session will be held at the end of spring semester 2002 to determine the effectiveness of the coordination efforts of the course leaders.

The report recommended that patient interviewing, public health, and brain and behavior be consolidated into one course on epidemiology. The MDCC has a established a task force on professionalism in the medical curriculum that will consider, among other topics, how the clinically oriented courses in the first two years may be restructured to provide students with 1) more long-term patient contact and more long-term involvement with practicing physicians, and 2) more clinically relevant experiences in all four semesters of the first two years of medical education.

Timeframe: A faculty-development retreat will be held in June 2001 to consider professionalism across the continuum in medical school, in the residency and during full-time practice in the hospital or office setting. Moreover, the professionalism subcommittee of the MDCC will present a white paper at the annual September 2001 strategic planning retreat of the curriculum committee discussing its major findings and recommendations. These will include course restructuring to ensure more clinically relevant instruction and the effective mentoring of medical students by clinical faculty in the community.

USMLE Preparation in Courses (3.5/9)

Student Concern: Students felt strongly that courses should have as a specific objective coverage of material that will appear on the USMLE Step 1 examination. The report also recommended that USMLE question formats should be used on in-class examinations.

Response: According to the USMLE, the Step 1 examination is "designed to measure basic science knowledge. Some questions test the examinee's fund of information *per se*, but the majority of questions require the examinee to interpret graphic and tabular material, to identify gross and microscopic pathologic and normal specimens, and to solve problems through application of basic science principles." We held a workshop in 1998 for our faculty on the content and format of the Step 1 examination. A member of the National Board of Medical Examiners participated and urged our faculty to teach what they feel is best practice in their discipline and not "to test for the boards" directly.

Since that workshop the Step 1 testing format has changed from a variety of multiple choice and matching questions with one or more right answers to a single question format with only one best answer. Not all course leaders may be aware of the new question format. Thus, preclinical course leaders will be sent a memo describing students' recommendations along with up-to-date Step 1 questions that they may use as model questions in their test construction. If course leaders express a need for more help in preparing such questions, we will hold a workshop with test construction as the focus.

In addition, a boards examination handbook is under development for students that will deal with the myths and realities of exam taking and include an annotated list of review books. It will also contain the names and telephone numbers of tutors at Brown who are available to help students prepare for the exam.

Clinical Faculty Interactions (3.8/9)

Student Concern: Students felt strongly that more clinical experiences and interactions with clinical faculty should be incorporated into the first and second years.

Response: We will ask first-year course leaders to recruit more clinical faculty to lecture in their courses. A change in this direction is already taking place in Bio 158–*Medical Microbiology*.

Timeframe: By academic year 2001–02, additional clinical faculty will be invited to participate in most preclinical basic science courses. An email survey of the course leaders will be taken at the end of each academic semester to determine the number of new clinical faculty asked to participate in preclinical basic science courses.

Elective Time (4.2/9)

Student Concern: Students felt that a continued commitment be made to maintaining elective time during the clinical years.

Response: The policy of the medical school on this matter states: "As an integral part of Brown University, the Medical School offers its students a wide variety of elective opportunities in clinical medicine, research, the liberal arts, and the basic sciences."

In revising the academic calendar for the third- and fourth-years, the MDCC was informed by the medical school policy to maintain at least 25% of time for electives. With the new third- and fourth-year calendar changes, elective time will be 30%. There are 80 required weeks of study: 58 weeks of core requirements (or 9 clinical required courses) and 22 weeks of electives.

In comparison, Dartmouth Medical School has 68 weeks of core courses (or 15 required courses) and 12 weeks of electives (15%), totaling 80 weeks. Harvard Medical School has 60 weeks of core courses (or 10 courses) and 26 weeks of electives (30%), totaling 86 weeks.

In addition to the 22 weeks of elective time, there are also about 12 additional weeks during the third and fourth years for students to take electives or pursue independent study. This is exclusive of the 8 weeks of vacation time built into the third- and fourth-year academic calendar. In past years, this has been sufficient time for students to pursue a variety of away electives, independent research, and international health projects.

As recommended by students, the surgery clerkship was reduced from 12 to 8 weeks. On the other hand, a new 6-week community-health clerkship has been added to the core curriculum that results in two more weeks of required clerkship time. This change also had the support of students. Beginning in academic year 2001–02, the third year will start during the first week in July rather than in first week of August. This calendar change was instituted to provide students with additional time to undertake electives or for residency interviews.

Reducing the other clerkships, for example, the psychiatry or obstetrics and gynecology clerkships from 6 to 4 weeks or the medicine clerkship from 12 to 8 weeks will be discussed at a forthcoming meeting of the clerkship directors. Any formal change in elective policy will have to be decided by the medical curriculum committee.

Timeframe: If the Medical Curriculum Committee (MDCC) were to vote to reduce clerkship time, it is unlikely that the change will take place until academic year 2002–03.

Pharmacology (4.8/9)

Student Concern: Students felt that the pharmacology course should include more clinical content and be more closely integrated with pathophysiology.

Response: The course leader for Bio 273/274–*Organ System Pharmacology* has been contacted about students' concerns. We and second-year students will meet with him to discuss the students' recommendations. Pharmacology objectives are being included in the small-group, problem-based learning sessions in the endocrine and human reproduction sections of pathophysiology this spring on a trial basis.

Timeframe: Curriculum changes can be completed by the start of academic year 2001–02 for the fall semester of pharmacology and by the beginning of spring semester 2002 for the second half of the course.

Neuroscience (5.4/9)

Student Concern: Students were concerned that the faculty from Neuroanatomy, Brain and Behavior, Intro to Psych, and Neuropathology should communicate with one another and attempt to increase coordination between their courses.

Response: A meeting will be scheduled shortly with course leaders who teach neuroscience to discuss more effective curriculum coordination.

Timeframe: Close and effective coordination can be achieved by academic year 2001–02 among the four courses: Bio 260: Human Neurology, Bio 370: Brain and Behavior, Bio 278: Introduction to Clinical Psychology and Bio 262: Neurologic Pathophysiology.

Anatomy (5.9/9)

Student Concern: Students expressed a desire for more clinical applications in the anatomy course. One specific suggestion was to use clinical faculty to teach surface anatomy correlated to physical diagnosis.

Response: Anatomy faculty felt that a careful balance needed to be maintained between invited clinical faculty and the core basic science teaching staff for the course and that the current balance was about right. No changes are contemplated.

Web Resources (6.7/9)

Student Concern: Students believed that more of an effort should be made to integrate web resources into courses.

Response: The Office of Curriculum Affairs (OCA) will form a course leader subcommittee to discuss priorities in developing web-based educational resources. Stephen Smeaton, M.D., the medical school's new web administrator, Dionne Gomez, the medical school course coordinator, and Tovah Reis, the medical library coordinator, have agreed to offer their services in setting up web pages for interested course leaders. In January 2001, the associate dean for curriculum at Tufts Medical School gave a workshop here on web education. The workshop provided course leaders with specific examples of how the web page may be used for instructional purposes, and it motivated several of the course leaders to begin to set up or to refine their own web pages.

Timeframe: By academic year 2003–04, all preclinical and core clerkships will have web pages.

Psychiatry (7.7/9)

Student Concern: The report recommended that students rotate through each of the psychiatry clerkship sites rather than spending all their time at one.

Response: The director of the psychiatry clerkship was contacted regarding student recommendations. We will follow up on the request that students be able to rotate from one clinical site to another during the 6-week rotation.

Timeframe: If student rotations are feasible, the change in the structure of the psychiatry clerkship can be in place by academic year 2001–02.

2) Faculty

Evaluations (1.7/3)

Student Concern: Students recommended that faculty evaluations should be used to reward good teaching and to require mandatory faculty development for poor/ineffective teaching.

Response: Good teaching is of primary importance to the medical school's administration. Indeed it is a topic we address regularly in an ongoing effort to monitor and improve quality. The Office of Curriculum Affairs will review all faculty evaluations. Faculty members who receive a rating below 2.5 on a 4-point scale will be sent a letter requesting the faculty member to review the student evaluations and to send written comments to the director of the Office of Curriculum Affairs. A copy of the faculty remarks will also be sent to the associate dean for medical education, the department chair and to the chair of the preclinical subcommittee of the Medical Curriculum Committee.

After receiving the letter, the director of the Office of Curriculum Affairs will meet with the faculty member to discuss specific ways the faculty member plans to improve

his or her course instruction. The faculty member will be encouraged to set up an individual consultation with the Sheridan Center for Teaching and Learning or with the OCA director to improve teaching effectiveness.

The results of the review process will be shared with students who sit on the preclinical subcommittee.

To encourage teaching excellence, the Office of Curriculum Affairs will continue to hold faculty-development workshops on best practice in teaching and learning. The curriculum affairs staff will produce a teaching effectiveness handbook prepared by medical students and Office of Curriculum Affairs staff on effective lecturing and small-group learning.

Timeframe: The review process will begin in the spring semester 2001. The teaching effectiveness handbook will be completed and distributed by the beginning of fall semester, 2001.

Mentoring (2.0/3)

Student Concern: Students were moderately concerned by the lack of mentoring/advising by faculty, and felt the need for more opportunities to interact with clinical and basic science faculty outside of the classroom. Many students specifically noted that their Affinity Group faculty did not fill the role of mentor and students from all four years noted that it was very difficult to find a faculty mentor.

Response: The student affairs office plans a structured mentorship program. The program will provide opportunities for medical students to develop a personal relationship with a member of the clinical faculty during the first year of medical school. Through this relationship the student can arrange early exposure to clinical medicine or research, begin to explore long-range career goals and understand the responsibilities and rewards of academic medicine. Faculty volunteers will take on one to two entering medical students and provide them with information about their clinical and research interests, activities that the student can participate in with their mentor, outside interests, and their personal view and philosophy of medicine. The program will begin with the entering class of 2005, provided sufficient numbers of faculty can be recruited.

The medical school also plans to provide more opportunities for faculty and students to interact outside classroom and hospital setting. A series of brown bag lunches will begin next fall with the faculty advisors from the postgraduate referral committee (the writers of the Dean's Letters), Career nights with faculty and alumni will also be held. We will invite these advisors and potential mentors to speak about their various specialties and to offer advice and counsel. A variety of forums will also be offered with the intent of providing opportunities for students and faculty to interact in a meaningful way through the exchange of ideas. A forum is planned for the spring semester en-

titled “Honesty, Honor and Professionalism” where students, faculty, and administrators will explore and discuss what embodies honesty in medicine.

Clinical Faculty (2.2/3)

Student Concern: Students suggested that the role of clinical faculty should be expanded in the first and second year. Students also expressed concern about delays in the submission of student evaluations, and urged recognition of clinical faculty teaching effort.

Response: The task force on professionalism in the medical school curriculum will discuss ways in which clinical faculty can mentor and increase interaction with first-year medical students. The PLME staff and the affinity group program are also developing plans to address professional development. The Office of Student Affairs is developing a faculty mentoring program (see above).

*Timeframe***:** Recommendations on the “Role of the Clinical Faculty in the Professional Development of Medical Students” will be presented to the Medical Curriculum Committee at its September, 2001 Strategic Planning Retreat.

Timeframe: Clerkship directors will endeavor to establish selection criteria by the end of spring semester 2001 so that the teaching awards can be given to faculty and residents in May or June of this year.

The medical education office is developing a new computer management system that will allow faculty members to submit grades and written evaluations on line. This program should be in effect no later than fall semester 2001. Once in place, this new computer software program will help enable clinical faculty to provide more timely evaluations of students’ clinical performance. The issue of late grades will also be discussed at an upcoming clerkship directors’ meeting.

3) Scheduling

Medical School and Undergraduate Calendars (2.4/7)

Student Concern: Students felt strongly that the medical school calendar should be uncoupled from the undergraduate calendar. Students were concerned that the calendar was too short. Recommendations were to reduce vacation time, start second-year classes earlier in the summer, and schedule examinations independently of the university registrar.

Response: To lengthen the school year and make it more in keeping with other medical schools, Bio 281: Pathophysiology has been extended into the January Term and Bio 282: Pathophysiology will now begin the week before the start of the second semester.

In addition, beginning in July 2001, the third year will begin on July 2 rather than July 30, adding four weeks to the clinical years. The new starting date is in line with most other medical schools. Presently, Bio 373: Introduction to Clinical Medicine begins in the last week of August. To begin all 2nd- or 1st-year classes in the last two weeks of August is difficult. Both the summer months and the first three weeks in January are considered "protected" time to be used by the basic science faculty for research and grant-writing activities.

Timeframe: Major calendar changes will go into effect in academic year 2001–02.

Winter Break for Second-Year Students (4.2/7)

Student Concern: Students were concerned that the winter break in 2nd year should be shortened and that the additional class time should be structured and well organized.

Response: Because of this request, we shortened the winter break as discussed in the preceding paragraphs.

Winter Break for First-Year Students (4.3/7)

Student Response: Some students felt that the winter break in the first year should be shortened, while others did not.

Response: Currently, first-year students may take January Term courses or undertake independent research during winter break. We discussed with the anatomy faculty the student recommendation for teaching several additional weeks of anatomy in January. They felt that the research demands and teaching responsibilities for graduate and postdoctoral students would preclude adding any additional time to teaching human morphology. No changes are contemplated at this time.

Number of Class Hours (4.6/7)

Student Concern: Students expressed a desire to have the number of scheduled hours in class reduced to allow more time for independent studying. The report suggested reducing the number of PBL sessions in pathophysiology to two per week, beginning earlier in the morning, and emphasizing that classes end on time.

Response: Given that Brown Medical School already has one of the lowest number of class hours of any U.S. medical school, further reducing the number of class hours will be difficult to accomplish without adversely affecting the quality of instruction or meeting the need to convey an ever-expanding knowledge base. One possible solution is to reschedule some pathophysiology small-group sessions to free additional afternoons during the second year. We will consult with the pathophysiology course leaders and the course section leaders to determine if it is practicable to hold lectures and small-group sessions on Monday, Wednesday, and Friday mornings

Given the laboratory components of many first-year basic science courses, we cannot reschedule first-year classes to free up more afternoons for students to undertake independent research or community service.

Two pathophysiology course leaders and a number of second-year students recently discussed the recommendation of reducing the number of PBL cases per week to two. The issue was also discussed with the MDCC subcommittee on the preclinical years. The subcommittee did not favor the suggestion because of the nature and structure of problem-based learning. Students need time to define learning issues, then find the answers before reporting back to the group. Compressing the time of small-group meetings would undermine this valuable learning modality.

Starting Second Year Earlier (5.0/7)

Student Concern: The report recommended starting the second year earlier.

Response: Please refer to the section on the Medical School Calendar and Undergraduate Calendar

PLME Students in Medical School Classes (5.4/7)

Student Concern: Students suggested that, in order to preserve fairness in grading and quality of teaching, PLME undergraduates should not be allowed to take medical school classes early.

Response: The PLME is considered a continuum and is unique in combined-degree programs largely because of the ability of PLME undergraduates to pursue medical school courses "early." The intent that PLME students who elect the option to enroll in medical school courses as undergraduates and are able either to fill their time in medical school with advanced degrees, to continue undergraduate courses in the humanities and social sciences, or to take on leadership roles in community service, is one that attracts many high school seniors to Brown's PLME over other combined-degree programs. This conclusion has been documented in a recent alumni survey. The admissions office also confirms that this is an attractive part of the program. Over 25 current or past medical students have pursued a master of medical science (MMS) degree as part of their 8-year educational plan. To facilitate the receipt of an MMS in 8 years, the majority of MMS candidates have taken a medical school course "early." Approximately 10 PLME seniors per class chose to pursue honors degrees in biology; many of these took one medical school course early for pedagogical reasons. The PLME administration feels strongly that the opportunity that this option offers PLME students should be preserved for those students who wish to maximize the PLME experience. We agree that the PLME deans should be more vigilant in advising and asking students to justify their educational plans and we will ask that they strive to do so.

Over time, the number of students taking advantage of this opportunity has decreased. Three factors contribute. First, for the last few years, medical school faculty have attempted to coordinate first-year courses more closely. This change was communicated to PLME undergraduates by the Meiklejohn student advisors and affinity group fellows and others with a resultant decrease in number of students opting to take medical school courses early. The curriculum committee is currently reviewing an even more significant integration of the first-year courses. If this integration is to occur to the same level as exists for the current second-year courses, taking medical school courses early could largely become impossible. However, for those students who have a valid pedagogical reason to take medical school courses as undergraduates, the administration believes that the opportunity should be preserved. Moreover, growing restrictions on space and laboratory supplies have limited the number of PLME students who have been allowed into the courses. Finally, with a greater number of PLME students taking a one or more additional years of deferment, it is likely that fewer undergraduates will choose to take medical school courses, due to time off between undergraduate and medical school years.

The perception that fairness in grading is undermined by allowing PLME students to take medical school courses as undergraduates concerns the administration. It should be noted that EIP students are also allowed to take medical school courses early. Any student may opt for a reduced load. Medical students may also place out of courses by dint of prior coursework or experience elsewhere. Thus, the normative situation is one where not all students will be taking the same course load. This also does not take into account other factors that might impinge on one student's time compared to another, such as family or work responsibilities.

The administration wishes to preserve the opportunity to take medical school courses. Therefore, beginning this year, the PLME office will provide guidance on this issue in its workshops for PLME faculty and Meiklejohn student advisors. These students will be asked to prepare a written justification for their choices. The justification will be retained in the student's academic advising files for future reference. The PLME deans noted that not every student's background is identical and that inequities are inevitable. The administration looks forward to working with the Medical Student Senate on ways to deal with issues of fairness and the underlying concerns in the context of teaching and learning professionally.

Starting First Year Earlier (5.5/7)

Student Concern: The report contained a mild suggestion that the first year should be started earlier than is now the case.

Response: Please refer to the section on the Medical School Calendar and Undergraduate Calendar.

4) Physical Facilities

Study space (2.8/8), Classrooms (2.9/8), Lounge (4.7/8)

*Student Concern***:** Students felt strongly that the amount of medical student study space should be increased and that there should be classroom renovations throughout the Bio-Medical Center, including better chairs, lighting, climate control and AV equipment. They also expressed some concern that the amount of medical student lounge/recreational space should be increased.

Response: A number of important steps have been taken already to address this concern. Pembroke Hall has been reopened for medical student use beginning with the time period needed for preparing for Step 1 of the national boards. Discussions are underway with University officials to make the assignment permanent. Many improvements have already been made in the classrooms. Room 202 underwent a $50,000 renovation in the summer of 2000 that provided new rugs, chairs, paint and hanging plants. Room 291 (Eddy Auditorium) is scheduled for a similar face-lift in the summer of 2001. We are exploring ways in which to enhance the technological capabilities of Room 291. Currently, the AV technology in the BMC is considered among the best on campus and the building is staffed with professionals with expertise in all the equipment.

As mentioned in the student senate report, new space will open in the BMC when the new life sciences building opens, however, short-term solutions are needed now. Peter Holden and the physical facilities committee have been looking at ways to improve the existing space in the BMC. A proposal to reorganize the student lounge and the lounge space next to the mailboxes to make the area more functional is currently being put together. Consideration is being given to purchasing two computers that could be attached to moveable carts and used by the students in the basement study rooms.

Even with some of these changes, space is a perennial problem at Brown for both study and classroom space. Most of the rooms in the BMC are university controlled. We are working with the university to increase space in the building for medical student use. Currently, room 202 is reserved for the second-year medical school class and 291 is reserved for the first-year class. The primary purpose of these rooms is for medical school class space. Its secondary purpose is to serve as a multipurpose meeting space for the Division of Biology and Medicine. For study purposes students can use other rooms for study purposes by reserving them through MDL. Card access makes these rooms available at all times. Still, study space is scarce. Students can reserve study carrels by filling out a form available at the circulation desk at the libraries and bringing it to Alex Morang for her signature.

The physical facilities committee is currently working with Peter Holden to design a detailed proposal that will meet the needs of the student body. A student lounge with recreational space, study areas, phones, photocopying machines, computers and other

equipment is part of that proposal. When completed, the proposal will be used in the final planning for renovations for the Biomedical Center.

Library Resources (3.1/8)

Student Concern: Students felt strongly that the library resources for medical students need to be improved.

Response: During the 2000–01 academic year, the library has added access to over 3,000 electronic journals, including 350 new clinical journals. A new proxy server has been installed which is making it easier to access electronic resources from off-campus. This year the library also added STAT!Ref, a database of 30 medical textbooks.

The medical school is committed to doubling the budget for the medical library through a combination of the capital campaign and the appropriation budget over the next three to five years. This will enable the library to add new journal titles, to acquire back files of online journals, and to add monographs. The library works continually with its users to determine the most useful mixture of journal subscriptions and book acquisitions.

The Library is reducing its reference collection on Level A at the Sciences Library. Once this project is completed, an area will be set up for medical students on Level A. The area will include medical textbooks and some research tools, workstations, and a sign stating that this area is for the medical students. This project should be completed by the fall of 2001.

Computers and Web Access (4.9/ 8):

Student Concern: Students were moderately concerned that the Biomedical Center needs more computers and web access in the small group rooms in the basement. Students remarked that at peak hours, the Biomedical Center computer cluster is very busy and it would be useful to have more computers. More importantly, students noted that existing computers and printers must be maintained at a functional level and replaced when they become outdated (underlines in the original report). Students also pointed out that it would be very useful to have computers in the small group rooms in the basement so that Internet resources could be accessed during small group discussions.

Response: The medical school reviews technological needs on an ongoing basis and is working to improve both hardware and facilities as well as technical support.
Staff checks the cluster daily, restores software on all machines regularly, and makes sure any broken equipment is sent to repair immediately. The computing office provides staff consulting and its number is posted.

Equipment is replaced a minimum of every three years and often more frequently. The replacement schedule is more generous than the one kept for faculty and staff equipment. Installation and maintenance of computers in the small group rooms is complex, because of the many uses to which those rooms are put. The computing office is examining the issue and will make a recommendation.

In response to the concern expressed in the report, a committee of faculty, students and staff will be formed to deal with computer related issues. It is expected to begin its deliberations by mid-April.

Parking (5.1/8)

See Section 8 discussion under the autonomy paragraph.

Call Rooms (5.9/8)

See Section 9 discussion under advocating for medical school interests at the hospitals.

Medical School Sign (6.2/8)

See Section 8 discussion under the autonomy paragraph.

5) Quality of Student Life

Social interaction between the classes (2.5/6)

Student Concerns: Students felt strongly that there should be more social activities and interactions between the classes.

Response: As the report notes, the social committee of the Medical Student Senate is largely responsible for developing opportunities for students to interact socially, and our primary goal in responding to this concern is to ensure we support student efforts. In an effort to increase social activities and interactions between the classes, this fall the second-year peer mentorship program was revised. Each year, second-year students are matched with entering first-year students. At the beginning of the year, the student affairs office sponsors a number of events. Additional outdoor trips and sports activities for all four classes are being explored. The student affairs office also sponsors student-initiated social events that are open to all medical students and will continue to do so. These social activities could also include the graduate school population if more interaction is desired there. The report made several recommendations on ways the medical school can interact with the graduate school that will be explored this year.

Because third- and fourth-year students have so few opportunities to interact, there is a proposal for a new student-to-student mentoring program. Volunteer fourth-year students would be matched with third-year students during third-year orientation. Fourth-

year students would offer advice on scheduling electives and rotations, residency planning, student affairs and other resources as well as their own career decision-making process. A kick-off dinner would start the program.

Student–Faculty Forums (3.1/6)

Student Concerns: Students expressed their hope that the medical school would promote more student and faculty interaction through such activities as shared forums similar to the one conducted in January 2000.

Response: It is proposed that one or two student–faculty forums be held each year. One forum will be held in the fall and/or one in the spring. Faculty and students will be involved in the planning. The overall theme of the forums will be training physicians to fulfill the medical school mission. Potential topics include professionalism, leadership, caring for the underserved, and cross-cultural health care. Forums will involve faculty and students in all four years, and will complement not duplicate other curricular and extracurricular offerings, providing a broader perspective on medicine.

A follow-up meeting will be held in February to continue planning a forum—to set dates, propose a format, and to obtain faculty and student input. Key administrators will be identified who will comprise a task force to begin the planning process for the student–faculty forums for the 2001–2002 academic year. Students and faculty will be invited to participate in the planning process including the members of the Committee on Multiculturalism. The goal is to conduct one forum in the spring of 2001.

Streamline Student Groups (3.5/6)

Student Concerns: Students requested an effort to streamline and improve communication between student groups. This year, for example, there are more than 25 formally recognized student groups within the medical school, many with overlapping goals and objectives.

Response: A Patient Advocacy Coordinating Council has been formed to enhance coordination and cooperation between the various student organizations. This student-led council will address coordination of meeting times. The Office of Curriculum Affairs staff will be available to coordinate and financially support collaborative activities of interest groups that focus on patient advocacy initiatives. In the Biomedical Center, a student organization office will be set up in the near future where student groups may store files and related materials. Also, we will place in the office space a large “Mark ‘N Wipe” monthly planner as well as a three-month planner so organizations can note what student activities will occur during the current month or semester.

Interaction with Graduate Students (3.9/6)

See discussion above on social interactions among the classes.

Brown Daily Herald (4.2/6)

See below on page 29, Information about Campus Events.

Outdoor Trips/Sports (4.2/6)

See discussion above on social interactions among the classes.

6) Financial Aid

Institutional Funding (1.7/3)

Student Concerns: Students asked that institutional funding be increased.

Response: With a fund raising goal of $18 million, medical school scholarship support is the second highest priority in the medical school's ongoing capital campaign. Thus, the medical school shares students' concerns about the priority for increased institutional funding. Realization of this goal has the twofold purpose of minimizing the educational debt levels of our current students while improving the medical school's ability to enroll a more socioeconomically diverse student body.

The Medical Student Senate report recommended that the assignment of institutional funding be independent of the amount that students are awarded by outside scholarships. Federal regulations (and most private foundations) unfortunately do not permit a student to retain financial aid funds that are in excess of the annual cost of attendance unless such funds are for educationally related expenses. Our financial aid policy has always required private funding to be utilized in a manner that is most beneficial for the student. In the overwhelming majority of situations, the receipt of such funding reduces the student's least favorable loan, usually the unsubsidized federal Stafford loan or replaces part of an unrealized parental contribution. While no change in this policy is planned, the Admissions and Financial Aid Office will emphasize in its annual award notifications that students with unusual expenses should contact the office to inquire as to whether such expenses may be covered by additional private funding.

Another recommendation was to provide more low-interest loans. Beginning with the 2000–2001 academic year, the medical school received a $1,000,000 grant to offer need-based loans to medical students. Income generated from this grant (about $35,000) was awarded to the first group of borrowers this year. These loans have no application fees, are interest-free during the in-school period, qualify for up to three years of deferment during residency training, and are repayable at a fixed rate of 5%. Preference was given to fourth-year students this year in order to accelerate the availability of funds to subsequent borrowers.

The director of admissions and financial aid is exploring ways to improve the terms of institutional loans. One proposal seeks to reduce the interest rate from 9% to 6%, extend the residency deferment period from one to three years, allow for a fellowship deferment, and provide a cancellation clause for death or disability. We are hopeful that these improvements will be approved and will go into effect for the 2001–2002 year.

We are also working to increase the medical school's allocation of Perkins loan funds from the university. Perkins loans are low-interest federal loans that offer many desirable deferments and cancellation provisions that are not presently available in our institutional loan programs.

The report recommended that the medical school provide additional support for "extra costs" such as medical equipment, board review classes, and travel for residency interviews. The first-year student budget has always included an allowance for the purchase of a diagnostic kit at the end of the year. The allowance increased from $580 to $600 in the 2000–2001 year. The financial aid assistant director consults with the medical equipment vendor annually to determine the cost of a midrange kit.

In the December 2000 issue of *The Pulse*, the Office of Admissions and Financial Aid announced the availability of institutional loans to cover the cost of board review classes for a limited number of students. While preference is given to recipients of institutional aid, all financial aid recipients may request financial support. Students who believe that they would benefit from a board review course or from practice exams or other types of preparation are encouraged to contact learning specialist Phil Tetreault for more information.

Unfortunately, since residency interviews are not a requirement for graduation, federal regulations do not permit medical schools to include the expenses associated with them to be supported with financial aid. However, there are several market-rate private loans that allow credit-worthy students to borrow up to $10,000 per year for interviewing and relocation expenses. Although the interest rates tend to be higher than in other loan programs, borrowers are able to defer payments for up to four years during residency and choose flexible repayment plans thereafter.

Often, the medical school can help students absorb these expenses if they arrange an away elective to coincide with the residency interview season. In those instances, the financial aid office can increase a student's budget and thus the student's loan eligibility to cover the cost of the away elective (most importantly, airfare and housing) and thus help the student pay for most, if not all, of the interviewing expenses.

The report recommended that the financial aid office send students their summary sheet each year at the time that they must complete the financial aid forms for the following year to make the paperwork easier. The financial aid staff sincerely appreciated this suggestion. Last month, the office enclosed with each financial aid application booklet a personalized, cumulative summary of the student's educational debt divided

by the academic year and by loan program. To the extent possible, data regarding debt incurred prior to enrolling in the medical school was included. This information was cross-referenced with data from the National Student Loan Database System and other sources.

Explaining tuition increases (2.0/3)

Student Concerns: Students requested that the use of tuition dollars and annual increases should be explained to them.

Response: As a result of this suggestion, the customary letter from the dean to the students announcing the change in tuition was modified to be more informative. Additionally, the full text of the medical school's report to the Budget & Finance Committee of the Brown Corporation was put on the medical school's web site. The letter to the students and the report to the Budget and Finance committee can be found at http://biomed.brown.edu/deansreport/index.html.

Socioeconomic Diversity (2.3/3)

Student Concerns: Students were mildly concerned that there needs to be a greater commitment to increasing the socioeconomic diversity of the student body. Students recognized the value of socio-economic diversity as an ideal and noted the advantages of having classmates from a variety of socioeconomic backgrounds.

Response: The medical school administration enthusiastically concurs. Two years ago, in anticipation of new income from the capital campaign, we began to admit a PLME entering class in which over 50% of the matriculants qualified for financial aid, compared to 35% to 38% in previous years. Last year, approximately 53% of the entering class of PLME students received financial aid. While we are pleased with these results, our ability to sustain these percentages with future classes will depend upon the success of the capital campaign in raising additional scholarship funds. If all goes according to plan, the medical school should be need blind within the next several years.

Effective for the 2000–2001 year, the Financial Aid Policy Committee approved a change that reduced the base loan requirements for institutionally aided students from $23,700 to $22,000. (The base loan is the amount that a student must borrow before he or she is eligible for scholarship support.) This policy change resulted in over 90% of financial aid recipients receiving an increase in their scholarship over the previous year's amount. The lower loan requirement coupled with the inevitable increase in student budgets resulted in students receiving an average scholarship increase of $3,000.

Although we were not able to further reduce the base loan for the 2001–2002 year, the majority of students nonetheless will continue to receive increases in their scholarships next year because budget increases will be absorbed by commensurate increases in scholarship funds.

The report also recommended that the medical school make a strong commitment to increasing the socioeconomic diversity of the student body and allow that principle to dictate changes in admissions and financial aid policy. We endorse this principle and have planned for an expansion in the Early Identification Program. We will include an additional linkage with an undergraduate institution that enrolls significant numbers of underrepresented minority and disadvantaged students, perhaps an historically black college or university or a school that is a member of the Leadership Alliance. The director of admissions and the associate deans for minority affairs will explore this recommendation in depth in the spring of 2001 with a target of establishing the linkage effective for the 2001–2002 year.

We are working to ensure that the composition of the admissions committee reflects faculty, students, and others who themselves fulfill the spirit of the mission statement and who represent the socioeconomic and ethnic diversity both currently represented and sought in our student body. Some progress has been made in this area for the 2000–2001 year, but more work needs to be done in the 2001–2002 year. With the assistance of the associate dean for faculty affairs, the director of admissions will identify potential faculty whose backgrounds and work experience demonstrate a predisposition for promoting socioeconomic diversity.

7) MD2000

Progress in Integrating MD2000 into the Medical Curriculum (2.2/6)

Student Concerns: Students felt strongly that MD2000 needs to be better integrated into the curriculum with more faculty support and fewer "extra assignments", and made a number of specific suggestions for improvement.

Response: While good progress has been make in implementing our competency-based curriculum, much still remains to be done. Below are noted some of the major benchmarks we have reached as well as a discussion of the remaining challenges that still need to be addressed.

Course Certification: All preclinical and clinical courses had been certified to address one or more of the abilities by the end of academic year 1999-2000.

Performance-based Assessment in Preclinical Courses: Performance-based assessment tools are employed in Bio 181–*Human Morphology* prosection; Bio 371– *Medical Interviewing* (direct observation); and Bio 373/374–*Introduction to Clinical Medicine* (direct observation by a preceptor and standardized patient physical examination). This year in Bio 158–*Medical Microbiology* and Bio 372–*Epidemiology* students read and report on research articles that promote critical analysis and lifelong learning skills.

While we are making progress in employing performance-based assessments that measure more accurately students' basic science skills and their beginning level of

clinical competence, we need additional forms of such assessments at the preclinical level. As course leaders begin to use more widely innovative technology, new performance-based assessment instruments will likely be incorporated into the curriculum.

Performance-based Assessment in Core Clerkship and Other Required Clinical Courses: In all of the core clerkships, as well as the sub-internships and the longitudinal ambulatory clerkships, there is now a common evaluation instrument employed to assess student competency in the abilities at the intermediate and the advanced levels. In the medicine, family medicine, pediatrics, and obstetrics and gynecology clerkships, there are Objective Structured Clinical Examinations (OSCEs) that assess student clinical competence. The fourth-year OSCE also addresses the **MD2000** competencies. In addition, the completion of a basic clinical skills procedural log is now required of all graduating medical students.

We need additional performance-based measures in the core clerkships and the sub-internships. Toward that end, the restructured eight-week surgery clerkship may add an OSCE in order to assess clinical skills. We will also meet with sub-internship directors to discuss the development of an OSCE in this four week advanced course.

Lastly, with the new graduation competency requirements instituted by the Accreditation Council for Graduate Medical Education (ACGME), residents' directors will also need to employ performance-based assessment measures in assessing the residents' clinical competence. Joint assessment projects involving both residents and medical students will help us expand our use of innovative evaluation approaches.

MD2000 Faculty-Development Activities: To educate the faculty and residents in our new competency-based curriculum, the medical school currently offers these workshop activities:

1. The curriculum affairs office holds two annual faculty-development workshops that are open to all faculty. These workshops center on issues related to our competency-based curriculum.

2. Each September, the Office of Curriculum Affairs (OCA) hosts a new faculty orientation meeting in which we discuss our competency-based curriculum.

3. Each January, the curriculum affairs office holds a workshop for preclinical course leaders on improving instruction and evaluation.

4. In the spring 2001, OCA staff will meet with residents and resident directors to discuss the challenges of teaching medical students and how the office may be helpful in enabling clinical faculty and staff to understand better our competency-based curriculum. Staff will also discuss with residents effective ways to evaluate our students' clinical competence.

The curriculum affairs staff is also in the process of developing an assessment handbook for faculty that will detail how preclinical courses and clerkships, the subinternships and the longitudinal ambulatory clerkships are addressing the abilities. This material will be placed in course syllabi for students' review. Moreover, in the handbook there will be a compendium of other assessment tools that course leaders might incorporate in their courses for assessing the nine competencies.

The report recommends that the implementation of the curriculum be suspended until competency requirements have been fully defined. Requirements for obtaining each of the nine abilities have been substantially defined and made operational. However, some requirements will necessarily have to be changed in light of evaluation data and recommendations by students and faculty to strengthen or improve the assessment process. Starting in academic year 2001–02, all **MD2000** requirements will remain stable and none will change during "midstream." We anticipate no major new requirements being introduced in the next several years.

Another recommendation of the report is that the criteria for advanced-level competency need to be realistic. The criteria for obtaining the advanced level in Ability VII–*The Social and Community Contexts of Health Care* and Ability VIII–*Moral Reasoning and Clinical Ethics* have been clarified and make more realistic to obtain. For instance, last academic year, no students received advanced-level competency in Ability VII. This year, so far, three students have been awarded Ability VII advanced-level competency credit.

The Ability VIII–*Moral Reasoning and Clinical Ethics* assessment committee will present to the Medical Curriculum Committee in February new guidelines for students gaining advanced level competency credit. The criteria in the other abilities are realistic and many students satisfy these competencies at the advanced level.

Students voiced concern in the report about the ways in which students had to demonstrate competence. In particular, objections were raised about having to write three to five page essays. The responsibility for assessing student competence rests with the course leaders. Those who require a written assignment in order to evaluate whether students have obtained a competency have been informed of students' concerns and have agreed to explore ways to develop alternative assessment strategies that are more related to day-to-day clinical activities.

Assess MD2000 (3.0/6)

Student Concerns: Students requested an assessment of the benefit of MD2000 to their medical education.

Response: For the last three years, we have employed an outside evaluator to assess the effectiveness of our competency-based curriculum. These findings have been conveyed to the dean, the provost and an institutional assessment committee composed of leading educational evaluators. All major recommendations have been acted upon. The

evaluation reports include the views of students, faculty, and administrators. These reports are available to students upon request. During the spring semester, we plan to interview recent graduates of the program who are now in the first year of their residency. This data will be presented to the Institutional Assessment Committee at its June meeting.

We also receive yearly formal feedback from graduating fourth-year students via the medical school graduation questionnaire and through our individual consultations with fourth-year students. Recently, at the suggestion of students, we were invited to attend first-year and second-year class meetings each semester at which **MD2000** concerns can be discussed. So far, we have implemented each student suggestion brought up in these meetings. These meetings with the first-year and second-year classes will be conducted on a regular basis each year.

It should be noted that student views of the effectiveness of our competency-based curriculum have varied widely as the innovation has been implemented over the last five years. We hope that by addressing the concerns and recommendations of students in this report that we will improve the quality of our curriculum innovation.

Timeframe: Ongoing evaluation and assessment of our competency-based curriculum.

Guidance on How to Meet Requirements (3.2/6):

Student Concerns: Students requested more guidance on how students can meet **MD2000** requirements, and noted that the requirements for a given ability do not seem to be consistent and often vary depending on which administrator students speak to.

Response: For the past two years, we have been developing an **MD2000** advising system that we will expand next year, particularly in light of student concerns and recommendations contained in the Medical School Student Senate's report.

At this time, **MD2000** handbooks are provided to PLME students, first-year and second-year students and third- and fourth-year students. Curriculum affairs staff meets individually with all fourth-year medical students to help them plan their program to meet the competency requirements at the intermediate and the advanced levels. This academic year, staff met with incoming first-year students, particularly postbaccalaureate students, and with Brown–Dartmouth students and other transfer students who are starting their third year. Two meetings are also held with the first-year class, first during orientation and then later at a class meeting. Similar meetings will be conducted next year. At these meetings, ability assessment committee chairs will address students' questions on the meaning and importance of their respective abilities.

A hard copy of student progress in meeting the abilities is now being sent to first-year and second-year students at the end of each semester. Copies of competency attainment charts are sent to each third- and fourth-year student at appropriate times during the

year, for example, after quarter II or III in the third year, at the start of the fourth year and in February or early March of the fourth year.

Make the Process for Retroactive Credit Less Burdensome (3.7/6):

Student Concerns: Students were moderately concerned that the process to apply for retroactive credit should be made less burdensome, especially for postbaccalaureate students.

Response: Obtaining retroactive credits is normally necessary for only two abilities: Ability VII–*The Social and Community Contexts of Health Care* and Ability VIII–*Moral Reasoning and Clinical Ethics*. Recently, The Ability VII assessment committee simplified the process by which students may gain retroactive competency credit at the beginning level for previous community service or research. Particularly, postbaccalaureate and EIP students will now only have to discuss their experiences with Office of Curriculum Affairs staff and present, only when necessary, documentation of their successful completion of the community service or research projects.

Likewise, Ability VIII–*Moral Reasoning and Clinical Ethics* has developed a simplified process that reduces paper work. Students need only submit to the assessment committee a course syllabus of a past ethics course to receive competency credit. At colleges and universities where students are part of the Early Identification Program, we have certified ethics courses that may be used to gain Ability VIII competency credit at the beginning level.

Standardize Competencies Across Electives (3.8/6)

Student Concerns: Students were concerned that faculty were not applying the same standards in certifying competency across the curriculum. Students were also concerned that not all faculty were adequately informed about the competency-based curriculum.

Response: Initially, when implementing **MD2000**, there was a consensus among assessment committee members that it was very important that course leaders have discretion in determining which ability(s) they wish to address in their electives. Balancing the needs of a school wide curriculum with the rights of the faculty to determine what and how they will teach is a challenge in every medical school, and one from which Brown is not immune. We will continue our ongoing efforts to monitor and discuss this matter with the faculty.

As the assessment committees review courses, they will be asked to address the standardization issue, particularly in regard to the various community-service/research projects that students undertake for Ability VII–*The Social and Community Context of Health Care* competency credit.
Also, some elective course leaders certify a student for an ability at either the intermediate or advanced level— given the student's performance and/or the number of weeks

the student spends in the elective. (For example, it is hard to assess a student's level of performance at the advanced level if s/he takes the elective for only one week.) Until the Medical Student Senate report, we were unaware that "students who are enrolled in the same clerkship or elective are often granted different level of competencies. The Office of Curriculum Affairs will email third-and fourth-year students asking them to identify such instances. We will then contact the course leaders and work out a more equitable and systematic certification process.

In several clerkships which certify for Ability VII–*The Social and Community Contexts of Health Care*, students do not automatically gain these competency credits by completing the normal clerkship activities. This ability is optional in these clerkships and competency credit is given depending on whether a student completes a special project. This is a temporary arrangement until the new community health clerkship is in place in academic year 2001–02. This clerkship will then certify for Ability VII.

In the past, the medical school has held information sessions with department chairs and faculty, but this has not been done on a regular basis in the last two years. We will implement the suggestion that we hold regular information sessions to make the faculty more knowledgeable in our competency-based curriculum. Curriculum affairs staff will attend course faculty meetings as well as attend department meetings. In addition, the director of the Office of Curriculum Affairs will now sit on the Graduate Medical Education Committee composed of Brown Medical School residency directors. Through these monthly meetings, he will be able to disseminate information on **MD2000** as well as engage in joint planning with residency directors in addressing similar competency-based curriculum issues.

In regard to students gaining information as to which abilities are addressed in a course, the OCA staff has included the information in the elective catalog that is in hard cover and on line through the web. The curriculum office also has distributed bookmarks that list the competencies addressed in the preclinical courses, the core clerkships, the sub-internships and the longitudinal ambulatory clerkships. The MD2000 handbook for the fourth year also contains a list of all the electives and the advanced competencies they are certified to give.

In March 2001, medical school administrators will attend a workshop on developing uniform answers to substantive **MD2000** questions and concerns. The Office of Curriculum Affairs will also develop written responses to substantive questions that will be published in the various **MD2000** handbooks.

MD2000 Web Program (4.8/6):

Student Concerns: Students asked that the **MD2000** web program, MedPlan, be made more accessible to students.

Response: MedPlan is now accessible from the computer cluster on Macs and PCs. It can also be accessed on any Brown computer and by spring 2001 it will be accessible

on the web. Directions on how to access MedPlan are found in the computer cluster and will be sent to all students. Directions are also included in many Office of Student Affairs and Office of Curriculum Affairs publications. The medical student handbooks provide information on what abilities require independent work and which abilities are met by successfully completing a course.

Timeframe: MedPlan will be online by April 1, 2001.

8) Relationship to the University

Autonomy (1.7/4)

Student Concerns: Students urged more recognition for the medical school by the University as an autonomous body with unique needs, and remarked that the medical school is not physically visible within the University campus.

Response: Questions about autonomy arise from several sources, of which the geographic separation of the various parts of the medical school and the organization of the Division of Biology and Medicine are the most important.

Many medical schools occupy a single campus; some others, like Brown, have the sites for clinical instruction separate from those for the basic sciences. There is little question that the arrangement in which we find ourselves promotes closer associations of faculty on the Brown campus with their colleagues from the college than with those in the hospitals. Efforts to bring the campus-based and hospital-based faculty together more have not been very effective because they cannot meet on a daily basis. While additional steps can and should be taken to bridge this gap, there is no prospect of moving the medical school completely off the Brown campus.

The Division of Biology and Medicine contains the medical school and the Program in Biology. This organization permits the creation of a single faculty, responsible for the medical school basic sciences and graduate and undergraduate education in the biological sciences. Many other universities have biology departments that are separate from the basic sciences in the medical school. Such arrangements are redundant and wasteful. The organization at Brown is much more efficient, and provides a stronger faculty in both the medical school and the college than either could have alone. The perception that the Division reduces the autonomy of the medical school is probably correct to some extent, but the offsetting advantage of the quality and quantity of the faculty that results is more than sufficient compensation.

The Biomedical Center, the Animal Care Facility, and the Grimshaw Gudewicz Building constitute a physical complex that is the single largest at Brown. The new Life Sciences Building, which will adjoin the complex, will be the largest single building on the campus. These are all medical school buildings, and they give us a physical presence that dwarfs anything else at Brown. A concern raised by others in

the University in response to these plans is that the medical school is coming to dominate the rest of the campus. We plan to place a sign in front of the Biomedical Center identifying it Brown Medical School. An architect is currently designing the sign and, if all goes according to schedule, the sign should be ready for the opening of the next academic year in September 2001.

The report recommends that the medical school calendar be uncoupled from the undergraduate calendar so that first- and second-year daily schedules are not so compressed, thus allowing medical students more time to learn the huge amount of material. The linkage of the calendars has been a long-debated issue in the medical school. Medical school courses in the first two years generally use the same recitation blocks used by classes in the college and graduate school, and have done so since the inception of the medical school. The purpose is to allow students the flexibility of taking courses in the college, medical school, and graduate school simultaneously. As noted in a previous section of this response, the opportunity to integrate course selection is considered an attractive and important feature of Brown's medical program.

The main thrust of the senate report, however, is on decompressing the density of material by extending the length of the semester. This has, in fact, been done at the students' behest. The second-year spring semester for the medical school starts in the first week of January for pathophysiology. The introduction to clinical medicine course begins in the last week of August. Skeptics of the change in the length of the semester believe that the increased time would be filled with more content rather than resulting in decompression. This appears to have been the case, though the first three weeks of the spring semester are less intense because only the pathophysiology course is running. However, this has also caused some problems with the goal of integration between pathophysiology, pathology, and pharmacology. Anecdotally, the administration is also hearing complaints from second-year students that the winter break is now considered too short.

The changes in the last few years demonstrate that the medical school is willing to modify the calendar in response to student concerns. However, the changes do not seem to have addressed the basic underlying concern that the medical curriculum is too dense. Also, the changes appeared to have had some of the negative consequences that were predicted, namely, addition of content rather than decompression and a feeling that the vacation time is too short. In addition, January Term opportunities are more limited because of the early start.

The administration remains committed to being responsive to student concerns. In this spirit, we suggest that a review of the changes in the calendar be conducted by the MD Curriculum Committee to assess the effect.

The report recommends that actions be taken to make the medical school more prominent in the minds of the university faculty. The administration agrees with this goal. However, this presents a challenge because Brown prides itself on being a "university–college" that is distinguished by its emphasis on undergraduate college education.

Brown has no professional school other than the medical school and has resisted any proposals to increase the number. Cultural mindsets change only slowly. Nevertheless, we believe that university faculty is more aware of the medical school's contributions and importance to the university. In its short history, the medical school has developed an excellent reputation among U.S. medical schools. The medical school has invested heavily in those areas designed to increase its within the university. This includes supporting a staff position in the Brown News Bureau, adding its own communication specialist to its core staff in external affairs, publishing *Brown Medicine* and integrating its development office staff with the university development staff in the same location. The new president, Ruth Simmons, has given an early indication of her strong support for the medical school. The university recognizes the PLME as a value-added component of the university that attracts the best and the brightest to Brown. The medical school's service to the community, which will now be strengthened even further with the addition of the associate dean for public health and public policy, Dr. Terrie Wetle, enhances the university's connections to the community. The substantial research effort of campus-based medical school faculty is a source of pride for the university, and provides important scholarly collaboration with faculty in other departments that enhance their own research efforts. With continued attention by the administration and with the passage of time, we remain confident that the medical school will become an increasing part of the consciousness and source of pride of the university faculty.

The report recommends that the university provide more parking facilities for medical faculty and students. This reflects a long-standing problem and source of irritation, especially to hospital-based faculty coming to campus to teach, do research, or attend meetings. The reinstitution of the shuttle between Rhode Island Hospital, the Jewelry District, where many faculty research laboratories are now located, and the Brown campus, will provide some relief. The university is working to develop a comprehensive plan for parking, which will benefit students, faculty, and staff.

Sense of Community (2.5/4)

Student Concerns: Students want more of a sense of community within the medical school. The report suggested that ways be found to make faculty feel more connected to the medical school through monetary compensation, teaching recognition, and interaction with the university and with students outside the classroom setting.

Response: The student report accurately points out the challenges that face us in creating a sense of community as a medical school. The administration agrees that this is a problem that the medical school should address more vigorously. The new associate dean of medicine for faculty affairs will be asked to make recommendations to the dean of medicine on ways to create a better sense of community among all our faculty in the Division of Biology & Medicine. The new associate dean will be named by the end of the winter. The recommendations should be ready by the end of the calendar year.

The report recommended monetary compensation for clinical faculty. This has, in fact, been instituted for some hospital-based full-time faculty who teach in the first two years of medical school. We are working to extend the plan to all full time hospital-based faculty who teach in the first two years.

The medical school recently created a new position of associate dean for clinical faculty. This dean, Dr. Faiza Fawaz Estrup, works to develop that very same sense of community and belonging alluded to in the report among the clinical voluntary faculty. New programs have been instituted that provide more recognition for excellence in teaching among the voluntary faculty as well as more faculty development workshops and programs tailored specifically to the needs of the voluntary faculty. The response from the clinical voluntary faculty to this recognition from the medical school has been gratifying.

The issue of space in the Biomedical Center for students, administrative staff, and faculty was commented on previously. Creating a space where medical students from different classes can interact with one another will be a high priority in redesigning the terrace level of the Biomedical Center once the new research building is completed.

The report recommended that vertical integration of students in affinity groups be instituted so that undergraduate PLME students could be in the same group as first- and second-year medical students. The affinity group program is actively studying ways to accomplish this and should have a plan ready by this spring. In the meantime, first-year medical students are being paired with a second-year medical student in the mentoring program. As the program matures, each student should be paired with a student a year behind and a year ahead in the medical school, thus enhancing linkages across classes.

Students asked that clinical conferences and hospital events be advertised to the entire medical school. The Office of External Relations is engaged in discussions with the Medical Student Senate on ways to enhance communication, not just about conferences, but broadly on a wide range of issues.

The report urged that more ways be created to support and achieve the mission of the medical school so that students feel that Brown is “the best” at something. This is addressed below in Section 10–Relationship to the Community, under “Advocacy and Activism.”

Exemptions from Registrar policies (2.8/4)

Student Concerns: Students were moderately concerned that the medical school should be exempt from certain University Registrar policies regarding specific medical school and bio-medical center issues (e.g. room reservations, exam schedules, etc.)

Response: The medical school is required to follow the policies set up by the registrar’s office. However, we do have a degree of autonomy. For example, a separate un-

official medical school transcript (the grade card) exists and is used within the medical school. This can be updated daily and reflects the medical school's grading system of H/S/NC. Students use this transcript for a variety of reasons including scholarship and residency applications. The official transcript will remain under the university. Strides have been made to improve the official transcript. As of 1999, the grade of honors is included on the university transcript.

The curriculum office, not the registrar, dictates the second-year medical school exam schedule. Even though most first-year courses have their examination dates set by the registrar, the medical school has been permitted to alter those dates when appropriate. This is done in conjunction with the registrar's office and has not been a problem. As stated earlier, the university currently controls most of the rooms in the BMC and has no plans to relinquish this control.

Information about campus events (3.0/4)

Student Concerns: Students asked that information about campus events should be more formally communicated to medical students.

Response: The Dean's office is creating a centralized calendar for the medical school. We hope to have at least a static format calendar this spring and will work to enhance its capabilities over time. Arrangements have been made to deliver the *Brown Daily Herald* to the BMC. As you are all aware, the Brown Daily Herald and the George Street Journal are available on the Brown University web site. Email blitzes will be sent out via the medical school listserv advertising programs of interest to medical students.

A calendar of events was recently created for the second-year class listing all spring semester programs and events. A similar calendar will be created for all four classes and given out at the beginning of each semester.

9) Administration

Advocating for Medical School Interests at the Hospital (2.4/5)

Student Concerns: Students urged the administration to advocate for medical school interests in relationships with the affiliated hospitals. Specific issues were listed.

Response: Health care in the United States is undergoing a complete reconfiguration driven by concerns about costs. Although not singled out for special treatment, teaching hospitals and the physicians who work in them have been impacted severely. As a result, administrators are preoccupied with costs, and have less opportunity to address academic needs. The problem is not unique to Brown, and it is as severe in many university owned hospitals as it is in those that are not. Despite this state of af-

fairs, the administrators at Brown's affiliated hospitals have sought to be responsive to the needs of Brown medical students who are serving their clerkships.

The student affairs staff hold regular meetings with third- and fourth-year medical students at the affiliated hospitals at which these issues are discussed. Following each of these meetings, Dean Smith contacts the hospital president and key faculty to report concerns expressed by students. As a result of these communications, student concerns about issues such as parking while on call, access to the library at night, internet connections, and on-call room availability have been addressed and rectified. These meetings are continuing.

Communication and Personal Interaction (2.7/5)

Student Concern: Students felt strongly that there should be more communication and personal interaction between students, faculty and administrators. Students noted that they have to go out of their way to get to know administrators despite the small size of the school. It is worth noting that students felt that some of the administrators were much more accessible and open than others. Students expressed frustration with the fact that different administrators often give different answers to the same question. Specific suggestions included:

- Establish the position of a liaison between administrators, faculty and students to facilitate communication and to ensure that one clear message is communicated to students.
- Move the administrative offices to the Bio-Medical Center.

Response: We are determined to improve communication and interaction between students, faculty and administration. Dionne Gomez now fills the position as medical school course coordinator. She is a single point of contact for students and faculty on matters related to courses during the first two years. Her office is in the Biomedical Center directly across from Room 202 (the Purple Palace).

To encourage more interaction between students and administrators, the Dean's Office will sponsor an annual get together for students and Medical School administrators.. The Dean's office will also commit to posting contact information, background and a photo of each of the top-level administrators on the Dean's Web Page to provide a greater sense of accessibility.

The Dean (2.8 / 5)

Student Concern: Students felt that the Dean should make more of an effort to interact with students in order to better understand their daily life and advocate for their interests.

Response: I maintain regular open office hours and schedule weekly luncheon meetings with students to establish and sustain my accessibility and willingness to discuss openly the concerns of the student body. These opportunities for student communica-

tion are listed below and will be posted on the web site along with additional special opportunities for interaction with the Dean as they arise.

I have open office hours the first Thursday of every month. My assistant sends out an e-mail reminder two weeks before. I encourage you to make an appointment by contacting my office at x3-3330 or by email to Melissa_Whiteley@brown.edu. In addition, I have been meeting students for lunch on a regular basis for the last six or seven years, twice in the fall and twice in the spring. The Medical Student Affairs office sends out email invitations. If you are interested in joining us please respond to the email or contact the MSA office at x3-2441.

I have been concerned about my lack of contact with third and fourth year students. I have sought ways to improve this communication, and admit I have not succeeded. I would welcome any suggestions from students.

In the fall of 2000, I launched, with my communications staff, a bi-annual *Dean's Letter* which addresses for students, alumni, faculty and friends the "macro-level issues that the medical school faces" and outlines my plans for addressing these challenges. The letter also articulates my strategic vision and the actions being taken to support it.

Already underway are plans for me to begin attending classes with students on a regular basis each semester. Some of these visits will be carefully planned in advance while others will be spontaneous drop-in opportunities.

This spring, I hired Ruth Kohorn Rosenberg in the newly conceived position of "Special Assistant to the Dean." Ruth is available on Brown e-mail, Ruth_Rosenberg@Brown.edu or by phone at x3-3336. One of her primary responsibilities is to act as special liaison between students and the Dean's office, bringing student concerns and special requests to my attention in a timely way and ensuring enhanced responsiveness to student concerns.

We recently added Stephen Smeaton, M.D. as web administrator for the medical school. The Dean's Office will be able to maintain a regularly updated web page to keep students broadly informed of important Medical School issues and of upcoming opportunities for interaction between students, the Dean and his administrative staff.

Specific Roles of Administrators (3.4/5)

Student Concerns: Students asked that more information should be provided to students concerning the specific roles and responsibilities of individual administrators.

Response: The administration is planning several meetings each semester with the first- and second-year classes. These have already been started and have proven quite beneficial. To clarify the roles of each of the administrators, new additions will be added to the medical school web page that will include pictures and clear job descrip-

tions for each of the deans, directors, and other administrative staff. An organizational table will also be provided to provide added clarity of roles, responsibility, and reporting lines.

From time to time in past years, students have been asked to evaluate the quality and effectiveness of administrative offices and administrators themselves. The report recommends that this be done. The administration agrees and will promulgate a regular cycle for these reviews

Moving the Administrative Offices (3.5/5)

Student Concerns: Students suggested that the medical school administrative offices should be in the same building as student classes.

Response: Moving the medical education staff to the Biomedical Center is also a goal of the administration. This issue has been discussed with the students on the Physical Facilities Planning Committee. The move will begin as space becomes available; it should possible even before the new research building is completed.

10) Relationship to the Community

Institutional Resources and Support (1.7/3):

Student Concerns: Students felt strongly that, in the spirit of Brown's mission of graduating socially responsible physicians, more institutional resources and administrative support should be provided in order to operationalize this goal. Specific suggestions included establishing an Office of Advocacy and Community Service, cataloging existing community service projects, creating a faculty fellow position in community service to mentor students, build in more time in the medical school schedule to allow students to participate in service activities, and to establish links with Brown alumni in other parts of the country who exemplify the socially responsive physician.

Response: The medical school administration endorses the students' goals. An important part of the educational process is learning through experience in the community, and the development of communication and organizational skills that are useful in a variety of settings involving persons of different ages, as well as cultural and socioeconomic backgrounds. Community-based projects and service comprise an important aspect of achieving this mission.

Several programs and departments within the medical school and across the campus have important functions and resources relevant to community-based service and learning. The newly developed Program in Public Health and Public Policy led by Dean Terrie Wetle is working closely with the affinity group program, the community health clerkship, the Swearer Center, and other programs in developing a collaborative strategy for identifying information and providing resources to medical students and

faculty interested in community service. One focus of this activity is identifying the many sources of information regarding community service opportunities and resources currently available across campus and to identify gaps in resources to be addressed. Catalogues of such activities are available through the affinity group program, the Howard Swearer Center for Public Service, and the community health clerkship.

The medical school also employs a service-learning coordinator, Bettye Williams, who works closely with student organizations that have a community-service focus. Ms. Williams works closely with the newly appointed health coordinator at the Swearer Center, Claudia Decesare. Together, Dean Wetle, Ms. Williams, and Ms. Decesare constitute a strong team to promote the medical school's mission of graduating socially responsive physicians. Over the next six months, they will propose a targeted strategy for improved coordination, information sharing, and resource identification for community-based projects and service.

Advocacy and Activism (2.0/3)

Student Concerns: Students were moderately concerned that the medical school should take a more active role in supporting community advocacy and activism by students. Students recognized a need for the medical school to put more effort into establishing and maintaining relationships with community members and agencies in order to foster a climate of mutual respect and collaboration

Response: The medical school is committed to fully realizing our mission of educating socially responsive physicians. We believe this is the heart and soul of Brown Medical School and what makes us stand out among medical schools. The medical school administration will work closely with the Medical Student Senate to make us "the best" in turning out future leaders who will be the "movers and shakers" of health care reform.

Since the time the data for the report was gathered, much has happened in this area. The medical school received a $198,000 grant from the Arthur Vining Davis Foundations to support activism and advocacy, a new associate dean of medicine for public policy and public health was appointed (Terrie Wetle, Ph.D.), a student-run free clinic was started, the MOM program was initiated by students (Medical Students Outreaching to Mothers-to-Be) and will be integrated into the first-year curriculum, two retreats for Brown students were held on activism and advocacy and regional meetings on the same subject are planned by the AMA-MSS (February 2001) and the SNMA (November 2001). A patient advocacy component was pilot tested in the second-year curriculum this semester with the expectation that it will be expanded and continued in the future.

In a similar vein, the Medical Student Senate requested that the dean institute a broad review of how well the medical school promotes professionalism. In response, the dean has charged the M.D. Curriculum Committee with that responsibility and a task force has been formed this semester to do that. The task force - includes broad repre-

sentation, not just from the medical school, but from other departments in the university and with the community.

A patient advocacy coordinating council has been formed consisting of leaders of all the medical student organizations and representatives from the administration and the Swearer Center for Public Service. The medical school has identified office space for all student organizations to share and has provided office equipment to support the student organizations. Grants for joint efforts by student organizations in the area of advocacy and activism are being provided through the Arthur Vining Davis Foundations grant and have so far been awarded for a spring health fair and a program on reproductive health advocacy and activism issues.

Faculty Involvement (2.5/3)

Student Concerns: Students asked that faculty should be more involved in student projects in the community. Students noted that this could be another way for students to identify clinical mentors early in their medical school careers.

Response: Brown Medical School faculty provide substantial community-based service both locally and regionally. They participate in a wide array of advocacy activities aimed at improving access and quality of services to selected populations, encouraging beneficial change in preventive care and health behaviors, and encouraging enactment of health policies that improve population health. Faculty also devote considerable time mentoring and providing other assistance to students involved in or planning community-based service. However, because there is not a systematic process for identifying and documenting this important community service, opportunities for collaboration with students and other faculty, or leveraging among service projects and activities are often missed. Moreover, competing demands and increased constraints may limit the capacity of interested faculty to provide as much assistance as they might want to.

Some progress had been made in identifying strategies for documenting and "crediting" relevant mentoring and service activities, and to provide administrative and academic support to students and faculty involved in such service. For example, the newly launched MPH program has targeted resources to a staff person responsible for serving as liaison between the university and the community internship placements (for example, with the Rhode Island Department of Health).

As effective models and strategies are developed for encouraging and supporting faculty for student mentoring and direct participation in community services, they will be promulgated throughout the medical school. Efforts will also be made to facilitate access to existing university resources, for example the new personnel in the Swearer center devoted to health-related projects. Discussions with external funding agencies are underway in an effort to identify resources for developing innovative programs to encourage community-based collaborations.

11) Issues of Race and Gender

Minority Faculty (2.2/4)

Student Concerns: The report called upon the medical school to make more of an effort to recruit minority faculty.

Response: In response to our own conclusion that Brown has an inadequately diverse faculty, a task force to improve recruitment of underrepresented minority members to our faculty has been formed. Dean Lois Monteiro serves as the chair. The membership will include administrators, the dean, faculty, two residents, and two medical students. The task force membership will be finalized and a meeting will be held in the late spring to establish the specific purpose, charge, goals, and timeline for the task force.

Baseline data will be gathered from Brown residency directors and department chairs regarding their plans and approaches to increase diversity among the house staff and faculty. The topic of workforce diversity will be included on the agendas of GME and Council of Clinical Chairs meetings. Current faculty from diverse backgrounds will be surveyed regarding any issues, concerns, or suggestions. A minority faculty reception and discussion will be held at the Faculty Club in April to promote dialogue with the medical school.

Curriculum (2.7/4):

Student Concerns: Students expressed mixed opinions on the need for greater emphasis of the influence of race, ethnicity, and culture on health and health care in the curriculum.

Response: Prior to the publication of the Medical Student Senate report, Dean Smith conducted a survey of faculty on the inclusion of cultural diversity in response to the Visiting Committee on Diversity's report to the university. The results of the survey indicated that little formal time was devoted to these issues in the planned curriculum, but considerable more teaching and learning occurred in the informal curriculum, including clinical teaching situations. In a national survey Brown medical students reported higher levels of confidence in their ability to practice in a culturally competent fashion than did other medical students. Brown students also performed well on OSCE stations designed to assess competence in multicultural medicine.

The results of this survey were shared with the Committee on Multiculturalism with the expectation that the committee would study the issue further and make specific recommendations to the dean. The committee has developed a draft of a medical student survey on diversity issues in the curriculum. The goal of the survey is to gather students' perspectives about how well the medical school curriculum addresses issues of diversity, and how well the curriculum prepares them to work with patients from different backgrounds. The student survey will be revised and piloted prior to admini-

stration this spring. A final report from the committee should be ready by the end of the semester or early in the fall semester.

Female Faculty (2.8/4):

Student Concerns: Students thought that more of an effort should be made to recruit female faculty. The report suggested that more female physicians be recruited to serve as course directors during the second year.

Response: The medical school administration is in full agreement with the Medical Student Senate that efforts should be made to recruit women medical faculty not only to serve as course directors for the second year medical school curriculum, but at all levels. The national problem, which exists to some extent at Brown as well, is the lack of women in leadership positions in academic medicine. This is a problem the dean is committed to solving.

Women faculty currently comprise nearly 30% of full-time medical school faculty at Brown. While faculty hiring and teaching responsibilities fall under the formal purview of each department, the Office of Faculty Affairs, the Office of Curriculum Affairs, and the Office of Women in Medicine (OWM) need to work with the departments in the process of searching for and hiring new faculty to further the goal of increasing the number and teaching role of women medical faculty.

A high priority for the OWM is to create a more visible female faculty cohort for medical students and for networking among faculty and medical students. For the past several years the OWM has offered a number of successful programs designed to achieve this goal.

Gender Discrimination (2.9/4):

Student Concerns: Students noted that gender discrimination still occurred in the clerkships. The report suggested that resources be clearly identified for students who feel that they have suffered from gender discrimination, that clerkship directors be encouraged to discuss gender discrimination with hospital house staff before students arrive on the clerkship, and that clerkship directors be encouraged to collect feedback from students regarding any discrimination they may have experiences during a clerkship.

Response: In the spring of 1994, the OWM surveyed Brown medical students regarding their experiences with gender bias and sexual harassment in medical school. In general, students' primary concerns were clustered in the area of what has been termed "micro-inequities" defined as "the common experience of being ignored or having lower expectations for success because of gender; e.g. women having comments ignored while the same comments by male peers are acknowledged. Also, gender-biased language, off-color remarks and sexually related jokes were noted. Students indicated

that they often discussed their concerns with their peers and chose not to speak to faculty or administration for fear of retaliation or being labeled as a troublemaker.

The booklet, "Preventing and Responding to Sexual Harassment and Sexual Assault, A Guide for Medical Students," was published in 1996 in response, and was well received both at Brown and nationally. Locally it was distributed to medical students, residents, faculty, and the administration. The guide is currently being revised.

As a next step, the OWM enlisted Dr. Patricia Recupero and Dr. Alison Heru of the Brown faculty to serve as independent, confidential resources for medical students seeking support and counsel on gender equity and sexual harassment. They offer educational programs for medical students on gender equity issues in medical school. Other medical faculty contacts and university procedures for reporting any incidents in these areas are listed in the Student Affairs Policy Handbook, (http://biomed.brown.edu/Medicine/StudentAffairs/SAPTitlePage.html). Each fall, the OWM distributes to medical students a description of the office's activities and programs, the medical school's Sexual Harassment Policy/Procedures, and the phone numbers and page number for Drs. Recupero and Heru. Drs. Heru and Recupero work to encourage medical faculty in a number of different leadership positions to provide leadership to their faculty on gender equity and the prevention of harassment.