Match ushers medical ed cycle: anticipation, hope, angst, realization

By Dr. Loretta Jackson-Williams

March comes along and everyone has a different thought and interest – spring break, the beginning of spring (officially!), St. Patrick’s Day, the NCAA basketball tournament . . .

For those of us in medical education, it is all about Match! This is the time when medical students find out where they will begin the next phase of their training. It is a time of great anticipation, hope, angst and realization.

I can’t help but reflect on my own journey in this process. I was a student in Massachusetts and had been on the Boston University campus for eight years (most of my adult life at that time!). One year as a senior undergraduate student, four years as a medical student and three years as a graduate student.

I had friends, mentors, colleagues and confidants who had shared my journey from a naive and idealistic college student from the Mississippi Delta to a poised and realistic medical student. I had a community and church family that supported me. I had a future husband in Colorado. AND I had a rank-order list that took me from my established safe haven all across the United States.

The week of Match for me was truly about the anticipation of the next stage of my professional and personal life, hope for this new future, angst about the changes, and realization of the new responsibilities. As I now help guide medical students through this process, I continue to think of it in those terms for both students and residency programs.

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However, there is much angst for both with the upcoming changes.

During the next three months as the M4 students prepare for graduation, they will have a growing realization of the responsibilities of physicians and the personal toll of this responsibility. We should all be prepared for these conversations.

This cycle of anticipation, hope, angst and realization in medical education continues. M3 students are seriously considering and choosing career paths. Faculty and residents are handling thoughtful questions about their lives as practicing physicians. Families are beginning to realize there is more after medical school.

Those of us who have been through this process have to remind all who are experiencing it for the first time that there is an end and that things are manageable on the other side. Remember: We made it through our own Match Madness!

Dr. Alan D. Penman

Dr. Alan D. Penman graduated from Aberdeen University Medical School, Scotland. Public health attracted his attention early.

“In my penultimate year of medical school, during my ‘community medicine’ block – which I was not enjoying because I did not really understand it – I came across ‘An Introduction to Social Medicine’ by Thomas McKeown, a famous British physician and epidemiologist,” Penman said. “I started reading and could not put it down. It completely opened my eyes to how health, in both individuals and populations, was determined by broad social and economic forces, not just by personal behavior or genes.

“Public health and social policy are as important (or even more important) as medical care. That message has stayed with me ever since.”

After his internship, Penman studied clinical tropical medicine at the London School of Tropical Medicine and Hygiene, then worked for four years in various South African hospitals, doing a mix of surgery, medicine, pediatrics, obstetrics – and community health, which was vitally important in the conditions of rural poverty which existed there.

After a detour into ophthalmology for about eight years, Penman joined the Centers for Disease Control and Prevention in 1993 to train in epidemiology and public health. He completed a preventive medicine residency there and a Master of Public Health at the University of Alabama at Birmingham.

From 1995-2004, Penman worked at the Mississippi State Department of Health, then crossed the road to UMMC in 2005. Since 2008, he has been the faculty member primarily responsible for teaching prevention and population health concepts to first- and second-year medical students. He also leads student trips internationally to focus on public health efforts in developing countries such as Uganda and Nicaragua.

Penman said he believes it is unfortunate that many physicians know so little about promoting health and preventing disease.

“As a profession we have never truly embraced this approach – partly, maybe largely, because we don’t focus on it enough in medical school,” he said. “Physicians are taught to ‘put out fires’ – to diagnose, fix and repair. Yet physicians in public health and physician advocacy for health are essential if we as a society want to make real improvements in health and quality of life.

“Physicians must take an interest in social and economic policy and speak out about the health impacts. Social policy is health policy, to quote the great 19th century German physician and founder of social medicine, Rudolph Virchow.”

Much of the current classes on public/population health, health disparities, health promotion and disease prevention are taught in the first year of UMMC’s medical school curriculum. However, Penman and other Department of Preventive Medicine faculty are working hard to incorporate more educational experiences focused on population health and prevention throughout the four years of medical education.
Graduate medical education: faculty development subcommittee

By Dr. Jimmy Stewart

Postgraduate medical training can be a daunting task, considering the myriad of requirements and rules governing the acquisition of skills to be competent in a medical residency or medical fellowship.

Residency and fellowship programs must balance clinical duties, teaching and scholarship while often being faced with limited resources. Equipping faculty to not only be productive in their areas of expertise, but to teach and evaluate residents and fellows in effective ways, also is challenging for programs.

Residency and fellowship program directors need personal and program development to ensure a successful training environment for their trainees.

With this in mind, a subcommittee has been created with a focus on residency and fellowship leadership development. The task of the Faculty Development Subcommittee covers key areas, including but not limited to curricular design; learner assessment; program evaluation; quality improvement; accreditation; human resource management; conflict resolution; identifying and comprehensively remediating underperforming trainees; early identification of trainee challenges; assessment of learning styles; selection of effective teaching strategies; teaching professionalism, learning and functioning in multidisciplinary teams; and medical education research.

One method of providing this support will be through twice-yearly program and fellowship director workshops (spring and fall), with content selected based on current program needs. Another will be piloting a program director/associate program director mentorship program, which will assist junior faculty in their program director roles and their personal career mentorships.

The support and training of all leaders involved in GME across all programs, including program directors, program administrators and all key faculty involved in GME, is critical to the educational mission area at UMMC. It is our goal that this new resource will help meet their needs.

Curriculum corner: Why curriculum mapping?

By Wendell C Douglas

Curriculum mapping is the process of mapping (via software, spreadsheet or both) the medical school curriculum’s flow to graphically connect School of Medicine objectives to course objectives; course objectives to sessions; and sessions to session objectives. This reveals academic gaps, redundancies and misalignments so coherence and effectiveness in the course of study can be created.

Usually 5-10 course objectives in the map represent the broad-but-succinct overarching learning objectives that describe the intent for learning in the course. Course objectives and other categories should begin with the following language: “Upon completion of this course, the learner will . . . (insert action verb that indicates mastery) (insert appropriate competencies).”

Course objectives in the map are linked to teaching sessions. Sessions are specific lectures, presentations, topics, etc., designed to accomplish one or more course objectives. As the mapping process continues, session objectives are linked to specific sessions and describe what the learner is expected to demonstrate or deploy after receiving the learning session material.

Other critical components of a curriculum map include teaching methods and resources for each session (how will teaching and learning be facilitated and what resources will be needed to accomplish this?); assessment methods (how will student learning be assessed both formatively and summatively?); and insertion of keywords that link the map to LCME and AAMC expectations.

Good news: If you are a course director or a course coordinator in need of assistance in developing your curriculum maps, you are not alone. Contact the SOM Instructional Design Office at 4-1212 or wdouglas@umc.edu for hands-on support with course syllabi and curriculum map development.

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Standard 6: Competencies, Curricular Objectives, and Curricular Design

The faculty of a medical school define the competencies to be achieved by its medical students through medical education program objectives and is responsible for the detailed design and implementation of the components of a medical curriculum that enable its medical students to achieve those competencies and objectives. Medical education program objectives are statements of the knowledge, skills, behaviors, and attitudes that medical students are expected to exhibit as evidence of their achievement by completion of the program.

6.1 Program and Learning Objectives

The faculty of a medical school define its medical education program objectives in outcome-based terms that allow the assessment of medical students’ progress in developing the competencies that the profession and the public expect of a physician. The medical school makes these medical education program objectives known to all medical students and faculty. In addition, the medical school ensures that the learning objectives for each required learning experience (e.g., course, clerkship) are made known to all medical students and those faculty, residents, and others with teaching and assessment responsibilities in those required experiences.

* From the “LCME Functions and Structure of a Medical School Standards for Accreditation of Medical Education Programs Leading to the MD Degree”