

# Practical Challenges of Changing the USMLE Examination Schedule on Regional Medical School Campuses

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# Distributed Medical Education

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- Regional Campuses in North America
  - 2003 42 Schools with Regional Campuses
  - 2008 10 More Schools
- Distributed Medical Education in Canada
  - 9/17 Schools
- Six Basic Science Schools with 17 campuses
- Illinois with 3-Year Campuses
- British Columbia with 3.5 Year Campus
- Four Year Campuses
  - Florida Atlantic University
  - University of Arizona

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- Question 1:
  - Does the “gateway” examination imply greater pressure to integrate basic and clinical sciences throughout the curriculum?

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## Comments to Question 1

- Answer: Clearly yes.
  - Big challenge to get BS into clinical years
  - Pressure to make BS relevant to practice
  - Great pressures on Regional Campuses
    - Telecommunication
    - Local BS faculty
    - Get CS faculty to teach BS
  - Best teachers of BS are clinicians
  - Will reduce emphasis on BS and devalue BS

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- Question 2:
  - Can evaluation systems reliably identify “at risk” students early in medical education without the Step 1 examination?

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## Comments to Question 2

Answer: Yes (one No)

- Must have way to show comparability across campuses (especially BS campuses of one school)
- Residency Directors want Step 1 results to help choose residents
- “Gateway” exam becomes more high stakes
- Remediation of failing students on regional campuses
- Cost issues

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- Question 3:
  - How will the “gateway” examination specifically affect educational programs at regional medical school campuses?
  - What adverse or beneficial effects can be anticipated?
  - What adjustments, if any, will regional campuses need to make?

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## Comments to Question 3

- Will encourage clinicians to be more involved in BS education
- Very positive change—plays to strengths of regional campuses
- Negative—most clinicians can't teach BS
- Problems for MD/PhD candidates
- Drive regional campuses to 4 year campuses
- Remediation issues
- Issue about consistency of curriculum between campuses
  - Role of Curriculum Committee
- Will further dilute BS courses
- Emphasis on BS will decrease
- Cost/faculty time issues
- Drive a more unified faculty across campuses

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- Question 4:
  - How can clinical campuses educate their students in basic science concepts relevant to patient care if they do not have basic science faculty?

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## Comments to Question 4

- Employ BS faculty. From local universities
- Go to 4 year campuses
- Revise curriculum so it does not depend on BS faculty
- Technology, Circuit Riders, more MD/PhDs
- Push campuses to work together better
- Need more interaction between BS faculty and clinicians
- Time/cost issues of MDs teaching BS
- Clinicians are best ones to teach BS
- Issues training clinicians to teach BS (from Illinois 3 year campuses)

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- Question 5:
  - How can basic science campuses appropriately educate their students in clinical sciences and enhance exposure to patients?

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## Comments to Question 5

- Shorten BS courses
- More clinical correlation. More patients
- Go to problem-based learning and cases with BS and clinical faculty
- Need more clinicians and more patient exposure
- More money to pay for clinicians
- Reform year 1 and 2 curriculum. What is relevant for doctors?
- Getting the “right” type of clinical faculty.
- This is a REAL issue for BS campuses.

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- Question 6:
  - How can regional campuses ensure their needs and opportunities are fully considered in curricular and administrative changes made by the medical school to adapt to the “gateway” proposal?

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## Comments to Question 6

- National and regional forums
- True integration with main campus NOT a reality at some schools.
- Need strong representation on Educational Council or Curriculum Committee
- LCME needs to ensure education is comparable across campuses
- Better communication with Executive Dean and Curriculum Director (Associate Dean)