University of Louisville School of Medicine: Request for LCME Reconsideration of Accreditation Findings and Action

January 28, 2014

Introduction

This report has been prepared for the LCME in support of our request that the LCME reconsider its decision of probation status. We were found out of compliance with ten standards; we acknowledge that we had not achieved full compliance for three of those standards at the time of the site visit and have taken steps to achieve full compliance. However, we believe we were in compliance with the remaining seven standards.

Over the past eight years, we have been on a continuous upward trajectory from a traditional educational program that was department centered, discipline based and lecture driven to a program that is far more centrally managed, integrated across disciplines and that actively engages our students in their own learning. The pace of change has accelerated significantly since 2011, and we have embraced the accreditation process to help drive change. This recent accelerated pace of change provides an important context and framework for the request for reconsideration because considerable new data and documentation were produced from the time of the database in 2011 and the self-study in 2012 to the time of the site visit in April 2013. This new information outlining those changes was provided to the LCME survey team, but we believe was not always used in our evaluation.

Therefore, this report focuses primarily on this updated information. We believe that looking at all of the information will result in a more complete and balanced description of the state of the University of Louisville School of Medicine at the time of the site visit in April 2013. For some standards found out of compliance, the evidence cited in the survey team report seems to weigh heavily on a single statement made during a site visit session or upon a single source; for other standards, the most recent data available are not included.

In addition, the independent student analysis (July 2012), which analyzes and interprets the student survey results (April 2012) and highlights patterns of response, school strengths, areas of concern, and areas that were discussed with administration and addressed prior to writing the analysis, was not included in the survey team report for use by the LCME at its October 2013 meeting. Without the student analysis report, the LCME could not know that many of the issues were addressed in 2012, well before the survey team visit in April 2013. We feel strongly that not having this critical component of the independent student self-study limited the LCME Committee's ability to analyze the raw student survey data in the context of a rapidly changing curriculum and learning environment. Our student survey team found that many of the concerns expressed by senior students about the preclinical curriculum had already been satisfactorily addressed by the Educational Policy Committee, and were able to reflect that in their interpretation of the survey data. Because we reference the independent student analysis several times in this request for reconsideration and it was not included in the document generated by the site visit team, we have included a copy of this important source of information (Attachment 1).

We look forward to discussing this material further with the Committee in February.

Rationale for Reconsideration

ED-5-A: A medical education program must include instructional opportunities for active learning and independent study to foster the skills necessary for lifelong learning.

LCME Finding: "There are limited opportunities and time for students to participate in active learning and independent study."

University of Louisville Rationale for Reconsideration: University of Louisville Rationale for Reconsideration: The Educational Policy Committee (EPC), has markedly increased the number of self-directed learning experiences in the formal curriculum and the time students have for independent study as a result of the self-study process that started in 2010. The EPC restricted instructional contact time to less than 20 hours per week. Overall lecture time was then decreased further by review of the entire preclinical curriculum and elimination of redundant or unnecessary content. Finally, lecture topics were reviewed and chosen for transformation into self-directed or structured independent learning activities. This resulted in a decrease in lecture time and increases in both percentage and actual hours spent in active self-directed or independent self-directed learning as shown below:

Type of activity	2011-12 Yr. 1	2012-13 Yr. 1	2011-12 Yr. 2	2012-13 Yr. 2
Lecture	411	363	416	377
Self-directed or Active learning	137	188	205	311

We provided updated schedule tables to the survey team via email and during the site visit that detail the various kinds of learning experiences in our schedule. These updated tables were not included in the section of the survey team report that describes these various learning experiences (lecture, small group, etc.) (survey team report, pp. 30-32). This may be due to a lack of clarity about what we reported in the "Independent Learning" column on our updated tables. The numbers in the *Independent Learning* column of our updated table (see p. 3 in this report) reflect the number of hours in the schedule dedicated to structured self-directed learning experiences as defined by the AAMC's Medbiquitous Curriculum Inventory Working Group Standardized Vocabulary Subcommittee (2012): "Instructor- or mentor-guided learning activities to be performed by the learner outside of formal educational settings (classroom, lab, clinic) (Bowen & Smith, 2010); dedicated time on learner schedules to prepare for specific learning activities, e.g., case discussions, TBL, PBL, clinical activities, research project(s)." All of the experiences accounted for in the Independent Learning column are self-directed learning experiences, which require that students take responsibility for their own learning, are assessed, and the assessment counts toward the course grade. These hours are not "independent study" hours, which are not reflected in the formal instructional hours count and are typically not assessed on a specific assessment tied to each self-directed independent learning experience. We track and report these independent learning hours because they are a high priority for our Educational Policy Committee and send a message about their importance in the curriculum as well as help students and faculty keep track

of the time students spend learning in the formal curriculum outside of direct faculty supervision. For the purposes of this discussion, our AY 2012-2013 table, which the LCME team had, is presented below.

2012-13 YEAR ONE: 44.2% LECTURE

		Formal Instructional Hours							
Course	Length in weeks	Lecture	Lab	Small group discussions*	Patient contact	Independent Learning	Exams	Other	Total
Embryology	9	17	0	4	0	24	3.5	0	48.5
Genetic & Molecular Medicine	15	85.5	0	12	8	5	9	0	119.5
Gross Anatomy	18	41	97	0	0	3	18.5	4[a]	163.5
Introduction to Clinical Medicine I	36	58.5	0	32	39	27	2	0	158.5
Microscopic Anatomy	9	39	32.5	0	0	1.5	7	0	80
Neurosciences	13	38	20	4	0	25	8	3[b]	98
Physiology	15	84	1	20	4	30	7	7[c]	153
TOTAL		363	150.5	72	51	115.5	55	14	821

*Includes case-based or problem solving sessions. **a**=4 h lab reviews, **b**=3 h review, **c**=7 h reviews.

2012/2013# YEAR TWO: 47.8% LECTURE

		Formal Instructional Hours							
Course	Length in weeks	Lecture	Lab	Small group discussions*	Patient contact	Independent Learning	Exams	Other	Total
Clinical Neuroscience	10	40	0	3	0	3	4	1[a]	51
Introduction to Clinical Medicine II	33	90.5	0	29.5	42	23	4	0	189
Medicine & Religion	4	1	0	2	0	0	1	4[b]	8
Microbiology	33	92.5	0	18	0	46	12	2[c]	170.5
Pathology	33	73	5	38	1	82	12	0	211
Pharmacology	33	80	0	18	1	48	12	0	159
TOTAL		377	5	108.5	44	202	45	7	788.5

*Includes TBL, case-based or problem solving sessions; Microbiology, Pathology and Pharmacology small group discussions include 1/3 of Interdisciplinary TBL classroom time. **a**=1 h video, **b**=4 h panel discussion, **c**=2 h POPS.

Numbers reflect new definition of Independent Learning provided by Medbiquitous Curriculum Inventory Working

Group Standardized Vocabulary Subcommittee (2012): Instructor- or mentor-guided learning activities to be performed by the learner outside of formal educational settings (classroom, lab, clinic) (Bowen & Smith, 2010); dedicated time on learner schedules to prepare for specific learning activities, e.g., case discussions, TBL, PBL, clinical activities, research project(s).

We believe that not having the Independent Learning column available to the LCME Committee may have limited the Committee's ability to fully assess our compliance. The column clarifies the role of self-directed learning experiences in the students' schedule and helps address the concern about ED-5-A regarding active learning. To illustrate, it is helpful to know that the AY 2012-2013 schedule contained 115.5 hours for dedicated independent learning experiences in the first year (14% of total hours in schedule) and 202 hours in the second year (26% of total hours in schedule).

In addition to self-directed Independent learning, the updated table given to site visitors reports 72 hours of small group learning experiences in the first year (9% of total hours in schedule) and 108.5 hours of small group experiences in the second year (14% of total hours in schedule). The notes on the updated table for AY 2012-2013 indicate that these small group experiences include case-based or problem solving sessions in first-year and team-based learning, case-based or problem solving sessions, and some of the integrated team-based learning time in second-year; all of these small group discussions meet the criteria for active self-directed learning as defined in ED-5-A.

The statement in the survey team report that "some courses are still basically all lecture format" is inaccurate (p. 33). It is difficult to quantify the term "some" since the survey team report identifies only one second-year course as lecture-heavy. The information presented in the updated course schedule table for AY 2012-2013 discussed earlier in our report (p. 3) shows substantial decrease in the number and percentage of lecture hours in the preclinical courses: Of the 13 courses in the preclinical curriculum, two courses were less than 20% lecture, four courses were 20 - 40% lecture, 5 courses were 40 - 60% lecture, and two courses were 60 - 80% lecture. The EPC has made steady progress in this area. The percentage of lecture dropped from AY 2011-2012 to AY 2012-2013 from 50% to 44% in the first year and from 56% to 48% in the second year.

The Educational Program section of our database describes active self-directed learning experiences in the curriculum, for example, Team Based Learning (TBL), Problem Based Learning (PBL), integrated Team Based Learning (iTBL), Interdisciplinary Clinical Cases (ICCs), and other individual and group self-directed activities that require students to take responsibility for their own learning, including decision-making about the kind of information they need to find and review in order to complete a particular assignment or solve a particular clinical problem. These student-generated objectives are more granular than the course-based objectives or session-based objectives, which are required by the Educational Policy Committee (and linked to the school's program objectives). The usual sequence includes independent preparation over an assigned problem or topic area application of knowledge in a small group or in-class case session or formative assessment, feedback from peers and/or faculty on their learning process verbally or in writing. We distributed examples of active self-directed learning experiences during the "Educational program design, implementation, management and evaluation" session of the site team's visit and on the survey team flash drive (Attachment 2).

The survey team report highlights some of the students' active self-directed learning experiences in the preclinical curriculum. For example, it describes the individual readiness assessment (iRAT) during team-based learning and integrated team-based learning experiences as feedback on the students' development of independent learning skills (p. 23); in AY 2012-2013, the iRATs occurred 18 times during the second year integrated team-based learning experiences (36 hours). Additionally, the survey team report highlights the Interdisciplinary Clinical Cases (ICCs), which require that students interview a patient, write up the case and prepare an oral case presentation, develop and answer a question, come to the ICC prepared to discuss and teach what they have learned to their classmates, and then generate and receive feedback from their mentor and colleagues. Students attend ICCs 20 times in first and second year, working with a stable group of peers and an assigned MD mentor to prepare them for clinical learning (40 hours).

Other types of self-directed learning experiences that require that students determine their own learning needs were highlighted as well in the survey team report, including "a self-instructional module in neuroscience that students must complete on their own; a web-based pharmacology exercise involving drug interactions; gross anatomy clinical exercises that are completed independently; a report on the pathologic basis of disease; and a genetics exercise focused on a particular mutation and its effect on an individual" (p. 23).

The results of the independent student survey further illustrate the existence and effectiveness of the active learning experiences in the preclinical curriculum. When students were asked about the "quality of the active learning modality" for each course, only 1% to 11% of the preclinical students registered dissatisfaction, with the percentage of dissatisfaction depending upon which course was being evaluated.

Our students benefit from many active self-directed learning experiences in the preclinical curriculum and have ample scheduled and unscheduled time to prepare for and complete the learning they must do to master the skills identified with lifelong learning. The survey team report describes our active self-directed learning experiences as "activities with school-prescribed learning objectives." We do not agree with their conclusion. Although these are assignments with a core structure or format, for example an assigned case of renal failure with an unknown diagnosis or a format for oral patient presentation and clinical question generation, these experiences require that each student determines his or her own personal objectives for the learning experiences in order to succeed. In approaching an unknown case of renal failure or writing up a patient's case, to succeed in making the diagnosis or generating effective group discussion and learning, students must determine 1) what they need to learn, 2) where they need to find information to achieve that learning, and 3) how to best organize what they learn when required to share that information with faculty or their peers in support of course or session objectives. For example, a second year student preparing for the Individual Readiness Assessment Test (IRAT) at the start of a team-based learning experience who is assigned to renal diseases would develop the following learning objective for herself: " I need to filter available information sources and find the aspects of one disease that distinguish it from similar diseases while excluding extraneous details." The results of the IRAT and then the discussion of the quiz with their TBL group as well as additional

feedback form the instructor on misunderstandings or misinterpretation of the data in the case provides the students with feedback on their ability to teach themselves what they need to learn to be successful.

We ask that the LCME consider the information we have discussed for standard ED-5-A on the types and number of self-directed learning experiences in our curriculum at the time of the survey team visit, which was available to the LCME site visit team last April, as evidence that there are adequate opportunities for student to participate in self-directed learning experiences and ample time for independent study in the schedule, and that we are, therefore, in compliance with this standard.

ED-31: Each medical student in a medical education program should be assessed and provided with formal feedback early enough during each required course or clerkship rotation to allow sufficient time for remediation.

LCME Finding: "There is insufficient evidence to determine the effectiveness of formative assessment strategies that have been implemented in the first and second years of the curriculum. With the exception of obstetrics and gynecology, family medicine and surgery, the delivery of formative feedback has been delegated to residents in required clerkships."

University of Louisville Rationale for Reconsideration: The medical school has an effective system for providing formative feedback in all preclinical courses and required clerkships; this feedback provides students with appropriate time for remediation. Full information on our approach to formative feedback was provided to the LCME team last April.

Preclinical students receive frequent formative feedback in all courses. The LCME survey team reports that "the preclinical course directors provide students with formative feedback opportunities such as practice test questions from old exams, review sessions before exams, post-examination reviews, anatomical digital images, and web-based supplemental modules for practice and formative assessment" (p. 42). The EPC monitors the effectiveness of this formative feedback with a question on the required individual course evaluations. The school's *Self-Study* provides the results to the "feedback about performance was provided promptly" question for AY 2011-2012, which ranged from 4.1 to 4.5 (on scale of 1 to 5) for all preclinical courses; student satisfaction with this timely feedback enables students to remediate deficiencies in time to ensure success in a course.

The survey team report identifies only one preclinical course—Embryology—as not providing students with adequate formative feedback. The survey team report explains that the students reported "limited opportunities for formative assessment in the embryology course" (p. 42). The student independent analysis, which accompanied the student survey results, also identifies the formative feedback problem in Embryology, specifically "the amount of graded material" (Attachment 1, "Addressed Concerns" section, p. 6). In response to these student concerns, the Educational Policy Committee (EPC) took steps to replace the Embryology course director with a practicing neonatologist, who added seven formative feedback quizzes and a review session before each course exam, resolving the issue and markedly increasing student satisfaction with the course and the amount of feedback provided.

The survey team reports that the problems with Embryology were solved when it states that "anecdotal satisfaction with the change was noted in interviews with students" (p. 42). The student independent analysis also endorses the changes made by the Educational Policy Committee, stating that "beginning with the class of 2016, the structures of Gross Anatomy and Embryology have been completely revised to address these student concerns" (Attachment 1, "Addressed Concerns" section, p. 6). These statements document that both the survey team and the students were satisfied that formative feedback concerns had been addressed.

Additional evidence of the existence and satisfaction with formative assessment in the preclinical years is provided in the survey team report, which notes that "formative assessment is now in place in all courses" (p. 33), "changes have been made in the 2012-2013 academic year to address these noted deficiencies" (p. 42), and that "formative assessment strategies have been enhanced in the M-1 and M-2 curricula" (p. 42). Since the LCME Committee's copy of the survey team report did not have the student independent analysis, it may be that its finding for standard ED-31 was based primarily on the results of the student survey. If that was the case, it is important to note that the first-year students who completed the student survey and whose comments are reported in the survey team report were members of the class of 2015, which did not take the completely revised Embryology course delivered to the Class of 2016. In fact, the Class of 2016 students, who completed the revised Embryology course with the clinician course director, enjoyed the highest results for the "received feedback promptly" question—4.5 (on a 5-point Likert Scale where 1=strongly disagree and 5=strongly agree). This result provides additional evidence that students were receiving appropriate formative feedback.

Regarding formative feedback in the clinical years, the LCME finding for standard ED-31 expresses concern about four clerkships in which "the delivery of formative feedback has been delegated to residents." This statement is simply not accurate. Not a single clerkship delegates or assigns this task to residents. What does happen is that in some required clinical clerkships, students have the option to seek out a senior level resident with whom they have worked closely and who knows their work and ask that resident to provide them with the required mid-clerkship feedback. However, when a resident provides a student with mid-clerkship formative feedback, it is always done with attending input. In many instances, the resident and attending conduct the mid-clerkship feedback meeting together, and, if for some reason the attending is not physically present, the resident briefs the attending on the session. In addition, the clerkship director reviews every completed mid-clerkship feedback form to ensure that any deficiencies noted either by the student, attending, or resident are correct and are accompanied by an appropriate remediation plan.

Additionally, our school considers training to give constructive formative feedback an integral component of every resident's training and educational experience. Every resident completes our mandatory Residents as Teachers (RATS) course, which includes a workshop on delivering formative feedback. Thus, when a resident delivers the mid-clerkship formative feedback, he or she has been trained for that task. For this finding, it should also be noted that the mid-clerkship feedback form carries no weight toward the clerkship grade.

As evidence of the effectiveness of this approach, the 2012 AAMC GQ (survey team report, p. 42), document high levels of student satisfaction with the feedback they receive. The percentage of U of L

medical students who agreed or strongly agreed that they "received sufficient feedback in clerkships" was above the national average for five of the six required clerkships, with the sixth clerkship at the national average:

Clerkship	UofL Satisfaction	National Satisfaction
Family Medicine	82%	81%
Internal Medicine	91%	85%
Obstetrics & Gynecology	92%	68%
Pediatrics	94%	89%
Psychiatry	94%	81%
Surgery	66%	66%

The independent student analysis affirms that students are "satisfied with how attending physicians and residents assess their clinical performance" (Attachment 1, "Strengths" section, p. 3). The results of the required clerkship student evaluations for AY 2011-2012, the school's baseline year, indicate that the four clerkships that the survey team report raises concerns about received the highest evaluations on the "the residents on this clerkship gave timely and constructive feedback" question: Medicine, 4.4; Neurology, 4.3; Pediatrics, 4.4; and Psychiatry, 4.6 (on a 5-point Likert scale with 1=strongly disagree and 5=strongly agree).

The additional information we have provided from the survey team report, the independent student analysis and survey, the GQ results, and the clerkship evaluation results (all of which were available to the LCME team) demonstrates that all of our preclinical and clinical students receive appropriate and adequate formative feedback and that this feedback is effective. On the basis of having received a more complete description of the role formative feedback plays in our students' educational experience, we hope that the LCME will change its finding for ED-31.

ED-8: The curriculum of a medical education program must include comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline

LCME Finding: "Clinical clerkships at the central campus have multiple participating sites. There is not a robust, comprehensive evaluation system in place to ensure comparability across clinical sites."

University of Louisville Rationale for Reconsideration: University of Louisville medical students experience a high quality clinical education program whose strength and effectiveness, in part, are a result of excellent clinical training sites and comprehensive oversight of those sites. The student independent analysis identifies "the quality of the clinical experience" as one of the medical school's "greatest strengths" (Attachment 1, "Strengths" section, p. 3).

The medical school has a strong and effective system for ensuring comparability across clinical sites, which ensures the quality and effectiveness of the clinical educational program. This system involves all stakeholders in our medical education enterprise—clerkship directors, faculty, educational leadership, and students. The components of our system for ensuring comparability across clinical sites are a) the Educational Policy Committee (EPC) requirements for clerkships and the EPC annual review of clerkships

and student learning outcomes; b) clerkship director responsibilities related to oversight of clinical sites and review of student learning outcomes; and c) real time formative feedback from students, mainly via track captains, at regularly scheduled, structured meetings with the Associate Dean for Medical Education and Associate Dean for Student Affairs.

Educational Policy Committee (EPC) Clerkship Requirements

The EPC clerkship requirements that provide the framework for this system and ensure that all students experience equivalent clerkships and are assessed in the same way align with the language of LCME standard ED-8 are as follows:

- All faculty at all clerkship sites teach to the same educational objectives and deliver the same content
- All clerkships use the same assessment instruments to measure student mastery of the knowledge, skills, and attitudes outlined in the clerkship objectives, for example, NBME shelf exams; web-based modules such as CLIPP, SIMPLE, WISE-MD, fmCASES; written and clinical assignments, and standardized patient OSCEs
- All students attend lectures together, regardless of the clinical site at which they are rotating at any given time during the clerkship, including the students at the Trover Campus, who attend these lectures via teleconference
- All students complete the same required patient encounters
- All students attend required clerkship activities together, such as Grand Rounds, conferences with the chair, and Standardized Patient or Simulation Center sessions
- All clerkships use the same form for evaluating students' clinical performance
- All students complete the same clerkship evaluation form

Clerkship Director Responsibilities

The clerkship directors are an important component of the school's system for ensuring comparability across clinical sites. Their responsibilities for ensuring comparability include 1) communicating regularly with site directors to ensure that students are experiencing the clerkship in ways that conform with clerkship requirements; 2) reviewing the results of the NBME shelf exams to monitor student performance across clinical sites; 3) reviewing each student's patient encounter report, which students load into our new curriculum mapping system (RedMed), to track completion and identify problems at any site related to specific kinds of patient encounters; 4) reviewing completed student clinical performance evaluations and addressing any concerns raised by these reviews; 5) reviewing the mid-clerkship feedback forms; and 6) reviewing the results of student evaluations, in particular the student comments, for patterns of response about individual clinical sites, faculty, or residents.

The survey team report summarizes the various clerkship responsibilities related to ensuring comparability across clinical sites. The team reports that it requested quantitative data for each clinical site in each clerkship but that this information could not be extracted from the database and "is not reviewed in that fashion by the clerkship directors or the EPC" (p. 25). We concur we could not generate the requested reports from the web-based course evaluation system we use (Blue) during the site visit;

however, the clerkship directors do review these data and others for any problems. We think it is important that the LCME understand that the clerkship directors and the EPC do monitor teaching and student learning at all clinical sites, and have developed student placement patterns within clerkships to compensate for site and rotation differences in usual work hours, patient population, and proportion of acute vs. chronic care. For example, on the Internal Medicine clerkship, all students must rotate through the VA and the University of Louisville sites to address differences in patient population and clinical care, and information is collected in real time from student feedback to the clerkship director regarding work hours on subspecialty rotations and addressed immediately when discrepancies arise to preserve work hours equity among students. This management of site differences, although not directed via statistical analysis, does effectively address educational comparability despite differences in clinical sites in the Internal Medicine Clerkship.

Student and Administration Responsibilities

The third component of the school's system to ensure comparability is the school's "track captain system." The third-year schedule consists of seven tracks; students participate in a lottery the spring before they begin third-year and select the "track" they will follow (the schedule for which clerkship they will complete first, second, etc.). *Track Captains* are students who are chosen to serve as liaisons to the clerkship directors as they and their classmates rotate through each clerkship; they also serve as liaisons to administration at formal, structured monthly meetings attended by the student track captains, third-year class officers, and the Associate Deans for Student Affairs and Medical Education. These monthly meetings provide real-time formative feedback about what is happening in each clerkship at each site and ensure prompt corrections to any problems identified at any clinical site.

The track captain system, which has been in place for years, works as follows: Each track captain emails the students in his/her track prior to the monthly meeting to solicit information about concerns or problems. These problems are then discussed at the meeting with the Associate Deans and a plan of action is developed. The Track Captain meetings are deliberately held one week before the Clinical Curriculum Committee (made up of clerkship directors) meetings so that any problem that requires quick action on the part of one or more clerkship directors can be brought to that committee in a timely fashion. The third-year class president and vice president serve on the Clinical Curriculum Committee and attend all Track Captain meetings, which ensures that knowledgeable students are present at the Clinical Curriculum Committee meetings to provide background on any comparability concern raised at a Track Captain meeting and referred to the Clinical Curriculum Committee. Similarly, if a problem is identified that requires the attention of the Educational Policy Committee (EPC), the Associate Dean for Medical Education, who also chairs the EPC, takes the concern directly to the EPC.

Although student concerns focused on issues related to comparability are raised infrequently, the Track Captain meetings with the Associate Deans have been instrumental in producing timely administrative responses to problems at specific clinical sites. For example, student track captains raised a concern about the kinds of patients students were seeing during their Psychiatry clerkship. At that time, students rotated at only one clinical site for the entire six-week rotation, and the track captains reported that students at different sites were seeing different kinds of patients and had significant workload differences. The Associate Dean for Medical Education, in her role as Chair of the Educational Policy

Committee, brought this concern to the EPC, which led to a two-site Psychiatry rotation with comparable patient experiences and workload for students in the rotation.

The survey team concluded that "the track captain system is not comprehensive and robust enough to ensure comparability across the clinical sites" (survey team report, p. 25). We believe that this conclusion points to a misunderstanding of the information about the track captains discussed with the survey team. The use of the term "track captain" may not have been clear since we use the term "track" to represent a group of students who are following the same clerkship schedule for third-year, which differs from the LCME definition for track—a parallel curriculum. And, while our Track Captain meetings represent one important component of our system for ensuring comparability across clinical sites, they are not, as the survey team report suggests, meant to serve as our entire system for ensuring comparability. Rather, these structured meetings with student leaders are an ongoing and real-time source of important feedback from students that is acted upon to correct problems in equity between sites.

Our philosophy is that students and administrators are partners in producing the highest quality education and educational environment; we believe that students are in the best position to identify problems in their clinical clerkships quickly, and they do. Sometimes these problems are specific to one clinical site, one attending, or one resident. Prompt reporting at a monthly Track Captain meeting produces prompt responses. As the students report in their independent student analysis, "Many students attest that 'responding to student concerns is something ULSOM truly excels at' and the administration is 'patient and very understanding in response to issues with courses, teachers, etc.'" (Attachment 1, "Interfacing with Administrators" section, p. 10).

Monitoring Student Learning Outcomes

A robust, comprehensive system for ensuring comparability across clinical sites must include mechanisms for soliciting and receiving input from the learners at those sites. As explained earlier, the Educational Policy Committee (EPC) solicits feedback from student leaders who represent their classmates through structured monthly meetings with the Associate Deans. In addition to this real time formative feedback, the EPC uses a required student clerkship evaluation instrument to monitor the students' clerkship experiences. Once these evaluations are submitted electronically, the Office of Medical Education (OME) staff produces a report for each clerkship that contains a summary of the student responses to quantitative questions about the clerkship and an analysis of all student comments for each clerkship, which the EPC uses as part of its annual review; occasionally, when a pattern of incomparability among clinical sites is identified, the EPC discusses the pattern and works with the clerkship director to solve the problem. For example, when student evaluations for the Obstetrics and Gynecology rotation showed a pattern of student concern about fewer deliveries at one site, the EPC initiated discussions with the clerkship director, which ultimately led to the identification of an additional clinical site. The EPC also reviews teaching effectiveness of faculty and residents using questions on the required clerkship evaluations.

A robust, comprehensive system for ensuring comparability across clinical sites must also review learning outcomes. And we do. As explained earlier, each clerkship director reviews NBME shelf

examination scores at the end of each rotation. The EPC also reviews student performance as part of its annual clerkship review. In addition to its review of student performance in each clerkship, the EPC reviews USMLE Step 2 scores; in the seven years following our last site visit, our students were at or above the national pass rate on USMLE Step 2 CK for six of the seven years. Lastly, the EPC analyzes reports that compare the results of student evaluations and student USMLE Step 2CK scores at the Louisville and Trover campuses; as the survey team report indicates, "This analysis showed no significant differences in results between the two campuses" (p. 25).

These three resources—the track captain meetings, ongoing review of NBME and USMLE results, and the annual clerkship review—provide the EPC with useful formative and summative information about the students' clinical experiences, including the various clinical sites.

We assert that the system in place at the time of the site visit was robust and comprehensive. We believe that the explanations and additional references to the independent student analysis and survey team report create a more complete description of the various components of the school's system to ensure comparability across clinical sites—a system that is in compliance with the requirements for LCME standard ED-8.

We would note too that the survey team report does not cite a single example of non-comparability between any clinical sites, and we believe that the system we have described for ensuring comparability across sites was responsible for this outcome.

ED-33: There must be integrated institutional responsibility in a medical education program for the overall design, management, and evaluation of a coherent and coordinated curriculum"

LCME Finding: "The AAMC Medical School Graduation Questionnaire and independent student analysis reveal student dissatisfaction with the lack of integration in some of the basic science courses. Horizontal integration across the first-year courses is just beginning. The second year subcommittee of the Education Policy Committee functions less cohesively in ensuring horizontal integration. It was identified during the visit that some second-year course directors rarely communicate about course content. Opportunities to integrate content, for example, from the *Introduction to Clinical Medicine* and *Medical Humanities* courses, have not been realized. While there are several examples of vertical integration of the curriculum and collaboration between the preclerkship and clerkship faculty, full vertical integration and content analysis will not be possible until the new curriculum database is fully implemented. Integrated institutional authority for the curriculum was cited as an area of non-compliance at the time of the 2005 full survey visit."

University of Louisville Rationale for Reconsideration: Since the last site visit, our school has made significant progress in the area of integration; this progress was made possible, in large measure, by an institutional commitment to providing the Educational Policy Committee with the authority it needed to direct the curriculum. This commitment was endorsed by the executive faculty when they approved revisions to the *School of Medicine ByLaws* in 2010 that make the committee "responsible for the overall design, management, and evaluation of a coherent and coordinated curriculum that achieves the educational objectives of the medical school. The Committee will have the authority to lead, direct,

coordinate, control, plan, and evaluate and report on matters related to the curriculum to Faculty Forum and the Dean." The EPC has used its authority effectively to fulfill the requirements of ED-33, as noted in the survey team report: "In the opinion of the survey team, the promulgation of the faculty responsibility for the curriculum has been effective" (p. 43).

The LCME finding for standard ED-33 focuses on the work we have done in the area of curriculum integration. One LCME concern is that the pace of integration is too slow; the finding states that "horizontal integration across the first-year courses is just beginning," that "second-year course directors rarely communicate about course content," and that "opportunities to integrate content...have not been realized." These statements do not present an accurate, balanced view of the school's accomplishments integrating the curriculum or accurately reflect the information available to the survey team at the time of the site visit.

In fact, the Educational Policy Committee (EPC) has been focused on integration for a number of years, and, while we have used a stepwise and logical progression to increase integration, this approach has resulted in significant evolution toward this goal. The student independent analysis recognizes this progress: "As stated, the administration has been working to improve integration" and " Improving integration and clinical applicability of the preclinical coursework continues to be a priority of the administration" (Attachment 1, "Addressed Concerns" section, p. 6).

The following curricular changes increased integration and speak to the LCME survey team concerns about the pace and progress we have made in this area. In 2009, the EPC annual review of the Pathology course resulted in changes in the course content and the addition of a clinical educator to increase pathophysiology and laboratory medicine content in the course. This approach used in the 2010-11 school year was so successful that the EPC created a new second-year schedule for 2011-12 that temporally aligned the second-year Microbiology and Pathology courses. This success then led to EPC creation of horizontally integrated courses for the 2012-13 academic year that aligned all of the content in the second year courses with the underlying organ studied in the Pathology course. In addition, the EPC required all courses to pool their formative assessment and small group learning time in order to jointly create the Integrative Team-Based Learning sessions to apply the knowledge from Introduction to Clinical Medicine, Pharmacology, Microbiology, and Pathology at the end of every week in a TBL format. Eighteen 3-hour iTBL's were created, and have been the major driver of continued topic and course integration in the second year of our program (please see Attachment 3 for a copy of the AY 2012-2013 integrated second-year curriculum, which was distributed to the survey team). Also in AY 2012-2013, two Educator Consultants worked with the faculty in two second year courses to strengthen integration; in Microbiology/Immunology, an allergy/immunology specialist provided content to increase clinical relevance of immunology content, and in Pharmacology, a Pharmacist provided assistance with clinical applications. Finally, the Block Exams, which test mastery of 5-6 week blocks of preclinical content, were revised to support the more integrated second year curriculum by introducing minimum of 15% "integrated questions"—questions that required clinical application of concepts across courses by students to test integrated learning, and that are written by clinicians working with basic science educators.

The integrative changes in the second-year curriculum were the result of serious and collegial collaboration over many meetings among the second-year course directors at the direction of the EPC. Thus, we do not agree with the statement that the "second year subcommittee of the Educational Policy Committee functions less cohesively in ensuring horizontal integration." They work very well together as a team, attend and participate in the Preclinical Curriculum Committee meetings regularly, and have provided leadership and support to the EPC efforts to integrate the curriculum. In fact, one of the reasons the EPC chose to focus on integrating the second-year curriculum first was that the second-year course directors were eager to move forward with integration across their courses. When the integrated team-based learning experiences (iTBL) were added to the second-year curriculum, each second-year course director willingly donated hours from his course to the new iTBL sessions to ensure compliance with the EPC schedule guideline requirements. This progress toward integration required cohesive teamwork from the second year course directors.

We would also like to respond to the statement in the finding for ED-33 that "opportunities to integrate content, for example, from the *Introduction to Clinical Medicine* and *Medical Humanities* courses, have not been realized." In AY 2011-12, the EPC shortened the length of the History of Medicine course because some of its content was already being taught in the Introduction to Clinical Medicine (ICM) course. Also, at the time of the survey team visit, the EPC was preparing to review the At the Intersection Between Religion and Medicine course, which students had reported contained content already being taught in ICM. We believe this statement in the finding reflects a discussion that occurred during the survey team's session with some of the second-year clerkship directors and was related to the pending EPC review of this course. When the EPC review of the Religion and Medicine course was completed, the EPC dismantled the course and did shift some of the content that was not redundant to the ICM course. We cannot claim that second-year course directors agree on all curricular content or integration, but they work together towards the common goal of integration

We also disagree with the statement that "horizontal integration across the first-year courses is just beginning." In fact, the first-year curriculum delivered during AY 2012-2013 was significantly more integrated than that delivered in previous years. Changes that had been made in the curriculum prior to the survey team visit include: the schedules for Gross Anatomy, Embryology, and Microscopic Anatomy were revised so that the same topics were taught across all three courses at the same time; a clinician educator (neonatologist) began directing the Embryology course and redesigned the course to increase clinical relevance; the second-year Genetics course and the first-year Biochemistry course were merged to create a new, more integrated and clinically relevant first-year Genetics and Molecular Medicine course; and the Interdisciplinary Clinical Cases component in the curriculum was merged into the Introduction to Clinical Medicine course, which also strengthened integration. One of the school's Educator Consultants, an anatomist, partnered with the new Embryology course director to ensure linkage among new and existing courses. All of these changes supported integration of the first-year curriculum and occurred under the central control, direction, and supervision of the Educational Policy Committee.

Finally, in AY 2012-2013, the Educational Policy Committee (EPC) directed the Curriculum Advisory Committee, one of its subcommittees, to design a fully integrated first-year curriculum that would

launch in August 2014; this work progressed throughout AY 2012-2013 as a collaboration between the Curriculum Advisory Committee members and the first-year course directors. Their plan was finalized and submitted for approval to the EPC just prior to the April 2013 survey team visit and was shared with the survey team during the "Educational program design, implementation, management and evaluation" session (Attachment 4).

The data highlighted in the survey team report for standard ED-33 also require elaboration. The LCME finding for ED-33 identifies the 2012 AAMC GQ and the independent student analysis as evidence of student dissatisfaction with integration "in some of the basic science courses." The survey team report cites the percentage of 2012 AAMC GQ respondents who agreed or strongly agreed that basic science content was sufficiently integrated across basic science courses—73% for UL, 80% nationally (p. 44). However, more recent data were available. The GQ results reported by the survey team are actually for students who completed their second-year preclinical courses in AY 2009-2010 prior to the implementation of the newly integrated second-year courses, which are described earlier in this report.

The second-year Pathology course provides a good example of the value of how reporting the most recent student feedback changes the conclusion one might reach about the current status of student satisfaction with integration in the curriculum. Students completing the 2012 AAMC GQ took Pathology in AY 2009-2010, before the EPC-mandated changes to the content and structure of the course had been fully implemented; those students rated the Pathology course far below the national average in terms of how well it prepared them for clinical clerkships (preparation was good/excellent: UL, 64%; National, 85%). In contrast, the independent student survey results for the class of 2013, which took the far more integrated and clinically relevant Pathology course one year later in 2010-2011, reflect far greater student satisfaction with the course—85% of the students were satisfied with how well Pathology prepared them for clinical clerkships. In our view, seeing both the "before" and "after" data produces a more balanced description of the state of integration in the curriculum at the time of the survey team visit and provides evidence that appropriate work was being done and good progress is being made.

Student response to these changes has been extremely positive, as reflected in both the independent student survey and the student analysis and has bearing on the LCME finding that our school was just beginning to integrate its curriculum. For the second year students who completed the independent student survey, 92% were satisfied or very satisfied with "recent changes in the preclinical curriculum." Regarding "integration of courses during the second preclinical year," 88% of the second year students were satisfied or very satisfied. First year student satisfaction with integration results were as follows: first year, first-semester course integration, 68% satisfied; first-year, second-semester course integration, 75% satisfied. (NOTE: We believe that first-year students were less satisfied than second-year students with integration across courses because the first-year students who completed the student survey took the first-year courses in AY 2010-2011, and thus did not benefit from the 2011-2012 first-year integration changes.)

The independent student analysis also comments on the preclinical curriculum: "Overall, students at the University of Louisville School of Medicine are satisfied with the pre-clinical curriculum, as well as with the recent changes that have been made to both first and second year courses" (Attachment 1,

"Preclinical Curriculum" section, p. 14). The "Strengths" section also states that "the class of 2014 applauded the addition of the new integrated Team Based Learning (iTBL) sessions" (Attachment 1, "Strengths" section, p. 4). Lastly, the "Conclusion" section of the independent student analysis states, "Our assessment indicates that students benefit from an organized and integrated curriculum" (Attachment 1, p.7). We believe this assessment by the students of their curriculum provides additional documentation that could have been helpful to the LCME Committee.

The student independent analysis also speaks to EPC changes in specific courses. None of this information was included in the survey team report, although its use would have provided a more balanced snapshot of the progress we have had in the area of integration. In the "Strengths" section, students write that "the class of 2015 [first-year students when the students administered their survey] was very satisfied with the new structure of the Neuroscience course compared to years past" (Attachment 1, p. 4) and in the "Addressed Concerns" section, they write, "Beginning with the class of 2016 [AY 2012-2013], the structures of Gross Anatomy and Embryology have been completely revised" (Attachment 1, p. 6).

The measured, incremental approach that the Educational Policy Committee has taken toward achieving the goal of full integration across all four years of the curriculum has had positive results and demonstrates compliance with the integration-related language in LCME standard ED-33. Results of the independent student survey show that 78% of the third- and year fourth-year students were satisfied with "integration of Basic Science Content in Clinical Clerkships." The survey team report would appear to support the systematic approach we have taken to achieve integration when it states that "since the 2005 LCME site visit, the school has been making incremental changes to the curriculum. The curriculum at the medical school is currently undergoing change and will continue to do so...." (p. 25).

We have cited extensive additional information from various documents provided to the survey team in an effort to create a more complete and balanced view of our efforts to integrate the curriculum. We believe that the approach the Educational Policy Committee has taken to achieve integration in the preclinical curriculum has had positive results and demonstrates compliance with this aspect of LCME standard ED-33.

ED-35: The objectives, content, and pedagogy of each segment of a medical education program's curriculum, as well as of the curriculum as a whole, must be designed by and subject to periodic review and revision by the program's faculty.

LCME Finding: "There is not an effective system in place to review the entire curriculum. The absence of an electronic curriculum mapping system has created a significant barrier to conducting a formal review of the curriculum at the "objective" level."

University of Louisville Rationale for Reconsideration: We believe we were in compliance with this standard at the time of the survey team visit, but that the formal process we use for review of the entire curriculum may not have been fully appreciated. At the time of the survey team visit, we explained the Educational Policy Committee's schedule for periodic review of the objectives, content and pedagogy of each segment of our curriculum and the curriculum as a whole: Individual courses and clerkships are

reviewed annually; individual years or academic periods of the curriculum are reviewed every 3-5 years, and the entire curriculum is evaluated every 5 years.

First, we will address the statement in the finding that we do not have "an effective system in place to review the entire curriculum." We disagree with this statement. The survey team report states that the curriculum at the medical school is changing "as a result of the extensive and intensive curriculum review that began early in AY 2009-2010 and ended early in AY 2011-2012" (p. 25). We view this statement in the survey team report as evidence that we did conduct a successful and an in-depth review of the curriculum and that the review resulted in curricular change.

We find the above statement at odds with another statement in the survey team report that "it was not clear to the survey team that there are formal, regular, scheduled reviews of individual years or academic periods," (p. 45). As we explained during the site visit, the Educational Policy Committee Chair led two task forces, the Clinical Block Task Force (2009) and the Preclinical Block Task Force (2010), each of which conducted a thorough, time consuming, and successful review of an academic period of the curriculum. Once the task forces completed their work, their recommendations were discussed and subsequently approved by the Educational Policy Committee and forwarded to the Dean for funding. After an endorsement was secured from the Dean, a Curriculum Implementation Committee (CIC) was formed, chaired again by the EPC Chair, and charged with developing plans for implementing the task force recommendations over the entire four years of the curriculum. At the time of the survey team visit, we reported that 37 of the CIC's 41 recommendations had already been implemented, with the remaining recommendations scheduled for implementation by the end of AY 2014-15, and we provided the survey team with the most recent documentation of the implemented recommendations update (Attachment 5). We also explained that task forces would review the preclinical and clinical curricula on a 3-5 year schedule. Thus, the next scheduled review of the clinical curriculum will begin in AY 2014-2015, followed by a formal review of the preclinical curriculum in AY 2015-2016.

We turn now to the statement in the finding that the "absence of an electronic mapping system has created a significant barrier to conducting a formal review of the curriculum at the 'objective' level." Regarding the "absence" of a curriculum mapping system, like many medical schools around the country we used CurrMIT for a number of years to assist in managing the curriculum, but knew that a better system was needed. As we explained to the survey team, we developed supplemental methods to review curricular content; for example, our database contains a report that the Office of Education (OME) produced for the EPC that details all of the learning experiences in the curriculum that teach objectives on the topic of "patient safety" (Attachment 6). Then, our LCME preparation efforts (2010-2011) underscored the need for a new database, and we began to explore the various curriculum mapping systems coming onto the market designed for medical school in order make sure that the system we purchased would support our needs. In 2012, we purchased our new curriculum mapping system (LCMS+), which we branded RedMed. At the time of the survey team visit, the preclinical curriculum had been fully loaded into RedMed, and the clerkship directors were preparing to load their content; we deliberately took a "phased" approach to loading content into RedMed because we felt we could learn and improve on the process by dividing this task into two phases. At the time of the survey team visit, we had already launched the patient encounter function of RedMed in the clinical clerkships

to strengthen the clerkship directors' and the EPC's ability to monitor this important clerkship requirement. We provided the survey team with RedMed sample reports that listed all of the learning experiences in the curriculum that had objectives focused on complementary medicine, herbal medicine, human sexuality, and cultural diversity content areas (Attachment 7).

We agree that curriculum review at the objective level is facilitated by an effective electronic curriculum mapping system and that curriculum review without such a system is labor-intensive. However, reasonable integration can be achieved by focused hard work. The reports we shared with the survey team were produced far more quickly than those we created using Excel; however, we do not agree that we did not have the capacity to analyze our curriculum at the objective level prior to having RedMed. We simply had to utilize other tools, for example, the weekly surveys students completed when we launched the new, integrated second-year curriculum, which identified redundancies in the content of the CNS, Pathology, and Microbiology courses; those redundancies were subsequently eliminated when the Assistant Dean for Medical Education met several times with the three course directors to review the content of their courses at the topic and learning objective levels. The first-year course director lecture notes served as another tool for curriculum review at the objective level; these notes were used by the first-year course directors, in collaboration with the Assistant Dean for Medical Education and the Curriculum Advisory Committee, to review all of the content and objectives for all of the first-year courses and then decide which content and objectives would be retained in the new integrated first-year curriculum they were designing. Finally, the RedMed reports we distributed to the survey team members during the site visit also provided evidence of our ability to review content at the objective level.

The LCME finding for standard ED-35 contains language that we ourselves used in the narrative for ED-35 in our school's database, which the survey team included in its report: "As noted in the database, the 'lack of an electronic curriculum mapping system created a significant barrier to conducting a formal review of the curriculum at the "objective" level'" (p. 45). We feel it is important to note that this statement in our database, which reflected an honest appraisal of our situation in 2011 when we wrote the database, was no longer accurate in April 2013 when the survey team visited our school. Moreover, our words were not meant to suggest that a formal review of the curriculum at the objective level was impossible, only that it was a barrier—a barrier that we successfully overcame with intense effort until 2012, when we purchased RedMed. The LCME *Connections* publication (June 2012) directs the Educational Program self-study committee to "assess the adequacy of the system for planning and managing the curriculum" (p. 98). As we explained earlier in this report, our self-study committee's assessment of the adequacy of the system then in place was instrumental in the school's decision to purchase a new curriculum mapping system. We believe this information highlights the value of conducting a serious self-study and the importance of continuous quality improvement. This information also explains why the statement the survey team cited in its finding for standard ED-35 does not accurately describe the school's situation at the time of the site visit in April 2013.

We affirm that we were using our new curriculum mapping system at the time of the survey team visit and that we had a structured and effective system in place to review individual courses, academic periods, and the entire curriculum prior to purchasing our new system in 2012. We ask that the LCME

consider the explanation we have provided and conclude that we were in compliance with the requirements for curriculum review outlined in the language of standard ED-35.

ER-4: A medical education program must have, or be assured the use of, buildings and equipment appropriate to achieve its educational and other goals.

LCME Finding: "Both faculty and students note problems with the educational facilities. In the independent student analysis, a significant proportion of the student body is dissatisfied with the lecture hall facilities due to the number of seats, an insufficient number of electrical outlets to support laptops, intermittent technology failures during educational sessions, and environmental room control. Current auditoria seat 160 for an M-1 class of 164. There have been some modifications including additional outlets in the periphery and improvement to the unit labs. Faculty expressed concern about the adequacy of small group rooms. A new instructional facility has been a university priority for two years. Additional capital funding sources are being explored at the university level. The adequacy of facilities was cited as an area of noncompliance in the 2005 full survey."

University of Louisville Rationale for Reconsideration: AY 2012-2013, the year of the survey team visit, was a very unusual year for our medical school in terms of class size. We pay close attention to the relationship between admissions and matriculated students, using historical patterns to determine how many students we should admit. In 2005, we were accepting 149 new students each year, but renovated our three lecture halls to hold 160 students in order to accommodate returning students and an anticipated increase in class size. We began admitting 160 students in 2009. However, at the time of the self-study, it became clear that with this number of new students we weren't in compliance with LCME Standard ER-4 and we reviewed the number of students returning from leave and repeating the first year. We found that this was usually 2-4 students each year. In 2012, as a result of this review, we decreased the number of new students admitted to 155, to facilitate compliance with ER-4.

However, despite our very deliberate best efforts, in AY 2012-2013, we had an unanticipated and unusually high number of students (9) who returned from leaves of absence or had to repeat the first year, which was at variance with recent historical data. This unusual occurrence did move us to 164 students. To accommodate this unusually high number of first-year students, we re-arranged the schedule so that many of the learning and assessment experiences that required all students to be present, for example, integrated team based learning sessions, block exams, and computer-based exams, were relocated to the unit labs or to the Kornhauser Library Auditorium, which seats over 400 people.

In response to student concerns identified as a result of the independent student survey, the administration worked with students to address their concerns. The following enhancements were made: 1) the addition of electrical outlets in the lecture halls; 2) the creation of an electronic system for reporting housekeeping concerns; 3) the renovation of the student lounge; 4) the purchase of new chairs for the student study spaces; and 5) the construction of eight new small group study rooms in Kornhauser Library. The survey team was provided with the slides produced by student leaders for an LCME Update meeting they convened and with an update summary that was produced by the Associate Dean for Accreditation (Attachment 8). Student concerns with the instructional facilities were largely

met before the time of the site visit. Regarding student concerns with the instructional building, the independent student analysis concludes, "Feedback indicates that overall, the facilities at the University of Louisville School of Medicine are adequate in providing a solid environment for students; however, it also identifies room for improvement" (Attachment 1, "Educational Environment" section, p. 8).

As we have explained, AY 2012-2013 was a very unusual year for our school in terms of returning and remediating students. We ask that the LCME consider the information we have provided and the work we have done to ensure that our instructional facilities are adequate to achieve our educational goals as documentation that we are in substantial compliance with the language and spirit of LCME standard ER-4 and reconsider its finding.

ER-9: A medical education program must have written and signed affiliation agreements in place with its clinical affiliates that define, at a minimum, the responsibilities of each party related to the educational program for medical students.

LCME Finding: "A new master affiliation agreement between KentuckyOne and University Medical Center came into effect in March 2013, superseding all prior agreements. This agreement does not include the required elements on the learning environment and specification of the responsibility for treatment and follow-up after exposure to infectious or occupational hazards. Affiliation agreements were cited as an area of noncompliance in the 2005 full survey."

University of Louisville Rationale for Reconsideration: Regarding medical student education, all LCME-required elements are covered in our Master Affiliation Agreements, which were in place and current at the time of the site visit, and include the LCME-required language related to needle stick policy and learning environment. There was a misinterpretation of the new academic affiliation agreement for the joint management and operation of University Hospital, specifically the phrase that the agreement "superseded" previous academic affiliation agreements. This phrase was in reference to previous management and operating issues and provision of services; it did not supersede the educational Master Affiliation Agreements and was not intended to do so.

Dean Ganzel discussed this language with the medical school and hospital attorneys and clarified this point for the survey team during their visit. Thus, we were unaware that any concern about the new management/operating agreement remained until we received the draft survey team findings. We want to emphasize that the clinical Master Affiliation Agreement for University Hospital that was provided to the survey team includes both the required needle stick policy and an addendum about the learning environment. This agreement was current at the time of the visit, remains in effect, and meets all LCME requirements.

Conclusion

Since the survey team visit, we have invested an enormous amount of time and thought into achieving full compliance with all LCME standards, paying special attention to the ten standards that were judged out of compliance. And, we have achieved a great deal as a result of these focused, intense efforts. However, we are not going to stop there. We will continue to strengthen, refine, and enhance the quality of our educational program, student learning experiences and student learning environment,

and we will draw upon the LCME standards to achieve our goal of providing the best educational experience possible for our students.

We appreciate the opportunity to prepare and present this written report, which we believe documents compliance with seven of the standards the LCME found out of compliance, specifically, LCME standards ED-31, ED-5-A, ED-8, ED-33, ED-35, ER-4, and ER-9. Our report reviews a great deal of information that we submitted to LCME and the survey team and emphasizes the analysis that the students conducted, which was not made available to the LCME Committee when it met in October 2013, in an effort to provide a more complete and balanced snapshot of the University of Louisville School of Medicine in April 2013. We hope that the LCME review of this report will lead to changes in the LCME findings related to compliance with LCME standards that were cited as out of compliance and a reversal of the proposed LCME action to place the University of Louisville School of Medicine on probation.

We look forward to speaking with the LCME Committee on February 26 and to answering any questions the Committee may have about our rationale for reconsideration of its findings and proposed action.