UNIVERSITY OF
LOUISVILLE.
SCHOOL OF MEDICINE

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Barbara Barzansky, PhD, MHPE
Co-Secretary
Liaison Committee on Medical Education

Dan Hunt, MD, MBA
Co-Secretary
Liaison Committee on Medical Education

Dear Drs. Barzansky and Hunt:

We have carefully reviewed your October 14, 2013, letter reporting the findings of the LCME Committee on the accreditation status of the University of Louisville School of Medicine, and we appreciate the opportunity to request that the LCME reconsider its decision of probation status.

We believe that reconsideration is appropriate because the survey team report findings and narrative in some cases do not fully utilize the materials submitted by the school that document compliance with LCME standards. For some of the standards determined to be out of compliance, the evidence provided in the survey report appears to weigh heavily on a single statement made during a site visit session or solely upon one data source, when additional, and sometimes more current, documentation materials were available. In some cases, the survey team narrative actually says that we are making progress or that we have taken action to achieve full compliance, but the finding is noncompliance. We believe also that a great deal of emphasis was placed on the student survey, which was completed at the beginning of our self-study process (mid 2012), while very little emphasis was given to changes that occurred after the student survey but well before the survey team visit, several of which were highlighted in the narrative section of the student independent analysis. The final LCME survey team report that we received did not include the narrative section of the student report.

Let me address the following areas of noncompliance.

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.

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.

We believe we have an effective system for providing formative feedback in all preclinical courses and required clerkships. We will provide documentation that was available to the survey team either before

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or during their visit that students receive appropriate and sufficient feedback in these courses (for example, 2012 GQ and 2011-2012 course evaluation results), and that this feedback is effective in terms of providing students with sufficient time for remediation. We also will clarify a misunderstanding that appears to have occurred during the survey team visit regarding the role that residents play in providing students with formative feedback, and we will provide documentation to that effect. Faculty provide students with formative feedback in all required clerkships.

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.

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

We believe that we were in compliance with this standard at the time of the survey team visit and will provide documentation from the materials supplied to the survey team. The body of the survey team report and materials shared with the team during the visit provide examples of student-directed learning opportunities in the curriculum that meet the requirements for the LCME definition of active learning and/or independent learning experiences. The survey team report also states that "the school has made progress in limiting the number of lecture hours...." At the time of the survey team visit, the first year schedule was 44% lecture, the second year 48%; active learning/independent study accounted for 23% of the first year schedule and 39% of the second year schedule; patient contact and laboratory experiences accounted for 25% of the first year schedule and 6% of the second year schedule, with other kinds of non-lecture learning experiences and exams accounting for 8% of the first year schedule and 7% of the second year schedule. We do not believe that these percentages support the finding that our curriculum provides only "limited" opportunities for students to engage in independent study and active learning experiences.

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.

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 all clinical sites.

We believe we are in compliance with this standard. The materials that were available to the survey team describe the components of the Educational Policy Committee (EPC) system used to review and monitor comparability across clinical sites, which is framed by EPC Policies that require that all clerkship clinical sites use the same objectives, deliver the same content, and use the same assessment instruments. Data sources for the EPC system include the results of student clerkship and evaluations; minutes from the clinical curriculum meetings and ongoing, timely feedback from student leaders rotating through all of the required clerkships at formal monthly meetings with the Associate Deans for Student Affairs and Medical Education. We will provide documentation that we had a comprehensive system in place at the time of the site visit and that we have comparable experiences across clinical clerkships.

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.

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 Educational 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.

We respectfully disagree with this finding. The survey team report cites results to a 2012 GQ question about how well the "basic science content was sufficiently integrated across basic science courses." These results reflect the experiences of students who had completed their preclinical courses in AY 2008-2009 and AY 2009-2010, prior to implementation of major EPC-mandated changes in some preclinical courses and prior to the launch of the integrated second year curriculum. In contrast, the student independent survey results, which reflect the perceptions of preclinical students who experienced a new integrated curriculum, demonstrate success and high satisfaction with the integrative changes that had been implemented, with 82% of the students satisfied/very satisfied with "recent changes in preclinical curriculum" and only 7% dissatisfied/very dissatisfied.

Evidence that the 2012 GQ results do not accurately reflect student perceptions of the curriculum in place at the time of the survey team visit can also be found at the individual course level. For example, students who completed the 2012 GQ took Pathology in AY 2009-2010, before the EPC mandated extensive changes to the content and structure of the course; 64% of those students agreed/strongly agreed that the Pathology course had prepared them well for clinical clerkships, the same as the national average. In contrast, the results of the student independent survey for second year students who took the entirely revised Pathology course in 2011-2012 (the year of the student survey) are dramatically more positive, with 87% satisfied/very satisfied with the "overall course quality."

Finally, while we concur that having a fully implemented database provides a highly efficient tool for achieving better vertical integration and content analysis, we believe that this component of the finding applies to LCME standard ED-35 more than to the requirements for LCME standard ED-33.

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

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."

We believe we were in compliance with this standard at the time of the survey team visit. We had an effective system in place, which was used to review the entire curriculum, and we provided the LCME with extensive documentation of the nature and outcomes of that review, which was conducted by two EPC-led task forces and an implementation committee chaired by the Chair of the EPC. We concur that the work of curriculum review at the more granular level is challenging but not impossible; like many medical schools around the country that are replacing CurrMIT with new, more powerful curriculum databases, our most recent review of the entire curriculum was labor-intensive but produced excellent outcomes in terms of enhancements to the curriculum. We implemented 40/41 recommendations from that process. We note too that our new curriculum database (RedMed) was up and running before the survey team arrived; also, at the time of the site visit, the first two years of the curriculum had been fully mapped and we provided the survey team with sample RedMed reports.

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.*

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.

AY 2012-2013, the year of the survey team visit, was a very unusual year for the medical school in terms of admissions and matriculation. Like many medical schools across the country that have increased class size in response to concerns about projected physician shortages expressed by the AAMC, AMA, and other national organizations, we pay close attention to the relationship between admissions and matriculated students, using historical patterns to determine how many students we should admit. In our case, we had even reduced the admitted class size from 160 to 155 to ensure compliance with ER-4. However despite our best efforts, we had an unanticipated and unusually high number of students (9) who returned from leaves of absence or had to repeat the first year, at variance with historical data.

And, while we are moving forward with strategies to fund more profound changes to the educational facilities, we can demonstrate that the materials we submitted to the LCME document that student dissatisfaction identified early in the self-study process became an administrative priority, and that the changes made to address student concerns before the site visit were the result of a highly effective partnership between students and administration.

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.*

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.

We believe we were in compliance with this standard at the time of the survey team visit. The finding references language in a new affiliation agreement with KentuckyOne Health for the management of University of Louisville Hospital that suggests it supersedes all prior agreements. In fact, this language refers only to the business aspects of the affiliation and is not intended to supersede the clinical educational aspects of the relationship, which are detailed in our master affiliation agreement for University Hospital. Although this language may have been a source of confusion for the survey team, I clarified it with the medical school and hospital attorneys and I personally conveyed that information to the survey team. 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.

In closing, we appreciate the opportunity to prepare and present a full written report documenting compliance with the above standards and look forward to speaking with the LCME Committee in February 2014 in Chicago. We are committed to the LCME accreditation process and to its important role in continuous quality improvement. We are aligned with the LCME commitment to delivering an educational program that graduates patient centered physicians whose knowledge, skills, and professionalism will address the health and vitality of the patients we serve.

Sincerely,

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