

**OU College of Medicine
Retreat on Admissions
June 26, 2007
Robert M. Bird Library, Health Sciences Center
Oklahoma City, Oklahoma**

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Process and Procedure The University of Oklahoma College of Medicine Retreat on Admissions

The University of Oklahoma Retreat on Admissions was held June 26, 2007 at the Health sciences Center in Oklahoma City, Oklahoma. The retreat process was designed in a case based format. Case design and input was from surveys of applicants, newly admitted students, current students, admissions board input, and the dean's senior staff. Those invited included past or present admissions board members, undergraduate pre-med faculty who serve as advisors for our applicants, and current students.

Planning sessions began in fall 2006 with a request from the Associate Dean for Academic Affairs for a summit to be held on behalf of the admissions processes of the college. The intent of the retreat was high level discussion to identify new requirements and/or preparation required of our applicants to meet the demands of a new medical curriculum. Additionally, the charge is to review the current interview process and identify those personal qualities that we favor in the education of a physician.

This retreat was focused on five areas of the admissions process including past and future needs for prerequisite courses and experience for applicants, new tools for admissions interviews, how to identify a lifelong learner, how we might measure or rank candidates during our deliberations, and how to be a better partner with our undergraduate institutions. Throughout the discussion, the common theme of professionalism in our applicants was addressed in small groups.

Introduction and Core Values The University of Oklahoma College of Medicine Retreat on Admissions

Dr. Hall reviewed the goals of the retreat and the status of the College of Medicine admission program. The AMA and AAMC initiatives were introduced with a reflection of how our student learners have changed. The environment of educating a physician has changed from being knowledge-based to being competency-based with a greater emphasis on behaviors, skills and attitudes.

Nationally, there is an American Medical Association (AMA) Initiative to Transform Medical Education (ITME) intended to promote excellence in patient care by implementing reform in medical education and training system across the continuum from pre-medical preparation and medical school admissions through continuing physician professional development. At the 2002 Annual Meeting, the AMA House of Delegates adopted the Council on Medical Education Report 2 thereby initiating a three phase study. Phase 1 identified current strengths and gaps or opportunities for improvement in physician preparation; Phase 2 developed and prioritized strategies for changes in medical education; and Phase 3 is intended to implement change in priority areas by first building consensus among the many interested groups. Broad based collaborations will be needed to overcome the barriers and to successfully implement needed changes. More information can be found at <http://search.ama-assn.org/Search/query.html?qc=public+amnews+pubs&qt=itme>.

In 2003, the Association of American Medical Colleges (AAMC) established an initiative entitled A Vision for Better Medical Education. An ad hoc committee of medical school deans issued a document Educating Doctors to Provide High Quality Medical Care with recommendations for medical education reform. The AAMC's Group on Educational Affairs has completed its systematic examination of the report, and has issued a statement regarding the implementation of this vision. For more information, go to <http://www.aamc.org/meded/iime/start.htm>.

National Trends The University of Oklahoma College of Medicine Retreat on Admissions

Dr. Hall reviewed the national trends based on current reports from the Association of American Medical Colleges (AAMC). A summary of her comments follows.

It is nearing the one hundredth anniversary of Abraham Flexner's revolutionary report on the state of medical education. Do we need a new revolution to sweep away the current system or is our work headed in the right direction? Are we preparing our students for a future of life long learning?

According to Dr. Darrell Kirch, President, Association of American Medical Colleges (AAMC), thirty years ago, the issues we value today were formed in the curriculum. Small group learning experiences were limited to electives. Simulation technology referred to crude audiotapes of heart sounds and the development of communication skills depended largely on hoping students would translate lectures into meaningful interactions with patients. Since then, medical education purposely links its learning objectives to outcomes. There is an emphasis not just on knowledge, but on competencies and accountability. Societal topics reflecting demographic, cultural and social changes as well as scientific discoveries are now included in a curriculum that is considered inflexible. Our teaching has migrated from the hospital to ambulatory settings. We have introduced standardized patients in structured clinical assessment that are observed by attending physicians. We have shifted to more small group (case and problem based) learning. We are interested in honing students' communication skills and have been using simulation and other computerized technologies to enhance the learning environment.

This new teaching technology requires a review of the process by which we select our students. Many premed requirements may be of less value to future medical education and practice, although still used by the Medical College Admission Test (MCAT). The reverse is also true – that there are requirements not currently in place that could facilitate a student's passage through medical school.

In general there are national trends that identify student deficiencies when they arrive in medical school. Overall, there is a desire for students to have more familiarity with statistics, with ethical decision making, philosophy and be better self-directed learners.

Setting the Stage

You are a member of the admissions board at the University of Amohalko © College of Medicine. Your charge is to identify the best and brightest among an applicant pool of approximately 1300 individuals with 400 Oklahoma residents. You also teach as a preceptor in the Principles of Clinical Medicine course in first and second year of medical school. The medical school offers a fairly traditional curriculum with discipline-based courses and clerkships, multiple choice examinations, A - F grading, narrative comments made in the clerkships, and central coordination of the curriculum. A year ago, the faculty approved educational objectives that are competency based and align with the ACGME competencies. It is a challenge to match these objectives to associated outcomes that address students' progress in achieving these objectives. The College is responding to the national and state call for an increase in class size and has accommodated 162 students for an 8% increase. The target may be a class size of 180.

The dean and faculty are interested in the national initiatives of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) and would support a new approach to the prerequisite requirements as long as the requirements prepare a student to perform competitively on the MCAT. Additionally, the process of review using standardized interviews, the literature of Daniel Goleman and emotional intelligence to craft questions during the interview, and a process of selection that tries to evaluate maturity, self-awareness, social consciousness is being debated. You are now at a retreat to discuss what personal qualities, behaviors and attitudes are to be assessed during the interviews and whether our prerequisite courses should be altered. All issues are on the table, e.g. what is our definition of a successful applicant? What is the relative importance of professionalism and maturity in our process? Do physicians of the future have an equally strong commitment to the public good? How do we assure that?

As planning moves forward, the admissions board members need to be mindful of educational "outcome" information to which the College has access.

- Students do well on national examinations and perform at the mean.
- Students match to residency programs of their choice and change disciplines at about the same rate as national – 23%.
- Nationally, students have more difficulty with issues such as evidence based decision making, professionalism, communication skills, etc.

Small Groups:

Premed Requirements – Past and Future
New tools for admissions interviews
Partnering for Recruitment

How to identify the lifelong learner?
Measurement of candidates (points?)

Group 1 Premed Requirements – Past and Future

Richard Reeder, Ph.D., Facilitator

Over 100 years ago, the American Medical Association published the first minimal standards for medical schools and curriculum. Over time, medical education has evolved into more case-based learning, use and evaluation of the literature in evidence based formats, earlier introduction of patient interactions, use of simulations as well as more instruction in social sciences and palliative care. Today, fundamental components of medicine go beyond the biomedical sciences to include its humanistic, legal and management aspects. Pre-med requirements have remained relatively static, still focused on the scientific training of an undergraduate.

By issuing admission requirements, medical schools have a profound impact on what thousands of college students learn and do not learn each year. Some premed requirements are considered of less value to future medical education and practice.

What deficiencies have been noted in our current educational environment?

- Students lack the ability to read medical literature and evaluate it. They cannot design research studies or discuss quality improvement initiatives.
- Students request and seem to require detailed syllabi of course work. They are hesitant, if not unable, to address the literature on subjects - the “Just tell us what we need to know...” syndrome.
- Although most medical students can regurgitate biochemical pathways, they have little background in genetics and molecular biology.
- As the moral ethos of generations change, students have greater difficulty in distinguishing ethical issues from communications, economics, aesthetics or just making an ethical argument. They have difficulty in providing ethical reasons that justify decisions.
- As students depend more and more on technology for communication and learning, we feel that they are losing skills dealing with people and human behavior. They lack the ability to appreciate attribution of error, hindsight bias, transference, moral distancing, etc.

For discussion:

- 1) Of the current premed requirements for OUCOM, which are integral to the preparation of a physician or contributory to an understanding of the science and art of medicine?
- 2) If you were making a list from scratch and not influenced by either the MCAT content or the COM current requirements, what would the list be?
- 3) What experiences might be useful and required for our applicants?
- 4) How do you feel about course credit, or degrees, earned online?

Group 1 Discussion:

This was an interesting discussion that became focused not on just OU, but on all medical schools and was a balance between the ideal pre-requisite requirements and the barriers of faculty and staff time at the undergraduate institutions. Both need to be considered. Additionally, there are pre-requisite course requirements that focus on language and content of courses, a second element of pre-requisites that address how the students problem solve and think and the third element is the social and interpersonal skill development. The group originally started with the course discussion.

It was felt that adjustments could and maybe need to be made to the traditional course listings. The constraints of the MCAT content don't allow elimination of some of the current course requirements and should be taken into consideration as formal changes are made. It should be remembered that essential changes to the MCAT may need to occur in order to implement some of these changes. However, one does wonder about the value of organic chemistry and physics. Biochemistry might be of use. Perhaps the issue is not the content of the individual courses, but reflects how students develop critical thinking skills.

The constraints of the process are many. One must consider that if "ethics" is required, what would be the core content that is necessary to include? Existing courses in business ethics or bioethics might be used, but are they equivalent in value to the student? What about the faculty time? How does a school add courses without attention to the faculty expertise and time to their multitude of responsibilities?

After considering various lists of potential courses, shifting to personal qualities of the student rather than course content and recognizing the constraints, there were several firm suggestions.

- 1) Basic biology (general, etc.) and general chemistry were essential.
- 2) Advanced biology (at least one, more preferable) to include genetics, molecular/cell biology, histology, or physiology.
- 3) Biochemistry was considered important by some.
- 4) Require an ethics course to familiarize the student with basic concepts and terminology such as autonomy, beneficence, justice, and non-maleficence.
- 5) Some statistics should be required.
- 6) Consider an approach that considers grouping courses students would take. The traditional sciences should be complimented by coursework in physiology, cell biology, immunology, genetics, and histology.

We then discussed how we might encourage and document students' demonstration of empathy, working as a team member, and people skills. The group could not identify a course where these qualities were "taught" or measured. It might need to be an independent project that allowed the student to identify a problem, show initiative through independent research and thinking, and establish communication skills. How might we make them better listeners? We want longitudinal evidence that documents a student's ability to show empathy and people skills. Mission trips, for example, might be a way a student could demonstrate their abilities.

(Hathorn) At a recent national meeting there was a plenary session on the humanistic side of medicine advocating that this quality be at the undergraduate and graduate level.

We might take some of our guidelines from this national initiative. An additional comment addressed the actual course requirements with attention to pre-requisite courses. If we eliminate organic chemistry and add biochemistry, organic is a pre-req of biochemistry so we are simply adding to the student course load.

(Wilson) We are interested in a liberal education that includes fine arts, languages, and humanities. The group did address this and recognizes that it is important to keep the pre-requisite courses flexible.

(Schmidt) Compliments to the group. Agree that we could cluster our expectations into three areas of language and content (coursework), some evaluation or documented experience of how students think, and attention to experiences that foster social and interpersonal skills. Can we identify the elements and the way a student can demonstrate “competency” in these areas?

(Minor) The advisors do a good job encouraging ideas for developing behaviors, skills, and attitudes. It would be great if this could be formalized as part of the pre-med advisory process.

(Reeder) Some of the student groups like Alpha Epsilon Delta (AED) fulfill some of the altruistic opportunities for students.

(Killam) Did the group address online courses? It is the wave of the future, but there is no way to make comparisons of courses. The group did not have an answer. Transcripts do not always reflect the online courses or identify them, but some schools are not accepting them as being comparable to other face-to-face classes. Although many universities are going more toward distance learning and online coursework, some universities are retaining the philosophy of in classroom teaching.

(McEntee) Is there a way to standardize community service or measure it? Do we want to actually quantify the number of hours of community service we would require or allow the students to follow their own interests. The group felt that establishing a number of hours would negatively impact our ability to look at the student commitment.

There should be some mechanism of recognizing special circumstances – for example, a single mother with children who does not have “free” time and judge her by the same criteria as a more traditional student.

(Hathorn) It would be a bad idea to require certain activities as part of admissions. We might lose the ability to evaluate student’s interests and initiative.

(Minor) It is important to have experiences, but disagrees that requiring is bad. Requirements might be reflective of testing motivation.

Next Steps Group 1:

- 1) Require an ethics course to familiarize the student with basic concepts and terminology such as autonomy, beneficence, justice, and non-maleficence.
- 2) Some relevant statistics should be required.

- 3) Perhaps consider an approach that considers grouping courses students would take. The traditional sciences could be complimented by such courses as physiology, cell biology, immunology, genetics, and histology.
- 4) Establish a three element evaluation process to address language/course content, behaviors, skills and attitudes, and social or interpersonal interactions. Provide an evaluation tool for such elements.

Group 2 - New Tools for Admissions Interviews

Lynn Mitchell, MD, MPH, M.D., Facilitator

Over the past ten years, the COM has used the literature of Dr. Daniel Goleman to address the emotional intelligence of our applicants. Being a successful physician goes beyond the knowledge of science and is dependent on the skills, behaviors and attitudes of the individual. Issues of self-regulation, maturity, acceptance of personal responsibility, commitment to the public good, etc. are increasingly important.

For discussion:

- 1) Is the current evaluation instrument capturing our ability to assess students' behaviors and attitudes?*
- 2) Should there be a requirement for community service and, if so, how would that be documented?
- 3) What new tools could be added to assess relevant personal qualities of applicants such as service orientation, team abilities, and commitment to lifelong learning?
- 4) During an interview, are you influenced by high scores and MCAT performance? Should we blind our interviews?

* Currently we use the following criteria:

- Self-Awareness
- Self-Regulation
- Social Skills
- Social Awareness
- Self-Motivation

Group 2 Discussion:

Dr. Mitchell's group wanted to define the "product" and what type of person we are trying to produce. Should it be in terms of the six required competencies and the need for diversity? It is important that the need for diversity does not negate the important individual qualities of each person. The group used "Assessing Personal Qualities in Medical students" as preparatory material.

Dr. Mitchell reviewed the six competencies (knowledge, patient care, interpersonal communication, professionalism, practice and systems-based knowledge). There were recommendations to provide feedback to the Admissions Board members and to the pre-med faculty so they could self-assess their effectiveness at predicting success. The common theme was whether the interview process and the instrument for evaluating candidates are really broken?

The group expressed a concern that we are losing diamonds in the rough who might not meet the standards and these special students might go elsewhere. The counter point was that we have enough well-formed diamonds and do not need to reach out to these

individuals who do not meet our standards. There is never any intent to lower the academic rigor of the process. We also wish to guard against having our applicants all look alike with similar strengths and weaknesses.

Perhaps we are capturing what we wish to evaluate with our current interview instrument. Maybe the system could be refined to include better or more extensive interviewer orientations. Each interviewer may have a different idea about self-regulation and what it means; however, better training might get the decision makers to more agreement. The key areas of evaluation are captured.

Question 2 for this group asked about requiring community service. We felt this had been discussed earlier, but (Belknap) expressed that any requirement we set would be met. It might negate the altruism. This is a very important trait, but requiring it dilutes the effort.

The group tried to identify new tools that we might use. After trained interviewers, we felt that adding a 360 degree evaluation process would assist in the final decisions regarding applicants. The applicants may be different with staff, with medical students giving tours, etc. It might either enhance the applicants experience or provide negative information about them.

Should we be influenced by high scores and MCATs? Most board members felt they were influenced and we might need to consider blind interviews or interviews where a part of the process was blinded. Therefore, we might need to modify the rolling admissions process so the first students don't always interview first. The applicant pool should be mixed and qualified student interviewed at will. The group discussed the relative value of all blinded interviews, not blinded and senior member have credentials and others are blinded. That may provide a different focus on personal qualities of the applicants. The interview would be used for evaluating more intangible qualities.

(Warren) The 360 degree evaluation is very well regarded and would provide additional feedback on candidates.

(Tucker) Is there any intent to quantify these intangibles? Would be very difficult to do.

(Jett) What currently happens when the student leaves the room? There is individual reporting of an interviewers impressions followed by a brief discussion for clarification.

(Schmidt) It is good to have a dialog on the pros and cons of team versus individual interviews. Might an individual interview be less threatening?

Individual interviews have been considered; however, the team interviews make the environment more conversational and provide four different viewpoints of questions asked and answered.

(Garrett) Is there a method of inter-interviewer rating? It would be useful for an experienced interviewer to provide feedback on their colleagues. This might identify if an individual interviewer is too malignant or inappropriate in their questions. Overall this might improve the process.

(W. Smith) We may be losing applicants in the interview process if the process is not conducted in an upbeat way to recruit the better candidates. We need to give a positive outlook for the students and not be so intrusive in questioning.

(Sawyer) The major challenge is whether we can improve this process and allow the GPA and MCAT scores to take a secondary position to some quantification of personal characteristics. We should use academics as a primary filter. Can we identify a near uniform way to assess character?

(Ball) Are the pre-med letters used? Yes and they are held in high regard. There is recognition of the amount of effort that goes into preparing each letter and an acknowledgement that the faculty know this student better and over time. These are more valuable to the process than a letter from an outside person who, for example, knows the family. Maybe we should standardize the outside letters? The pre-med letters should remain as is.

Next Steps Group 2:

- 1) More in depth training for interviewers
- 2) Define board members in terms of senior members or leaders of interview teams and have a senior member on each team
- 3) Strive for consistency in the interview
- 4) Perhaps consider a psychological tool of assessment
- 5) Consider a 360 degree evaluation instrument for the admissions day
- 6) Consider setting a minimum interview standard, interview candidates at will rather than in academic ordering, and blind the interview or partially blind the interview.
- 7) Provide opportunity for the interviewers to evaluate each other and give feedback.
- 8) Should we standardize the outside letters of recommendation to a common format?

Group 3 – How to identify a lifelong learner?

Jill Warren, MD, Facilitator

The Liaison Committee on Medical Education (LCME) is responsible to the U. S. Department of Education for oversight of and quality of medical schools. As such they issue educational standards and schools are held to the accreditation standards. In October 2006, the LCME added the following standard with annotation:

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

ANNOTATION TO ED-5-A: It is expected that the methods of instruction and evaluation used in courses and clerkships will provide students with the skills to support lifelong learning. These skills include self-assessment of learning needs and independent identification, analysis, and synthesis of relevant information, as well as the assessment of whether information sources are credible. Students should receive explicit experiences in using these skills, and evaluation of and feedback on their performance.

It is suggested that premed requirements be used to start the process of lifelong learning while students are undergraduates. For the discussion questions, please use a definition of lifelong learning to include those skills of self-assessment of learning needs (identifying strengths and weaknesses), independent identification, analysis and synthesis of relevant information, as well as assessment of sources of information.

For discussion:

- 1) How might we identify this skill set during the admissions process?
- 2) Is there some information applicants could provide that would address their abilities?
- 3) Are there undergraduate experiences that assist students to learn in this manner?

Group 3 Discussion:

Dr. Warren represented Group 3 discussion and felt like their conversation was in agreement with the previous reports. The group addressed the definition of a lifelong learner to include the ability of the student to self-assess independent of external pressures. The students need to figure out what they know and don't know and what to do about it. They agree that we can teach some of these behaviors, but self-assessment is an issue of the heart. Do they have a desire to learn? Consistently, but informally, we should evaluate extracurricular activities and the type of coursework (atypical?) the students are interested in taking. We might be able to identify a skill set in this process. We need to send an important message that we care about self-assessment. The learners don't respect what we expect, but will respect what we inspect!

Some pre-med faculty in attendance felt they could identify their students who were going to be life-long learners based on their personal experiences with them. No

outcome measures were presented. How can we prompt them for this information? What happens when students by-pass the pre-med advisory system? Should they be faulted? Split opinions from students. Faculty think we should ask why.

Maybe we should add to the supplemental information required and ask the student to write about what it means to be a lifelong learner. Be prepared for shallow answers since students are not valuing this quality and may not know of its importance to us.

The next item was identified as “dicey” and controversial – could we administer a psychological tool during the interview process to better identify character traits. A psychologist involved in the interview process could likely help identify applicant’s who are being genuine versus those giving us the “right” answers. The instrument to use is unclear but perhaps at first we could at least collect this information and then look at it retrospectively in comparisons to a student’s progress and identify if indeed valid predictors are present on interview days about issues of life long learning and professionalism. Could we flush out personality disorders? There was a lot of discussion and a bit of hesitation to undertake this process.

It is good to have balance when thinking about blinding an interview. This group agreed with establishing a cut point for academically qualified applicants and then have all applicants assigned an interview date not based on credentials. However, we recognize the problems with the rolling admissions process. We could then allow the interview to focus on the student character and personal qualities.

We should use structured questions during the interview. One of several common questions should challenge each applicant to identify their personal strengths and weaknesses. Another might be to identify problems in the health care system and ask for solutions the applicants might have considered.

The group felt that undergraduate experiences could be used to assist students in obtaining these skills. (Halliday/Hathorn) introduced the concept of inquiry based learning through Bio 2010. It focuses on problem solving abilities of students.

Encourage applicants to do supervised research and formalize the assessment of this lifelong learning experience.

Consider training workshops for members of the admissions board to better equip them with skills to evaluate character traits at the time of the interview.

(C. Hill) Students working with StAT have the ability to recognize good and bad attributes in candidates as they spend time with them on tours and over lunch. Students should have the ability to provide feedback. Also liked the idea of mixing students for interview.

(W. Smith) We still need to sell the school.

(Hathorn) Does it really matter who we accept as long as they are academically qualified? The group felt strongly that we don’t want to lose the better (gpa and MCAT) students simply based on the timing of their interview. We want to retain those students in Oklahoma!

(Sideman) Are we losing our top students based on financial deals? Yes, we are.

(Wilson) The early acceptances are important to the student and we do capture some students' interest. It is possible that they will change their mind, but some students even cancel national interviews and choose Oklahoma.

(Gonzales) Are later applicants discouraged? Her impression through the interviews is that a negative feeling about "no space in the class" impacts the students' ability to participate. Figure out some way to still have rolling admissions, but mixed interview days.

(McNamara) Mixing on any one day would be useful.

(Minor) Students aren't really faulted for later interviews, but there is a perception that it is to their disadvantage. Students have fewer numbers of positions to compete for.

(Franz) We should favor partially blinded interviews.

(Jett) We are preparing life long learners. Hold onto the character component during the interview.

Next Steps Group 3:

- 1) Establish a standard and focus for "self-assessment" and ask pre-med advisors to include this in their student letters or student evaluation forms.
- 2) Add an essay to the supplemental information and ask what it means to be a lifelong learner.
- 3) Structure questions during the interview. A common question should be to challenge each applicant to identify their personal strengths and weaknesses.
- 4) Structure a 360 degree evaluation system including staff and student input.
- 5) Create a model that allows students an interview based on a minimum standard, then award interviews with a mix of students. Consider blinding interviewers to scores and grades. Consider keeping the rolling admissions process.
- 6) Consider a workshop to develop interview skills for admission board members.

Group 4 – Measurement of candidates

Dotty Shaw Killam, Facilitator

Although true point systems show bias, we use a numeric generated by half weighting the average MCAT performance and the cumulative grade point average. Currently, this ranking is used during the offers of interviews and for the presentation of deferred candidates for board review.

Several questions have arisen that require our attention:

- 1) Students are not uniformly faulted or complimented for having taken the most recent MCAT. The MCAT is now offered 22 times a year in a web-based format. How should this alter our perceptions and interpretation of the MCAT? How can we be more consistent with the use of the MCAT?
- 2) The state requirement for offers of interview set a minimum standard of average performance of 7 on the three areas of the MCAT that are numerically graded. Some students are faulted for having, for example, a 6 on one section of the MCAT. Should we modify our approach and eliminate candidates with below a 7 in any individual component of the MCAT?
- 3) Are we satisfied with the mechanism of evaluating the deferred candidates to fill the class and construct a waitlist?

Group 4 Discussion:

Dr. Wilson gave the report.

The group discussed the validity in requiring students to provide a current MCAT score in an application cycle. It was expressed that the MCAT was evidence of an applicant's ability to learn and comprehend undergraduate material. It was felt by the majority of the group that once you started medical school the information learned at the undergraduate level was not a factor in your ability to learn the medical curriculum. Therefore the group suggested that an applicant with a minimum MCAT score of 30 (10 average), which is current within a three year period, not be required to provide a new score or be penalized for not retesting.

The minimum MCAT score required of an applicant is 21 (7 average) with no minimum score requirement on the individual sub-sections of the exam. However, statistical analysis of our current medical students indicates a correlation between the Physical Sciences sub-score with academic difficulty in the first two years of medical school and success on USMLE Step 1. Based on this evidence, the suggestion was made to require a minimum Physical Sciences sub-score of 7 but allow flexibility in the other two sub-scores.

The group discussed the effects of a defer vote on applicants interviewed early in the process. The defer vote needs to be used strictly for candidates who should not be offered an immediate acceptance or rejection. It is strongly suggested that the interview group talk out any questions remaining about an applicant at the conclusion of an interview. Hopefully this will result more immediate accepts or rejects and eliminate the

defer that is given as a result of indecisiveness. The group is satisfied with the mechanism of evaluating and ranking deferred candidates. They wish to continue to hold a number of positions open.

Next Steps Group 4:

- 1) Consider changing the advising system for taking the MCAT. If MCAT is greater than a ten average within three years of application, it is good. An average less than ten is different and the applicant should be advised to retake.
- 2) Require a minimum score of 7 in physical sciences to get an interview.

Group 5 – Partnerships

Melissa Beben, M.S., Facilitator

Recruitment: The University of Oklahoma College of Medicine is dependent on our undergraduate partners to provide recruitment, advice, and guidance to our applicants. To date, we arrange at least bi-annual visits to our primary undergraduate institutions where the preponderance of our applicants complete their studies. We have an on campus, once a year soiree inviting current applicants to our campus, and we teach and present at various Alpha Epsilon Delta meetings or teach classes across the state.

Resources: The Office of Admissions is staffed with a director and one secretary and we have arranged to share time of the MD/PhD program coordinator for recruitment. We also recognize there is less emphasis on pre-professional advising on many of our campuses and faculty time is overcommitted.

Policies and Updates: Twice a year we issue an admissions newsletter reviewing new policies, procedures, application deadlines, news from the national front, MCAT changes, etc. The entire process is becoming more electronic - this is the phase in year for implementing online submission of letters of recommendation.

Accountability: As outcome measures, at the annual Counselor's Workshop (usually October every year), we provide a performance chart of students from undergraduate institutions and their performance in the first year of medical school. We conduct studies of the predictive value of the Medical College Admission Test (MCAT) and the ability of students to successfully pass the United States Medical Licensing Examination Step 1 (USMLE).

Points for discussion:

- 1) What other recruitment activities would be useful to your students? With limited staffing on both sides, what activities would be effective and efficient use of time to help our students make informed decisions?
- 2) What type of outcome measures are you asked to provide to your home institution? What information would you wish to receive on an annual basis?
- 3) How might we be better partners?

Group 5 Discussion:

Dr. Bradley Jett gave the report for Group 5. They focused on what OUCOM can do to improve recruitment. Some suggestions include:

- 1) Research is mentioned as important. Could we attend the state and regional academies of science organizations and recruit from the student participants?
- 2) Continue the simulated medical school with mock lectures.
- 3) Set up a list of alumnae for shadowing opportunities. We noted the difficulties of shadowing in these days of protecting patient privacy. Perhaps volunteering at hospitals would be a better placement of time and easier to be compliant with HIPAA regulations.

- 4) Would love to have current medical students included in the recruitment visits. If occurring in the evening, this may be possible. The medical students love to present. We already have dress codes and PowerPoint presentations should they be invited.
- 5) Use the university's Counselor's Workshop in a different way. The timing of the sessions are difficult for teaching faculty at our sister institutions.
- 6) Keep a list of pre-med students and correspond with them over the application year.
- 7) Increase OU's presence on the undergraduate campuses.
- 8) Provide outcome measures of our classes to the advisors – overall class profile would be preferable to not break the issue of confidentiality.

We discussed our website and its current content. We appreciate input from anyone on what other information might be provided.

(Franz) He works in emergency rooms across the state and frequently has some students interested in applying to medical school. Although he personally knows that pre-med committees are almost always uniformly supportive of students, there seems to be a misimpression with some students who express anxiety about the pre-med committee. After discussion, it was felt that most students are comfortable and appreciate with the process of pre-med advisors support.

Next Steps Group 5: See above

Proposed New Initiatives Retreat on Admissions

- 1) Basic biology (general, etc.) and general chemistry were essential.
- 2) Advanced biology (at least one, more preferable) to include genetics, molecular/cell biology, histology, or physiology.
- 3) Biochemistry was considered important by some.
- 4) Require an ethics course to familiarize the student with basic concepts and terminology such as autonomy, beneficence, justice, and non-maleficence.
- 5) Some relevant statistics should be required.
- 6) Consider an approach that considers grouping courses students would take. The traditional sciences should be complimented by coursework in physiology, cell biology, immunology, genetics, and histology.
- 7) Establish a three element evaluation process to address language/course content, behaviors, skills and attitudes, and social or interpersonal interactions. Provide an evaluation tool for such elements.
- 8) More in depth training for interviewers
- 9) Define board members in terms of senior members or leaders of interview teams and have a senior member on each team
- 10) Strive for consistency in the interview
- 11) Perhaps consider a psychiatric tool of assessment
- 12) Consider a 360 degree evaluation instrument for the admissions day
- 13) Consider setting a minimum interview standard, interview candidates at will rather than in academic ordering, and blind the interview or partially blind the interview.
- 14) Provide opportunity for the interviewers to evaluate each other and give feedback.
- 15) Should we standardize the outside letters of recommendation to a common format?
- 16) Establish a standard and focus for "self-assessment" and ask pre-med advisors to include this in their student letters or student evaluation forms.
- 17) Add an essay to the supplemental information and ask what it means to be a lifelong learner.
- 18) Structure questions during the interview. A common question should be to challenge each applicant to identify their personal strengths and weaknesses.
- 19) Structure a 360 degree evaluation system including staff and student input.
- 20) Create a model that allows students an interview based on a minimum standard, then award interviews with a mix of students. Consider blinding interviewers to scores and grades. Consider keeping the rolling admissions process.
- 21) Consider a workshop to develop interview skills for admission board members.
- 22) Consider changing the advising system for taking the MCAT. If MCAT is greater than a ten average within three years of application, it is good. An average less than ten is different and the applicant should be advised to retake.
- 23) Require a minimum score of 7 in physical sciences to get an interview.
- 24) Research is mentioned as important. Could we attend the state and regional academies of science organizations and recruit from the student participants?
- 25) Continue the simulated medical school with mock lectures.

- 26) Set up a list of alumnae for shadowing opportunities. We noted the difficulties of shadowing in these days of protecting patient privacy. Perhaps volunteering at hospitals would be a better placement of time and easier to be compliant with HIPAA regulations.
- 27) Include current medical students in the recruitment visits.
- 28) Use the university's Counselor's Workshop in a different way. The timing of the sessions are difficult for teaching faculty at our sister institutions.
- 29) Keep a list of pre-med students and correspond with them over the application year.
- 30) Increase OU's presence on the undergraduate campuses and invite pre-med faculty advisors to campus occasionally.
- 31) Provide outcome measures of our classes to the advisors – overall class profile would be preferable to not break the issue of confidentiality.

Appendices

Invitees and Attendees

Group Assignments

Agenda

National Trends in Medical Education

Handout material from Browsing Table

Curriculum Overview