Continuous quality improvement (CQI) is a hallmark of an institution devoted to excellence. For an educational program, this ever-present quest is demonstrated by periodic, internal monitoring and reviewing of the program’s curriculum, practices and policies. Such assessments are often informal and may reflect students’ questions during a course activity to identify revisions or to revamp curricular units based on conversations with colleagues about teaching techniques. However, these assessments also may be formal, as in the case of a review or self-study that is part of a reaccreditation process.

For medical education programs, accreditation is granted by the Liaison Committee on Medical Education based on the evaluation of 12 overarching standards that comprise 93 elements on an eight-year cycle. The School of Medicine is currently engaged in its LCME self-study in preparation for its full survey reaccreditation visit in February 2020. Self-study committee participants received their charges from Dr. Loretta Jackson-Williams, vice dean and faculty accreditation lead, on Feb. 28.

Responsibilities of the self-study include:

- Collecting and reviewing data about the medical school and its educational program,
- Identifying institutional strengths and challenges that require attention, and
- Defining strategies to ensure strengths are maintained and problems are addressed effectively.

Jackson-Williams and a task force comprised of educational leaders, students and administrators from across the university are leading the School of Medicine in this yearlong process.

A team of more than 70 individuals – who make up five self-study subcommittees and a task force – is carrying out the self-study responsibilities. The five subcommittees are: “Institutional Setting,” “Academic and Learning Environment,” “Educational Program,” “Medical Students” and “Faculty.” The self-study committee participants are “Putting the Pieces Together,” the theme for the LCME SOM self-study. They are combining their expertise to evaluate and identify strategies to enhance the medical education program.

Each of the five subcommittees will evaluate a subset of elements and standards. All of the subsets are critical to creating an environment and curriculum that supports the development of skilled and compassionate physicians who provide high-quality and equitable health care.

On July 19, the subcommittees will reconvene after having completed a major portion of data collection and the first round of analysis, resulting in an initial list of institutional strengths and challenges. The self-study – a formal self-evaluation – will be the first step in the school’s reaccreditation process.

The Office of Medical Education will provide progress updates in a pair of SOM town hall meetings scheduled for 7 a.m. Wednesday, Aug. 17 and 4 p.m. Thursday, Aug. 16. During these meetings, Jackson-Williams will discuss changes that are yielding a more integrated curriculum, preliminary findings from the LCME self-study, and strengths of and challenges for the SOM.

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**Education Tip**

**Medical Education to offer instructional consults**

By Wendell C. Douglas

Beginning next academic year, the Office of Medical Education will offer instructional consults to support and enhance teaching services provided by dedicated instructors in the M1 and M2 curriculum.

Using OME Instructional Consult Services, teaching faculty will have access to instructional consults regarding writing session learning objectives, effective presentation delivery, observational feedback, the effective use of resources to support instruction, learner engagement and interactivity techniques, and the use of formative feedback and summative assessments to inform teaching and learning.

Similar services regarding syllabus construction and writing effective and informative course objectives are already available and being used by course directors. The instructional consults, completely voluntary in nature, will provide opportunities for teaching faculty members to pair their depth of knowledge and experiences with proven best practices for teaching to ensure optimal learning by students.

For more information about OME Instructional Consult Services, call 4-5006. To arrange a consult, visit the LearnTrax website on the UMC intranet and navigate to the Instructional Consults page using the right-side navigation menu. A Consult Request form link is at the bottom of the page. Upon submission, a request will be forwarded to the OME.
UMMC’s medical education transformation: Past, present, future

By Dr. Patrick Smith

UMMC’s chief faculty affairs officer reviews graduate medical education in the state of Mississippi:

The past: Following Mississippi’s 1817 entry into the union, the state’s health care needs were abundantly clear as evidenced by widespread disease, a lack of medical professionals and the dissolution of the Board of Medical Censors.

Following 33 years of discussion, a “department of medicine” was established at the University of Mississippi in 1903. The department was designed to provide the first two years of a recommended curriculum for schools of medicine.

During this era of medical education, “medical teachers” were expected to impart knowledge focused on the scientific basis of medicine. The paradigm of medical education was fundamentally “pedagogical teaching” by formal instruction with the focus on the teacher.

The present: Jumpstarting to a four-year curriculum of study in 1955, our current School of Medicine has a history of students doing the same thing at the same time with a predominate core structure of two years of basic science followed by two years of clinical work, referred to as a two-plus-two time-fixed curriculum model.

The SOM, housed in a new structure, has 23 departments with approximately 860 faculty members and was most recently accredited in 2011 by the Liaison Committee on Medical Education with an exceptional review. The school is now at an inflection point for the continuum of medical education.

More contemporary medical educational methods encourage the active participation of medical students as curriculum design evolves. With urging and oversight from accrediting bodies, medical schools are helping medical students and faculty shift from teacher-centric to learner-centric curricula in which inculcating the process of continuous learning is the cornerstone of professional development.

Now medical education’s archetype is the “andragogy of lifelong learning” using learner-centric models where the educator focuses on improving student learning more than delivering facts.

The future: With an emphasis on learner-centric and lifelong learning models, the vanguard of medical education for the future medical school will revolve around longitudinal and integrated competency-based curricula. Such curricula will be time-variable and outcomes-fixed.

Pioneering schools of medicine will define competencies and the variable will be the amount of time it takes to get there. Instead of once-a-year graduations, there may be numerous per year.

The shift from predominately teaching to learning will focus on inter-professional team-based experiences, including systems management and the social and behavioral sciences as represented in the new MCAT. Learners will immerse themselves in learning opportunities at their own pace using a wide array of artificial intelligence, robotic, virtual reality, digital and online tools and resources.

A challenge to the faculty will be to learn to design the competency assessments that interface with these technological resources. These extraordinary forms and sources of learning will plunge the learner into the tasks and actually do them.

In upcoming frameworks of medical education, faculty coaches will oversee learner-centric, team-based, inter-professional, real, virtual and digital-learning structures.

As medical education evolves from the groundbreaking Flexner report of 1910, the spirit of our time is to continuously readjust toward revolutionizing a medical school curriculum that is outcomes-focused while taking full advantage of technological advances to accommodate learner variation.

Curriculum Corner: Applying andragogical principles to medical education

By Dyon Williams

Take a moment to recall the best educational course you have ever experienced.

What factors made it so great? Was the facilitator’s delivery enthusiastic? Did the facilitator appear passionate about the learning content?

As a student, were you engaged and vested in the subject matter? Were you able to relate to the information being delivered and was it delivered in a way that empowered you to provide input? Was it safe for you to ask questions and drive the conversation forward?

I can guarantee you answered “yes” to two or more of those questions. I know this to be true because andragogy shows that adult learners learn best when they:

- Understand why the learning content is important and what’s in it for them,
- Are in an educational environment that allows them to be self-directed and encourages participation,
- Are able to combine their current knowledge and experience with the new information provided, which deepens their learning, and
- Experience learning delivery that enhances their readiness to learn and incorporates opportunity for real world application and problem-solving.

We can thank Malcolm Knowles for his extensive research in the adult learning principles. Applying andragogical principles to your course delivery methods can enhance student learning. I challenge you to take a look at your instructional design. How does it measure up? Does it satisfy any, if not all, of the above factors?

We must do what we can to ensure educational experiences maximize the opportunity for learning.