In the previous two issues of the newsletter, I have addressed some issues related to the LCME accreditation process. In this issue I will focus in more detail on the self-study process. The accreditation process is designed to help schools carefully examine their entire educational system so that the school itself can identify problems and perform corrective action before the actual site visit. The goal of the process is not to deny accreditation but to bring schools into compliance with the accreditation standards. While this process is onerous, I believe it is in fact beneficial for us to work through this together.

The first phase of the self-study process is compiling the database. The database is built around the accreditation standards and the LCME defines its content. For each standard (or in some cases two related standards combined) specific information is requested to address LCME priorities. The specific data requested may change from year to year based on evolving concerns identified at other schools even if the standard is unchanged. The months of August, September, and October were spent building the database. The database is substantially completed though a few areas remain incomplete.

Following preparation of the database, the self-study committees started their work in November. There are seven self-study committees operating under the oversight of the LCME Task Force. The committees and their chairs are: Institutional Setting – Academic Environment (Dr. Scott Champney), Institutional Setting – Governance (Dr. John Franko), Educational Program for the MD Degree (Dr. Ken Olive), Medical Students (Dr. Tom Kwasigroch), Faculty – Basic Science (Dr. Pris Wyrick), Faculty – Clinical (Dr. Charlie Stuart), Educational Resources (Dr. T. Watson Jernigan). Self-study committee members include faculty, staff, and students. The charge to each committee is to review the relevant portion of the database for accuracy and completion. This is a critically important role since the database is large and complex. The more members of the QCOM community that are involved in examining the database, the better it should be. Once each committee has assessed the database for completeness and accuracy, then they will make a determination regarding our compliance with the standard. If we are deemed to not be in compliance, then the committee will make recommendations for actions needed to attain compliance. The self-study committees will submit their reports to the LCME Task Force by March 1, 2011.

The Independent Student Analysis is another important part of the institutional self-study. As the name implies, this is an independent analysis organized and implemented by the students. This is to serve as an independent data source for the LCME – essentially a form of check and balance in data reporting. The Organization of Student Representatives (OSR) is organizing this activity. The
LCME provides a general template for this in their document “The Role of Students in the Accreditation of Medical Education Programs”. The survey will be administered to students anonymously on line and will be released in December. Like the self-study committee reports, it will be completed by March 1.

All of the working documents for the self-study are available for review on the T: drive under a folder entitled “LCME 2010”. Within this folder the data for the current self-study is in the folder entitled “LCME Self-Study Committees 2010-2011”. This folder then has an individual folder for each self study committee. Within each committee folder are three items: the portion of the database relevant to each committee, the list of committee members, and appendices related to that portion of the database. If you are interested in reviewing the database, I would encourage you to do so. If you have feedback on any portion of the database, you may provide it directly to the chair of the respective self-study committee. In providing feedback, it is very helpful to cite the page number and standard number, e.g. MS-29.

The LMCE Task Force is responsible for reviewing the individual self study reports, determining if the reports need any modifications, and determining if any institutional actions need to be taken based on the reports. Updating the database with newer data will also occur in this time frame. The Task Force will then be responsible for developing the final institutional report to be submitted to the LCME by June 1, 2011.

Once the final report is submitted, the LCME will typically request clarifications, additional data or more updated information. This will occur next summer up until the time of the site visit September 18-21, 2011. The site visit has a structured itinerary which results in the visiting team meeting with a variety of constituent groups such as students, junior faculty, course directors, department chairs, and various administrators. At the conclusion of the site visit the team will meet with the president, vice-president and dean to give their initial impressions. However, the final LCME report and decisions will not be presented until they have been reviewed by the full LCME. Hopefully we will have a favorable decision by early 2012.

If you are interested in knowing more about the process, information is available at the LCME web site: http://www.lcme.org/pubs.htm. The document “Functions and Structure of a Medical School” defines the accreditation requirements. The document “Guide to the Institutional Self-Study” provides more detail about the process described above.

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I got into medical education by chance when I moved to the area. We selected Johnson City because it had two positions for two people in mental health. My husband is also in mental health. I was working at the mental health center locally and teaching adjunct in psychology. I always knew I wanted to be involved in some sort of academic endeavor when the opportunity arose by being involved in the mental health center. I was able to make an association with the College of Medicine to start providing counseling to medical students. That was, at that time, basic mental health on a sort of contract basis. I was teaching adjunct on the main campus in psychology. At that time, there were shared positions between psychology and the department of psychiatry where people had joint appointments. So I knew the people in psychology, some of them were also working in psychiatry. I made some connections that way; got to know some people. An opportunity arose to shift. I was working at that time just adjunct in psychology and had a 50% appointment with the college of medicine to do counseling to medical students and 50% still at the mental health center doing mental health center work. A position came open in psychiatry after a faculty person left, that allowed me to move full-time to psychiatry. So I didn’t start out with a specific focus of medical education just the fact that I wanted to be in an academic environment. It worked out well because I found out I really liked medical education. I had a pretty steep learning curve early on because medical education is its own thing.

I did my internship in Memphis at the UT Center for the Health Sciences a consortium training program in Memphis. Before that I was in graduate school in Alabama.

When I decided to go to graduate school in Psychology I really had a misunderstanding of what it was going to be. I really thought a PhD in Psychology was going to be much more definitive than it was, than it ended up being. It ended up being wonderful. I chose Psychology by default. After graduate school, I took a year off and was a VISTA volunteer - Volunteers in Service to America, sort of the domestic Peace Corps. I worked in a mental health law project. This was in the 1970’s when warehousing of mental patients was still very common. The landmark federal case Wyatt vs Stickney had just occurred in Alabama. As a result, states were having to confront the fact that they were not providing adequate mental health care to the people that were kept for an inordinate amount of time without adequate treatment in state mental facilities. My placement was with the mental health law project essentially working with attorneys who were advocating on behalf of the mentally ill; filing lawsuits to try to require states to either provide adequate care or provide alternative placement or be institutionalized. That was an exciting thing to do. I got to work with a group of attorneys who were very passionate about civil rights, who were very passionate about addressing a social injustice.

When I was in undergraduate school, I had been considering law. I liked history and political science and writing which seems to lend itself to law. But I got out working with these attorneys who were very passionate. That seemed important to me but it, for them, was almost a technical exercise. They saw a wrong that they perceived a legal wrong and their goal was to legally redress that wrong and how it played out in the lives of the patients really didn’t make a dent in them. So I spent a lot of time in the mental institutions. I met a lot of really wonderful people who happened to be chronically mentally ill, who had never known anything but institutionalization. When the attorneys would file the lawsuits and when they were discharged, they would be discharged back to communities that had absolutely nothing to do with them. They had no resources. The community mental health center movement was in its infancy, there were no housing options, no advocates in place in the community. In the attorney’s minds, they had been victorious. These people had been released from what really was an unjustifiable institutionalization and incarceration and deprived of their civil liberties without treatment. On the other hand, when they were released to the community, their lives were really not any better because there was nothing in place to care for them. From the attorneys perspective, that was not their problem. Their problem was that the law needed to be addressed. I decided that’s not how I wanted to approach it. I did find out that I really liked the area of mental health. I thought there were a lot of opportunities to do things that still mattered to me. Things like social justice matter a lot to me. That kind of led me to decided I didn’t want law
and because I like the mentally ill I probably belonged in psychology.

I didn't even consider medical school. I knew I didn't want to be a physician; didn't want that approach to it at all but psychology, which I thought was going to give me a way to know what to do about mental illness. And, in fact, what graduate school teaches you is how little you can know and how important it is to always be searching for more information and to be open to constantly evaluating and trying to know more and to understand better and understand differently and to be on this quest rather than ever getting you to a destination. I didn't know what I was getting into when I got into graduate school. I thought I was going to a destination and it put me on a journey but it's ended up being a good one.

When I got in graduate school, I went to a program that was combined community and clinical psychology program. Community psychology is a little bit different from community medicine or community psychiatry. It shares some principals but it really has to do with not just looking at the individual but looking at the social systems within which the person functions and how the power structure, how the organizations of the social system, the community, influences and has an impact on that individual in their psychological functions not just in their interpersonal or group functioning. So it folds in this is a time when the mental health movement, community mental health movement, was getting some traction and looking at things like trying to prevent mental illness by trying to deal with social problems and social issues so that larger community context, social context, as a part of addressing psychological problems was an equal emphasis to my training in clinical skills relating to treatment and diagnosis and evaluation. I've always valued that. There hasn't been as much of an opportunity to use those community oriented skills or that part of my training but there's been a few opportunities along the way. I think doing that as much as I can is what gives my work meaning.

Service Learning, initially for me, was a part of a first year medical student course. I put it into the first year medical student course called Behavioral Sciences & Lifespan Development. That course has been redesigned with the modification of the first year curriculum. The required service projects has been transferred to The Profession of Medicine course. It's still in place and since I'm a co director of that course I still feel like I have a lot of investment in it. It's something I've been doing for 12 years. Regardless of what course it's housed in, it's something that's been a part of what I think medical education should include. It does involve not just service but service learning, which is different from just pure service. Pure service is about altruism which is absolutely crucial and essential in a core part of professionalism for medicine and traditions. Service learning has to do with taking service which is directed at the benefit of someone else and then using reflection and structured opportunity to learn from that service in a way that enhances your understanding of your academic preparations. Service learning, the learning part of it,

Welcome to the Standardized Patient Center

Everything turned out nicely. I have eight beds in discreet cubicles, eight cameras, eight separate recording stations, two monitors that will share the monitoring so I can see all eight cubicles at the same time. I can just tap the screen and bring one cubicle up in case I want to see something specific that looks like a problem. That won't change the recording, it just changes my viewing. Each one will have its own discreet channel, its own discreet recorder. Even if I'm viewing just one, I can put somebody in number seven, if we have a special make up or something, turn on number seven, and I can record it just by itself. Although there are eight cameras, each one will stand alone.

We can watch and get the PA system saying everyone get ready and then everybody will start and everybody will close at the same time. There are separate cameras to monitor each one of our first year Head-to-Toe physical exams. It will be great for that because, in a testing situation, I have one SP in a chair with a check list and they check off what's done. The SP on the table, it's their job to remember what wasn't done. Then they compare notes and get a really good solid result. Now we'll be able to back it up with the filming. So if the student comes back and protests about something, we can pop in the disc, sit there and watch it and say okay now you show me.

I was concerned with getting numbers in here that it would be too noisy. There's background rumble but even if you're in here and you've got four or five people you can hear what you're doing and you can hear the SP. It's just like if you were in a clinic. You don't get drowned out. It's

Office of Academic Affairs
just a background noise. For *Head-to-Toe*, I’m using all eight bays and I’ve got as many as five people in each bay plus a SP. Plus you throw in the doctors and myself so it’s 50 plus. It’s very useful; surprisingly quiet. What I love about it, the student’s get in here and pull the curtains closed (the curtains come all the way around). So you walk in and it’s like you’ve got eight little separate cubicles with people in there and it’s just like a clinic. It’s really like some of the family clinics that you will find in the area.

We’ve done this on a limited budget. A lot of your other hospitals, if you go to visit their Standardized Patient Centers, you’re talking $100 to $200 thousand dollars. This one was done for about $60,000. A lot of the equipment is older equipment that we’ve not used in other places. What we’ve had to do is buy semi-old equipment so that the two will be compatible and that’s what we’re using. The cameras aren’t the newest but for in here they will be fine. The only thing that Kevin and I worry about is the sound system. He’d like to put independent little drop microphones.

The communications course used to be eight weeks long, now it’s sixteen weeks because it’s grown so. It has doubled in size. We have sixteen weeks with fifteen groups. We need fifteen to twenty-five SP’s each Thursday, depending on what the cases are. Usually it’s three separate cases so I have three one-hour presentations of three different cases on any particular Thursday. The only one that is different is *The Practice of Medicine*. *The Practice of Medicine* is designed for disease of the day kind of thing. They do a half hour interview and then a half hour focused exam. That’s where the students get their information that they then have to go and present in the afternoon to a doctor. All the SP’s are doing the same case at the same time.

In *The Practice of Medicine* there is no lecture. The students show up and here’s your patient, this is their complaint, go to it. It’s their first exposure just like they would be if they were making rounds. They have to present the same way in the afternoon to the doctors of their three choices of disease and their treatment of each one; their primary, secondary, and third choice. They then have to have their methodology; how they would approach each one. The course is both first and second semester. Second semester they get a little bit more complicated, a little bit more esoteric because Dr Eason wants the students to question and think and listen to what the patients are saying.

Dr Eason and I had worked together at the University of Louisville before I came here and when he came here he pretty much brought his check list for head-to-toe training. When I came in, that’s what we were using. I’ve trained three of my SP’s to be trainers. We do refresher courses each year. What we do now is a half-hour refresher before each session, just to brush people up on what we’re doing that day.

The teaching/learning environment has changed greatly. The students are so much happier because it is more of a doctor environment. The SP’s are much happier. They’re more comfortable working here than in Building 178. When you have happy people, it comes across in their teaching. They’re much more relaxed and much more concentrated on what they are doing. Everyone’s so much happier. It just comes across as more professional. When people walk in and you’re, as a SP, teaching in the space, you feel more confident because you know that people respect you a little bit more because you’re in a professional environment. Being in a dedicated space gives a whole different tenor to the Standardized Patient encounter. I think it is much better all the way around.

It looks like a clinical environment. That’s what we were striving for. There had been plans around for a long time. Then Kevin and I kind of resurrected the old plans when we found out that pharmacy was out of here. This space was ours and I put my bid in for it and said why! Then we were able to find some grant money. Everything just fell into place. They did a great job. I’m very, very pleased. It looks great. It’s a good use of the space, as far as I’m concerned.

When Bill learned of the value placed on interactions between ETSU colleges, being the loyal ETSU employee that he is, he asked Carmen Allen, (College of Pharmacy) to marry him. The two were wed on December 28, 2009. Hoping for a happy long lasting relationship between the couple as well as departments.
I came to ETSU in the summer of 1979. This is my 31st year here and 12 years in Academic Affairs as of last month. I had just moved to the area, was working part-time and met someone who ended up being my manager at the University Bookstore. They had an opening for the Trade Book Buyer. I went right into that great job. That was long before Books A Million and Barnes and Noble were in Johnson City. In addition to textbooks, University Bookstore had a large trade book as well as other departments that were open to the public. I was able to hand pick every book, including when publisher’s sales reps came in and showed me the new releases.

The University outsourced the Bookstore. I had 19 years in and if I had stayed I wouldn’t have been a state employee. As soon as I found out, I started making phone calls to people I knew all over campus. It all worked out for the best. I was losing my job, thinking the worst, and then to come into Academic Affairs and get to work with Dr Leo Harvill and Dr John Kalbfleisch. Dr Harvill immediately handed over the entire course evaluation process to me. It was on paper then. Forms were printed and distributed to students in the classrooms. He was such a good teacher and spelled out exactly how everything was to be done. The same thing happened with Medical Student Education Committee (MSEC). Within a month after I was hired, I started doing the minutes of the meetings. I’m still responsible for those two things.

Evaluations have been online for years now. We still have the original survey system in place and have recently implemented a multifunctional system from New Innovations. That is a new software challenge, as is another aspect of my work with the survey system in its use for various research projects. It takes time to develop the instruments and the logistics of how it will be carried out. An ongoing project is associated with the new Profession of Medicine course. It will follow a student through their four years after taking that course and make comparisons with others who did not have the course. Dr Eason and Dr Hooks recently initiated another project related to Transitions to Clinical Clerkships, the four day course in preparation for third year.

Providing administrative support for MSEC, including having a role in the M1 curriculum revision, is very important to me. Dr Olive’s leadership and the direction toward focus on patients and professionalism are important for Quillen.

I truly enjoy coordinating the courses that I do, working with great faculty like Dr Monaco, Dr Lura, Dr McGowen and Dr Woodside for Case Oriented Learning, The Profession of Medicine, Keystone, and The Healer’s Art elective. The last two years, I put together the Community Agency Fairs. This event is part of first year medical students’ requirement to participate in a service-learning project, but also provides an opportunity for all students, faculty and staff to learn about the contribution these nonprofit organizations make to the welfare of our region. We worked with people on campus originally to get a list of agencies and contacts. The last two years, I stayed in touch with those people and found out more about their mission and who their clients were and what all they did and put the fairs together.

It’s especially interesting to me to be involved in areas of medical education that go beyond the basic and clinical sciences, like Healer’s Art—"remembering the heart of medicine." I stay on top of current events. I’m very aware of the complicated issues in our health care system. I hope some of these courses will inspire our students, will spark some interest in our students to take a leadership role and maybe turn some of this around. They’re going to be with their patients in their day-to-day life, but some of them just may help improve the U.S. ranking among world health systems. I love my niche in our office family, in the educational process and seeing new groups of students every year with potential to make big changes.

I grew up in Fairfield, Ohio, north of Cincinnati and graduated from The Ohio State University. I do want to go back. It’s been years since I was there. At the time, just doing undergraduate work there, I wasn’t even aware of the medical school. Now I want to go and see it. After time spent traveling in the Southwest, visits to relatives in western North Carolina led to trips over the mountain. I still live in the same unusual and beloved house on the hill that I moved into when I chose to settle here for awhile. I could not have imagined I would stay so settled. I have one big sweetheart tom cat who does not want brothers and sisters. In the past, stray cats have found a home with me and lived to old age on that hill. Now Thomas Gray guards the perimeter.

My life outside of work is filled with good times with friends and family. I often go to Asheville and Roan Mountain; my sisters and I have a tradition of spending St Patrick’s Day...
in New Orleans. Books remain one of the joys in my life; reading music and quiet walks among trees and ferns. I have to include the fun of driving my Mini Cooper Clubman. A decision made thanks to Dr Rowe letting me test drive his Mini.

People who know me, know I can quickly launch into social and political discussions particularly in defense of human rights, equal rights, women's rights. That is something that is really on my mind all the time and that I deeply care about. Dalai Lama’s “Be kind whenever possible. It is always possible,” is something I believe in. That’s what I feel, to be kind and sympathetic, and empathetic and patient with people. I am—I am with my family and others. Kindness and respect for all people and creatures and our little island of a planet. I’d like people to know those things and that I’ve learned a lot from some very difficult times and life changes I’ve been through. Those experiences have made me stronger. I am tougher than I look. I have fun. I truly do. I get stressed but you know usually I’m not—now I am so happy. It’s amazing to have peace of mind. I didn’t know that was possible. It’s amazing.

An Interview with Dr Ramsey McGowen cont’d

has to do with tying a service to the educational objectives and using personal reflection to make sure that it is actually an educational as well as an altruistic experience. I’ve been involved in that for a long time and I think it’s something that a lot of college of medicine are starting to adopt. I’m happy to say I’ve been involved, I think since pretty early on, with that.

It’s a required first year course both semesters. The title of the course is The Profession of Medicine: Patients, Physicians & Society. I think the reason that course was created was the well recognized need to formally include issues related to professionalism from day one. The other part of it was the need to address many topics that don’t fit in other ways into medical education. A lot of those things have to do with behavioral, psychological, and social aspects of The Practice of Medicine so, whether its culture in medicine or social determinate of health, understanding that a patient’s social context and how it affects their functioning, understanding how healthcare systems work, which is a part of the social system that medicine functions in, understanding the sort of roll that personal and demographics aspect of social lifespan and how over time especially a chronic disease takes a different approach to being an effective physician and chronic disease education. All those things have strong core elements of social and behavioral sciences so they are all clearly connected to my background in psychology.

I’ve been at ETSU for 25 years. In terms of where I want to go next, I would like to substantially increase the things we have been able to do with making a beginning with The Profession of Medicine: Patients, Physicians and Society. I think there is still a lot of room to improve in terms of how we can effectively educate our students. I really transfer and motivate and make meaningful to them some of the issues that precipitated the creation of this course. It’s a work in progress and I think there’s been a lot accomplished and a lot yet to accomplish. We’re sort of getting to where we want to go. I would love to see more opportunities for dealing with some of the social and community aspects of medicine. Not to minimize in any way what is already going on because like I said community psychology is a little bit different perspective from community medicine. I was thinking of the specific sorts of things that I would like to see in terms of really dealing with the individual patients within the social context and enabling students to understand that effectively or finding a way to make that just meaningful; more meaningful. It’s a hard thing to do. Medical students have so much to master and right now I don’t think we have a real efficient way to make that part of the experience. So that’s an area that I would like to try to pursue to create ways to make it educationally effective and efficient to strengthen that part of our curriculum in an educational experience.

Prior to going to college I had been in high school in New Orleans and had gone to a high school that was diverse in many ways but moved from New Orleans to Jackson, Mississippi. The school systems in Mississippi had not desegregated. I moved there and a week later the federal courts assumed control of the school system, closed all the schools and mandated desegregation. The schools had had 18 years since Brown vs the Board of Education, but obviously, in Mississippi, it had never had any impact. When that happened, it was I think it was one of those opportunities where a lot of things were in a state of flux. I had just moved from a school I
loved and a place I loved in New Orleans with great angst to a city I didn’t really want to go to. There was a lot of disequilibrium for me as a 15 year old kid going to a school system that was in complete chaos because the powers that be were no longer powers that be. The federal courts had taken over. There was a mandated desegregation where all the teachers and all the students were transferred all hither and yon trying to create some sort of balance in the school system to get to segregation and also to get to sort of a breaking down of lots of barriers. The school systems was in a lot of chaos. I think out of that chaos, out of that disequilibrium, I was able to have some opportunities that I would never have had had I stayed in New Orleans where I was very happy and content and I think would have been on a very predictable path.

Because of all the turmoil in the community I was living in and the attempt to make segregation work in Jackson, I got involved. I didn’t have any friends so I got involved in groups that were students that were working to try to build bridges and make integration work, some council of students that were trying to build an integrated community and also do service to try to reach out to areas of the community that had been disenfranchised. I think that happened at a time in my life when I was, as an adolescent, establishing my identity. So that just became a very formative kind of experience that helped me see how individuals function within social systems and how it takes human connection to make communities work whether you’re talking about education or medicine. I think that shaped my values in a real meaningful way. I was lucky that I just happened to like school so it was a real positive experience for me. And then liking it so much, I didn’t know what I wanted to do and taking that year to be in VISTA and having that opportunity to really again take those earlier formative experiences and say I want to do something that works with people that maybe are disenfranchised or don’t have control and power that need advocates and I didn’t want to do it through law. I wanted to do it through psychology and then finding a graduate program that had the community and the clinical emphasis that I think enabled me to develop.

I was fortunate enough to have formative experiences that allowed me to get to know and work with people I would not have otherwise had close relationships with. I had to confront some preconceived ideas (many of them implicit) about how the world works and how peoples’ lives are determined. I saw first hand how complicated every person’s life can be and how social and psychological factors interact in powerful but often subtle ways. This awareness fits neatly with the biopsychosocial model which states that medical education should prepare students and residents to treat the whole person, not a disease or set of isolated symptoms. It also corresponds to many of the tenants of professionalism that we try to teach. Teaching the behavioral sciences within medical education and using educational approaches like service learning have given me the chance to use the lessons of these formative experiences daily in my work in medical education.

I really love to teach. I like education, I like academics, I like reading, I like thinking, I like all those things and so being at ETSU and the College of Medicine has been a wonderful opportunity and I’m grateful for that; grateful for the opportunity to have been with colleagues in an academic setting and to work with students.

"I am not discouraged, because every wrong attempt discarded is another step forward."

Thomas Edison