



### What Are Schools' Policies Regarding Struggling Students?

Medical students struggle for a number of reasons, both academic and personal. Although struggling students are a minority among medical students, they present a continuing concern for faculty. Sandra L. Frellsen, MD, and colleagues surveyed a national cohort of clerkship directors in an effort to characterize the policies of US and Canadian medical schools regarding struggling students during the core internal medicine clerkship and fourth-year internal medicine rotations.

Respondents were asked about the percentage of students in the core clerkship who received a less than passing grade, the percentage who are identified as struggling, the typical final-grade options for these students, how often the director used those grades, and what remediation options were available. They were also asked whether they routinely shared (or should share) information about struggling students with other course and clerkship directors or instructors, and whether the respondent's school had or should have a formal written policy about sharing struggling students' information.

Respondents said that between zero and 15% of students each year were identified as struggling during the core internal medical clerkship, and between zero and 11% of fourth-year students were tagged as struggling. These students received a variety of grades; however, 77% of respondents said that struggling students who received unsatisfactory grades were always presented to a medical school promotions committee.

## Highlights From ACADEMIC MEDICINE

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A majority of respondents (64%) felt that they should share information about struggling students with other clerkship directors. Reasons for sharing information included the need to provide a supportive educational environment, the necessity of identifying struggling students early, and the importance of viewing medical education as a continuum and not focusing solely on a single clerkship. Those who did not favor sharing information felt that doing so might create bias or prejudice against students, and did not trust that clerkship directors would use the information appropriately.

The authors conclude that there is a need to accurately identify and remediate struggling students, and advocate for the development of national standards to promote grading uniformity, as well as the development of effective remediation plans for struggling students.

*Frellsen SL, Baker EA, Papp KK, Durning SJ. Medical school policies regarding struggling medical students during the internal medicine clerkships: results of a national survey. Acad Med 2008;83(9):876-881.*

### Point-Counterpoint on 'Forward Feeding' about Students' Progress

Several medical educators commented on the article by Frellsen et al. (above). Lynn Cleary, MD, opined that sharing information is the right thing to do, for the following reasons:

- ❖ The acquisition of knowledge and clinical skills is a longitudinal and cumulative process.
- ❖ Early identification of areas of concern maximizes the time available to work on improvements.
- ❖ Individual faculty may understate concerns and avoid submitting negative evaluations.
- ❖ Struggling students may not be noticed if information is not shared.

- ❖ A series of marginal performances is reason for serious concern.

Dr. Cleary makes several recommendations for minimizing the risks to students and communicating respectfully and professionally:

- ❖ Schools should have longitudinal, integrated, and shared assessment programs.
- ❖ A limited number of faculty should participate in an information-sharing committee.
- ❖ Students should participate in assessments that contribute to their cumulative performance profiles.
- ❖ Qualitative evaluations should describe specific behaviors and issues.

Susan M. Cox, MD, disagrees. She feels that information should not be shared because of the likelihood of breaches of confidentiality, the introduction of bias and stigmatization, the creation of unfair advantage, and other related legal issues. She posits that there is no evidence of value or proven benefit to forward feeding information that would justify the risks. In addition, the current litigious environment will encourage students to file lawsuits against schools, alleging that forward feeding led to irreparable harm to their careers. She believes that attention should be focused on correcting the systemic difficulties inherent in the current structure, and not on developing intrusive, costly, and risky arrangements that, she states, have little or no proven value.

Finally, Louis Pangaro, MD, lists a number of questions that educators should ask themselves in order to decide on their institutions' policies about forward feeding:

1. Are there particular types of behaviors that merit forward feeding so that patterns can be established and documented?
2. Is the history of a "first" problem in a clinical course different for the professionalism domain than for cognitive issues?
3. What preconditions are in the educational system and culture for consistent evaluation of students?
4. What is the empiric support for the notion that a framework for educational goals can be used consistently?
5. Can clerkship directors be trained to avoid bias coming from forward feeding?

6. What evidence exists that forward feeding has been successful in remediating struggling students' problems?

Cleary L. *'Forward feeding' about students' progress: the case for longitudinal, progressive, and shared assessment of medical students.* Acad Med 2008;83(9): 800.

Cox SM. *'Forward feeding' about students' progress: information on struggling medical students should not be shared among clerkship directors or with students' current teachers.* Acad Med 2008;83(9):801.

Pangaro L. *'Forward feeding' about students' progress: more information will enable better policy.* Acad Med 2008;83(9): 802–803.

### Creating a New School from the Old

The University of Colorado Health Sciences Center (UCHSC) has undergone several major changes over the past decade, not the least of which is its name change to the University of Colorado Denver. M. Roy Wilson, MD, and Richard D. Krugman, MD, describe the history and nature of these changes.

The UCHSC was established in 1976. As the school grew, it became clear that it was unlikely to be able to expand in its current location, as it was surrounded entirely by residential neighborhoods, whose citizens were concerned about parking and congestion problems. A solution was found when the Fitzsimons Army Medical Base in Aurora, located about six miles from the UCHSC campus, was closed. UCSHC was granted 227 acres to build a new academic health center at this location. Although several department heads initially objected to the plan, feeling that it would drain resources from the institution and hinder the school's research mission, faculty buy-in was eventually achieved after faculty realized that the new facilities would be superior to the old ones, among other factors. By April 2008, 3.4 million square feet of additional educational, clinical, and research facilities had been completed.

As the new school was being built, the University of Colorado leadership began to consider the future of both the Aurora and Denver campuses. A feasibility study was

done to determine whether the UCHSC and the University of Colorado at Denver should be combined into a single institution, with different missions but sharing a common future. This consolidation was accomplished in 2004; at first, the administrative units were combined, but the campuses continued to function as separate entities with different cultures. The new institution is named University of Colorado Denver, branding the consolidated university as a single entity.

Wilson MR, Krugman RD. *The changing face of academic health centers: a path forward for the University of Colorado Denver.* Acad Med 2008;83(9):855–860.

### What Direction Should Internal Medicine Training Take in the 21st Century?

Various voices have been heard regarding the future of training in internal medicine. Some say that internal medicine must accommodate the increasing need for subspecialists. Others note that role differentiation should be acknowledged earlier in the training process. Still others call for increased attention to ambulatory training. However, Thomas S. Huddle, MD, PhD, and Gustavo R. Heudebert, MD, argue that the traditional Oslerian model is the one that should be followed, as it produces seasoned clinicians who possess a knowledge of internal medicine that is both wide and deep.

The increasing complexity of health care delivery, along with increasing role differentiation, threatens the viability of the "consultant-generalist" ideal in medical practice. Budgetary pressures make it increasingly difficult to combine office and hospital practice, leading to a division between office-based and hospital-based internists. The authors point out that the multiple roles now played by internists still require the kind of general competence provided by traditional training, which involves familiarity with the broad range of internal medicine illness and with managing such illness in both inpatient and outpatient settings. Calls for reform, which imply that inpatient and outpatient training should be conducted indepen-

dently of one another, are misguided, they say, as the two are actually less separate than they were previously.

The authors maintain that inpatient rotations should provide the core training in diagnosing and treating disease in its most demanding aspects; after they attain this experience, trainees will be able to progress to outpatient rotations and gain a supplementary view of the same diseases in their less acute manifestations.

Huddle TS, Heudebert GR. *Internal medicine training in the 21st century.* Acad Med 2008;83(10):910–915.

### Experiential Learning of Systems-Based Practice

In order to prepare for the systems-based, interdisciplinary approach to health care delivery that is the model for the 21st century, residents must learn both sophisticated information technology and the way in which various components of the health care system interact with each other. Arnold R. Eiser, MD, and Joanne Connaughton-Storey, MD, report on a two-week supervised experience developed at Mercy College Medical Center in Philadelphia that permits first-year residents to experience the care provided by other health care professionals.

The residents, under the supervision of experts in the various disciplines, spend clinical time in home nursing care, home hospice care, pharmacy services, clinical laboratory services, utilization management, and nutrition services. A component in physical therapy is also planned.

After this experience, a substantial majority of residents indicated that they definitely had a better understanding of available medical resources to optimize the medical care of their clinical patients and to better arrange for resources after the patients are discharged. Almost all the residents felt that their overall knowledge of nonphysician services within the health care system increased to some extent.

Eiser AR, Connaughton-Storey J. *Experiential learning of systems-based practice: a hands-on experience for first-year medical residents.* Acad Med 2008;83(10):916–923.