WINDSOR UNIVERSITY
SCHOOL OF MEDICINE

Windsor Insight

ISSUE #3 FALL SEMESTER 2016

SUMMER 2016 RESEARCH DAY

By Guri Tzivion

With the culmination of the 2-semester long Principals of Biomedical Research course, graduating MD3 students held their first research day on August 5th, 2016. This event included poster presentations by the research groups as well as short talks. School wide participation of both students and faculty fostered stimulating discussions of diverse biomedical topics, allowing exposure of our students and faculty to cutting edge biomedical research.

A broad judging panel helped in selecting the top three poster presentations and oral presentations. We would like to thank all the students and faculty who contributed to the success of this important educational event. We are looking forward the next research day which will be held during December of this year. The fun spirit of the event can be seen in the accompanying pictures.

The titles of the research projects and authors are listed below with the top three in each category indicated.

1. Increased prevalence of neurodegenerative disorders in diabetic patients: the role of insulin resistance in neuronal tissues and limited efficacy of

WHATS INSIDE

Summer 2016 Research Day

current anti-diabetic treatments. Ashley Armogan, Ali Eghbalian, Ayobami Olaleye, Anshu Dhir, Abdi Suldan, Aaron Simpson and Guri Tzivion ***(Poster 2nd; Talk 3rd)***.

2. Effects of Calorie Restriction on Aging and Cardiovascular Health. Bassey Enun, Benedict Ikeudenta, Bhavik Patel, Charles Meregini, Chikaodi Odoemelam, Chimdindu Emeka-Emeh and Vivek Joshi.
3. Important Causes Leading to Medical Abortion. Fadumo Mohamed, Fowzia Hassan, Ochuko Omonode, Danish Iqbal, Dana Willoughby, Chukwumuanya Abuah and Bikramajit Singh Saroya.
4. Dietary restrictions along with dietary supplements are found to have a profound effect on the prevention, development and treatment of type 2 diabetes. Kamal Agarwal, Ifunanya Okonkwo, Jane Oparah, Khalil Ali, Kapish Sharma, Kenechukwu Igbokwe and Jeevan Divakaran.
5. Academic Performance based on student-learning profile, age, degree obtained prior to entrance, GPA from prior academic institution at Windsor University, St. Kitts. For graduation 2018-2020.
   Kiran Sagar, Kirit Sahi, Koteswar Alla, Majd Zubi, Lada Pascar and Soumitra Chakravarty ***(Talk 1st)***.
6. Triple negative breast cancer (TNBC) in African American women. Maryjane Nwankwo, Micheal Anekwe, Micheal Michail, Faith Adelegan, Marlesa Shields And Sanjib Das.
7. Current Options In The Management Of Diffuse Large B cell Lymphoma. Muni Hassan, Ritha Mera, Najma Abdullahi, Oluwanefemi Ajigbolamu, O.J Akinwale, Richard Orji and Fatai Oluyadi ***(Talk 2nd)***.
8. The effects of HPV vaccination, PAP smear screening and awareness raising in prevention of cervical cancer in developing countries. Udeme-Obong Isang, Rose Elizabeth Gogo, Tochukwu Nwosa, Tanjyot Sidhu, Tokuibiye Bright and Kusai M. Alsalhanie ***(Poster 1st)***.
9. Obesity as a risk factor for Breast Cancer in Asian Americans and African American women. Maria Fatima, Marianne Grace Gumaru, Nausheen Dhanani, Vashti Geer, Zareena Khan, Zayd Mughal and Samal Nauhria ***(Poster 3rd)***.

Summer 2016 Research Day

Introduction of Virtual Pathology Lab at Windsor

By Jeevan Divakaran

A good understanding of pathologic changes at the microscopic level is essential to develop a satisfactory knowledge base in Pathology. The technological boom over the last decade has made it extremely important that we move beyond the traditional school lab system using student microscopes and glass slides. Even with well annotated static images, it is not possible to duplicate the experience of examining an actual slide and therefore most medical schools make provisions for the microscope and glass slide based labs. Some disadvantages of the traditional method include - glass slides fading over time, cover-slips separating or breaking from the glass slides, periodical replacement of the glass slides etc. To overcome these issues, many medical education programs that had been using light microscopes to train their students have decided to make the shift to virtual microscopy in their educational curricula in recent years. [1-5]

The aim of the "Virtual Path Lab" project at Windsor University School of Medicine is to provide a novel mean for histopathological education that would help to address some of the problems the students may encounter in effectively developing histopathology skills and to enhance their learning experience.

Digital imaging technology is rapidly becoming a universal buzzword in diagnostic pathology and it is now possible to effectively utilize this technology as a teaching tool. This resource makes microscopic information available to the medical students in real time with a single click on their computer workstations. Some of the advantages of virtual microscopy include - the lab sessions are now much more efficient as the students have access to all the slides at a click at anytime and anywhere, in focus, with proper lighting and condenser adjustment, and a far superior quality in comparison with common quality of student light microscope.[6] The students are now able to examine entire tissue sections. They can also be visualized at any magnification and the students are able to move across the entire slide in both axes, as opposed to static images of selected fields. It provides a close simulation of the traditional microscope and glass slide without the associated limitation. [7] The institute also benefits from this system because there is no longer any

need to support expensive traditional labs.

The entire set of training slides was obtained from the University of Iowa and traditional student microscopes were replaced by computer workstations. The process was initiated in the 2016 summer semester and was fully implemented by the 2016 fall semester. Since Pathology is taught over 2 semesters, and the sessions were implemented for both batches at the same time, the senior batch was able to experience the superiority of the virtual microscope in terms of morphological clarity, efficiency, accessibility and ease of use. The students have endorsed it enthusiastically and we have noticed a surge of intrigue and fascination among them during these lab sessions. Initially there was a lot of concern regarding technical issues especially the browser speed. However, at the time of writing this article, more than 4 sessions had been successfully conducted without any technical glitches. The lab sessions are mandatory and faculties supervise all sessions and are available to react to the students needs.

Over the next few semesters we intended to assess the efficacy and usefulness of these digitized slides. The aim is to incorporate gross images, radiological findings and patient clinical data with the slide sets and allow students in small groups to examine these slides with the associated data. A comprehensive evaluation will be conducted using a questionnaire to assess the morphological clarity, efficiency, accessibility and ease of use.

- Mukherjee MS1, Donnelly AD1, DeAgano VJ2, Lyden ER3, Radio SJ4. Utilization of virtual microscopy in cytotechnology educational programs in the United States. J Pathol Inform. 2016 Mar 1;7: 8. doi: 10.4103/2153-3539.177682. eCollection 2016.
- Krippendorf BB, Lough J. Complete and rapid switch from light microscopy to virtual microscopy for teaching medical histology. Anat Rec B New Anat.2005;285:19–25.
- Kumar RK, Velan GM, Korell SO, Kandara M, Dee FR, Wakefield D. Virtual microscopy for learning and assessment in pathology. J Pathol. 2004;204:613–8.
- Blake CA, Lavoie HA, Millette CF. Teaching medical histology at the University of South Carolina School of Medicine: Transition to virtual slides and virtual microscopes.Anat Rec B New Anat. 2003;275:196–206.
- Heidger PM, Jr, Dee F, Consoer D, Leaven T, Duncan J, Kreiter C. Integrated

approach to teaching and testing in histology with real and virtual imaging. Anat Rec.2002;269:107–12.
- Szymas J, Lundin M. Five years of experience teaching pathology to dental students using the Web microscope. Diagn Pathol. 2011 Mar 30;6 Suppl 1:S13. doi: 10.1186/1746-1596-6-S1-S13.
- Glatz-Krieger K, Spornitz U, Spatz A, Mihatsch MJ, Glatz D. Factors to keep in mind when introducing virtual microscopy. Virchows Arch. 2006;448:248–255. doi: 10.1007/s00428-005-0112-2.

New Additions to the Windsor Family!

Dr. Lee HangFu, MD
Associate Dean of Clinical Academic Affairs
Dr. Lee received his M.D. from the University of Western Ontario, London, Ontario Canada. He interned at the Victoria Hospital, London Ontario, General Surgery in Memorial University, St. John's Newfoundland Canada, researched at the McMaster University and completed his Plastic Surgery Residency with Dr. Thoma at McMaster University, Hamilton, Ontario Canada. He received his ASPS board certification in 1991. He worked as an Assistant Professor at the University of Medicine and Dentistry of New Jersey before entering private practice.
He worked in private practice for 25 years and taught all levels of medical students and residents. He earned the rank of Professor in 2015. He arrived in the Caribbean in 2014. He held the post of acting Dean before joining Windsor. His greatest moment is when he received the highest honor as the Teacher of the year on April 2016. He is an avid sports fan and his hobbies include biking and cooking

Dr. Rukevwe Odjimogho, MD
M.D. – Windsor University School of Medicine (WUSOM), St. Kitts, 2014.
B.Sc. Microbiology – University of Benin, Benin City, Edo State, Nigeria, 2007.
Dr. Rukevwe Odjimogho started his medical education journey with a first degree in Microbiology. Thereafter, he taught Microbiology at the Bauchi State School of Nursing, Bauchi, Nigeria. In May 2011, he commenced his medical program at WUSM and recently concluded his M.D. program. He joined the Windsor academic staff in May 2016.
Dr. Rukevwe is very passionate about teaching, patient-centered care and has an insatiable hunger for knowledge and growth. He is also an avid student of transformational leadership and personal development and has worked with several individuals and organizations in developing both. His favorite pastimes include writing, reading and music.

Recent Developments in Windsor University School of Medicine Clinical Rotations

By Sandeep Mellacheruvu

Introduction

Windsor University School of Medicine (WUSOM) offers clinical rotations to students at teaching hospitals during the third and fourth years of the MD Program. Currently our clinical department consists of a Clinical Dean, Associate Clinical Deans, Assistant Clinical Dean, Department Chairs, Hospital Associate Clinical Deans, Clinical Preceptors, Clinical Coordinators and Clinical Instructors. This article predominantly focuses on policies and procedures in the US. For detailed descriptions of individual components and resources students can contact clinicals@windsor.edu.

Hospitals

Clinical rotations are offered to Windsor students at Jackson Park Hospital, Westlake Hospital, Holy Cross Hospital, Norwegian Hospital, Access Community Health Network Madison Clinic in Chicago, Memorial Herman Hospital in Houston, Texas, Georgia Regional Hospital in Atlanta, Griffin Memorial Hospital in Oklahoma and May Pen Hospital in Jamaica. We are constantly looking to expand our clinical sites. In case students are interested in doing rotations in teaching hospitals elsewhere we work with them and the Hospitals to facilitate an affiliation.

Preclinical Checklist

Since September 2014, WUSOM has adopted a policy which requires students to pass USMLE Step-1 in order to be eligible to start clinical rotations in the United States. Once the student passes USMLE Step-1, he/she is expected to contact our clinical coordinator to schedule their rotations. Students are required to complete a preclinical checklist which includes USMLE Step 1 Score Report, Proof of Tuition Payment, Background Check (Police Report), Drug Screening report , Immunization Records (Up to date within 1 year), Blood Titers (MMR, Varicella, Hep B), CPR/BLS Health care provider certificate (American Heart Association), Last page of clinical package, Flu shot record, Photo ID, Health Insurance Portability and Accountability Act (HIPAA) & Blood Borne Pathogens (BBP) training certificates obtained from http://www.compliancepublishing.com, PPD record on the health forms and Cultural competency certificate at https://cccm.thinkculturalhealth.hhs.gov/default.asp.

Orientation

Prior to starting clinical rotations students are required to attend one week of mandatory orientation at Chicago Medical Training Center, 7415 S East End Ave, Chicago, IL 60649, or Clear Choice Medical & Dental Center, 7080 Southwest Fwy, Houston, TX 77074. During the orientation our clinical department faculty address the following topics Professionalism & Medical Ethics refresher, History taking skills , Dress code policy, Substance abuse policy, Leave of absence policy, Clinical Grading Policy, NBME Policies, Library resources such as Access Medicine, Uptodate, EBSCO host, resources to prepare for NBME shelf exams and Step 2 CK and Step 2 CS, code of conduct during clinical rotations, Graduation and Residency time line, ERAS Applications, ways to obtain access library facilities by contacting our librarian, ways to obtain access to Uptodate and EBSCO host, through student portal, ways to access the student portal by contacting our IT department, ways to obtain Windsor.edu email and ways to obtain Student IDs. On day 2 of orientation, we demonstrate physical examination skills, let the students practice through peer to peer practice scenarios, and give them access to few clinical videos for their review and independent study. On day 3, we go through the clinical documentation checklist, guidelines to write an Electronic Patient Encounter Note (EPEL), SOAP Note, and Case Report. We also explain how to obtain access to DocCom Modules for improving their communication skills, and MedU cases for virtual

patient experience.
On day 4 students are required to do patient education presentations using evidence based practice guidelines and online resources on topics such as Smoking Cessation, Alcohol and Drug Abuse prevention, Immunizations, Nutrition guidelines and dietary recommendations, Obesity and Weight loss, Domestic violence, Exercise recommendations, Screening methods (Hypertension, CAD, Breast, Colon, and Prostate Ca.), and Safe sexual practices. On day 5 students are required to do clinical scenario evidence based presentations on topics such as Chest Pain, Cough and Shortness of breath, Abdominal Pain, Low back ache, Headache, Diarrhea, Dizziness, Weakness, Confusion, and Depression.

Cores, Selectives, & Electives

Students are required to complete core rotations before they could start any elective rotations. During the core rotations they are expected to follow board certified physicians in their respective fields such as Family Medicine (6 weeks), Pediatrics (6 weeks), Internal Medicine (12 weeks), Surgery (12 weeks), Obstetrics and Gynecology(6 weeks), and Psychiatry (6 weeks). Following core rotations they complete 12 weeks of selectives, 4 weeks each in Emergency Medicine or Neurology, Community and Preventive medicine, and Research. After selectives, students are free to do their 12 weeks of elective rotations in medical and surgical sub-specialties of their preference.

Standardization

To standardize their experience at various clinical sites, the clinical curriculum committee has devised various solutions such as a mandatory one week of orientation, uniform syllabus for every core rotation made available to students during orientation and through our website, use of web-resources such as DocCom modules, MedU cases, Uptodate, Access Medicine, and EBSCO-host.

All students get their midcore and final evaluations by their preceptors which account for 40% of their grade, complete a core examination which is an NBME shelf examination which accounts for 30% of their grade, clinical documentation of electronic patient encounter logs, SOAP notes, and case reports which account for 10% of their grade, weekly quizzes which account for 10% of their grade, and OSCE skills which account for 10% of their grade. Recently in the last 3 years monthly meetings were started to bring all the clinical students at different sites together to discuss the challenges, take core examinations, and network with practicing physicians, alumni, department chairs, and residents. Since 2015, the frequency was changed to bimonthly meetings with regular didactic lectures by board certified physicians. In June 2016, we have implemented biweekly webinars to impart medical knowledge to students by residents in various US programs. These didactic lectures through webinars are intended to address their NBME shelf and USMLE Step 2 CK preparation. In September 2016 we have introduced bimonthly OSCE meeting to improve our Core rotation OSCE, Exit OSCE, and USMLE Step 2 CS performances.

Exit Examination

Once the student completes all the core rotations, and their respective requirements, he/she is allowed to take NBME comprehensive clinical sciences examination (CCSE) which contributes to 50% of the exit examination grade. Windsor University is currently recommending all the students in clinical rotations to take their USMLE Step 2 CK and CS examination in the 4th year after completing all the core rotation, NBME shelf examinations, and NBME CCSE. After completing the 12 weeks of selectives and 12 weeks of electives students are allowed to take their OSCE exit examination which consists of 8 active stations

(FM, Pediatrics, IM, Surgery, OBGYN, Psychiatry, Neurology, Emergency Medicine) and 4 inactive stations (EKG, Lab interpretation, Radiology, and Surgical Instrument). OSCE Exit examination contributes to another 50% of their exit examination grade.

Preventing Infections: It's in your own Hands!

By Brijinder Gupta

Hand Hygiene: Still a Challenge

The increasing incidence of healthcare-associated infections caused by multidrug-resistant pathogens, the diminishing supply of effective therapeutic regimens, and the paucity of new antimicrobial agents in development have made preventing transmission of healthcare -associated pathogens more important than ever. Although hand hygiene is considered one of the most effective measures of preventing healthcare-associated infections, convincing healthcare personnel to clean their hands still remains a daunting challenge. To promote better hand-hygiene practices among healthcare personnel, the Center for Disease Control and Prevention, and more recently the World Health Organization (WHO) have published evidence-based guidelines that prescribe strategies for improving hand hygiene.

Alcohol-based hand rubs are recommended as the preferred method of hand hygiene in most clinical situations when hands are not visibly dirty or soiled with proteinaceous material. Compared to soap and water, alcohol-based hand rubs are more effective in reducing bacterial counts on hands, can be placed in more convenient locations, take less time to use, and cause less skin irritation and dryness.

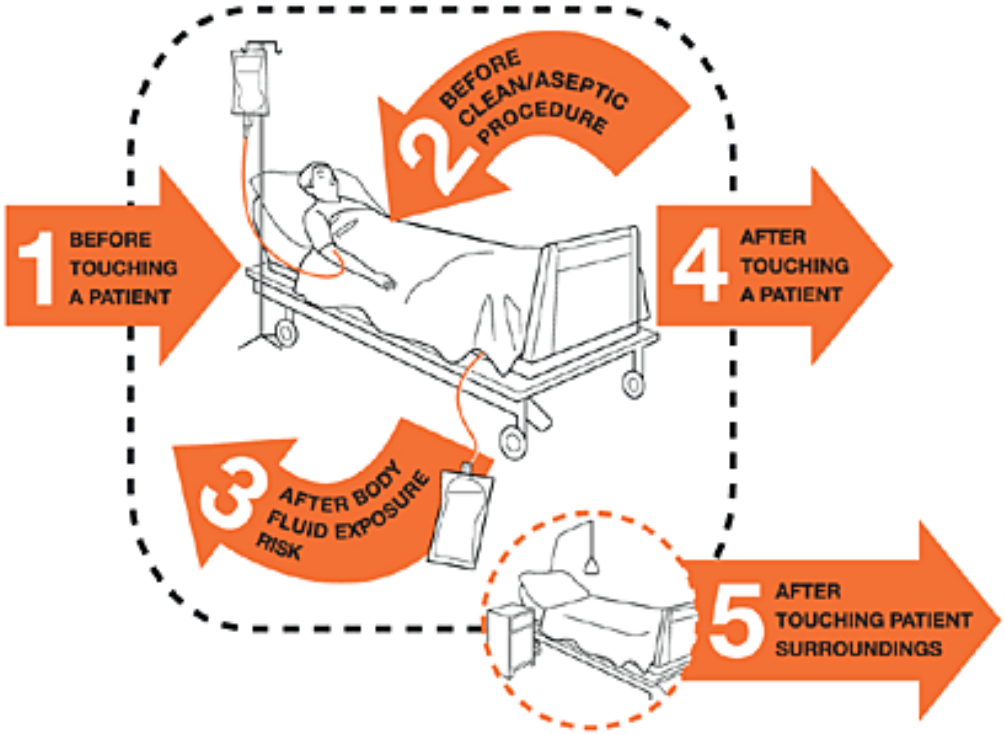
Alcohol-based hand rub dispensers should be readily available at the point of care, such as in patients' rooms or examination rooms. Locating dispensers in hallways near the doors to patients' rooms has also been found to be useful as this allows healthcare personnel to clean their hands as they enter the patient's room. This also allows the patient to see that the caregiver is performing hand hygiene, without delaying any contact that may be planned with the patient.

If physical facilities make it difficult to place wall-mounted hand rub dispensers near patients (because of insufficient wall space), consideration should be given to providing table-top pump bottles, or making pocket bottles of alcohol-based hand rub or small wearable dispensers available to personnel. Although some healthcare personnel have expressed concern that the outside surface of pocket bottles may become contaminated with bacteria present in the individual's pocket, this should not be a problem if hand rub is applied to one hand, and then the top of the bottle is closed with the other hand and the bottle placed back in a pocket before rubbing the product over all surfaces of the hands. Wearable dispensers that can be clipped to a belt or any other part of the caregiver's clothing must deliver a dose of hand rub large enough to require more than 15 seconds of hand rubbing to feel dry.

A Case for Clean Hands

It is equally important to educate healthcare personnel about the importance of hand hygiene, when it is required during patient care and the appropriate technique for using alcohol-based hand rubs and when to wash hands with soap and water. Amongst Physicians, Hand-hygiene compliance is traditionally lower than among nurses, essentially because of the difference in attitude. Nurses tend to appreciate the need and efficacy of hand hygiene more. Anecdotal data suggests that some physicians are not convinced that sufficient evidence exists to support the notion that hand hygiene has a role in preventing healthcare-associated infections.

Therefore, healthcare personnel should be made aware that during the past 2 decades, at least 28 published studies of varying design and rigor have found that improved hand hygiene was associated with reduced healthcare-associated infections. In addition, in the 1960s, a National Institutes of Health-sponsored prospective controlled trial assessed the rate of acquisition of *Staphylococcus aureus* among 2 groups of newborn babies. One group was cared for by nurses who did not wash their hands between caring for different infants, whereas the other group was cared for by nurses who washed their hands with an antimicrobial soap between care giving encounters. Babies cared for by nurses who washed their hands between caring for different infants were significantly less likely to acquire *S aureus*. Moreover, the few infants in the hand washing group who acquired the organism did so after being in the nursery significantly longer than infants in the no-hand washing group.



Healthcare Hand washing: 5 Moments

To achieve high levels of hand-hygiene compliance, healthcare providers must be aware of when to clean their hands. The 5 major indications for performing hand hygiene during patient care have been outlined in the WHO Guidelines on Hand Hygiene in Health Care and by Sax and colleagues, and are often referred to as **"My 5 Moments for Hand Hygiene"** (Figure).

"My 5 Moments for Hand Hygiene" Image courtesy of the World Health Organization.

These indications are:

- Before touching a patient;
- Before performing a clean or aseptic procedure;
- After body fluid exposure risk;
- After touching a patient; and
- After touching patient surroundings.

The first 2 indications in this list are necessary to minimize transmission of pathogens to patients, whereas hand hygiene after potential exposure to body fluids and after patient contact is designed primarily to protect Health care personnel.

Hand hygiene measures are recommended after contact with such items as bedside rails, linens and medical equipment near the patient, because these surfaces are frequently contaminated with pathogens harbored by the patient. By touching such surfaces, personnel can contaminate their hands or gloves with methicillin-resistant *S aureus*, vancomycin-resistant enterococci, *Clostridium difficile,* and other pathogens. Owing to a lack of awareness of this contamination risk, healthcare personnel often fail to clean their hands as recommended after only having contact with environmental surfaces near patients. Hand hygiene is recommended after removing gloves because the gloved hands of healthcare personnel are frequently contaminated by the patient's flora. This presumably occurs because bacteria penetrate small holes in gloves, or because caregivers contaminate their hands during the process of removing gloves.

Hand-Hygiene Compliance Technology

Appropriate techniques for washing hands with soap and water and for use of alcohol-based hand rub are required to achieve optimum benefits from hand hygiene. Unfortunately, many healthcare personnel exhibit poor hand washing technique (eg, often washing hands for only 10 seconds or less). The WHO guideline suggests that the entire process for hand washing (wetting hands, applying soap to all surfaces of hands, rinsing, and drying) should take 40-60 seconds.

Applying inadequate amount of hand rub results in poor removal of bacteria. When an appropriate amount of an alcohol-based hand rub is used, it should take 15-30 seconds of rubbing hands together before they feel dry.

Monitoring hand-hygiene compliance rates and providing healthcare personnel with feedback about their performance are essential elements of an effective hand-hygiene promotion program. Hand-hygiene compliance rates are most commonly determined by having trained individuals directly observing caregivers during patient care. Although this approach can provide the most complete information on hand-hygiene compliance, it is time-consuming and allows only a small fraction of all hand-hygiene opportunities to be monitored.

Measuring the amount of alcohol-based hand rub or soap that is used on each nursing unit in a hospital can provide useful information about the frequency with which hand hygiene is being performed, but does not provide data on actual compliance rates or information on who (healthcare providers or visitors) accessed the dispensers. As a result, electronic hand-hygiene monitoring systems of varying complexity and design are under development or are in the early

stages of marketing. "Door minder" systems time- and date-stamp whenever someone enters or exits a patient room, and record whether an alcohol-based hand rub or soap dispenser was accessed at the time of room entry or exit. Such systems use hand-hygiene events at the time of room entry and exit as proxies for hand hygiene before and after touching patients.

However, such systems cannot tell whether the person entering or exiting the room was a healthcare worker or another individual, such as a visitor. Electronic monitoring systems that provide an electronic badge for each healthcare worker can estimate individual compliance rates at the time of room entry and exit. These systems can identify the healthcare personnel with the lowest levels of compliance and permit targeted feedback to those in most need of improvement. However, additional research is needed to address such issues as the acceptance by personnel of badge-type systems, who should have access to healthcare-worker-specific compliance data, how the data will be used by hospital administration, and the cost-effectiveness of electronic monitoring systems.

Improving Hand-Hygiene Compliance: The Bottom Line

Having posters or screen savers with hand-hygiene promotional messages that change periodically may also improve compliance rates. Hand-hygiene champions (eg, nurses and physicians) on the front lines of patient care, as well as visible and vocal support from high-level administrators, can contribute significantly to the institutional safety climate and to improved hand-hygiene compliance rates among personnel. In some facilities, engaging healthcare personnel to provide immediate feedback to coworkers about compliance (or lack thereof) and implementing policies and procedures to deal with individuals with persistently low compliance have achieved and sustained high levels of compliance.

Although many healthcare institutions have been reluctant to hold healthcare personnel (especially physicians) accountable for failing to comply with evidence-based practices, new evidence suggests that there is an increasing belief among both attending physicians and patients that there should be consequences (eg, penalties or fines) for noncompliance with evidence-based practices, such as hand hygiene. Programs that promote an institutional climate of safety, use of electronic hand-hygiene monitoring technologies, and policies for holding healthcare personnel accountable for performance of evidence-based safety practices are among the strategies which are likely to be used increasingly by healthcare facilities to improve hand-hygiene practices and minimize healthcare-associated infections (Table).

Table: Summary of Major Points for Improving Hand Hygiene

- Alcohol-based hand rubs are the preferred method for hand hygiene when hands are not dirty or visibly soiled with proteinaceous material.
- Make alcohol-based hand rub available at the point of patient care.
- Educate healthcare personnel about the importance of hand hygiene and when hand hygiene should be performed (eg, "My 5 Moments for Hand Hygiene").
- If an adequate amount of alcohol-based hand rub is used, it should take 15-30 seconds of rubbing before hands feel dry.
- Monitoring hand-hygiene compliance and providing healthcare personnel with feedback about their performance are essential elements of effective hand-hygiene promotion programs.
- Having nurses and physicians serve as "hand-hygiene champions" and strong support from hospital administrators can contribute significantly to improving hand-hygiene compliance rates.
- To achieve and maintain high levels of hand-hygiene compliance and provide patients with a safe environment, institutions need to develop policies for holding healthcare personnel accountable for performing hand hygiene when indicated.

Adoption of ACGME Competencies in various Instructional designs at WUSOM

By Sanjib Das

The comprehensive objective of the Windsor University School of Medicine (WUSOM) M.D. program is to produce physicians who are competent, to the satisfaction of the faculty, the standards of the goals and mission of the profession, in the following areas:

Competency-Based Learning Objectives (adopted from ACGME)

By the end of their medical education at Windsor University School of medicine, students will be able to

achieve the following core competencies –

1. **Patient Care** – Students must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health related issues.
2. **Medical Knowledge**- Students must be able to apply scientific principles and a multidisciplinary body of scientific knowledge to the diagnosis, management, and prevention of clinical problems.
3. **Interpersonal and Communication Skills** – Students must demonstrate effective and compassionate interpersonal and communication skills towards patients, patient families and other health care professionals that result in the effective exchange of information and sustain effective medical care.
4. **Professionalism** – Students must demonstrate the ability to understand the nature of, and demonstrate professional and ethical behavior in, the act of medical care. This includes respect, responsibility and accountability, excellence and scholarship, honor and integrity, altruism, leadership, cultural competency, caring & compassion, and confidentiality.
5. **Practice-Based Learning and Improvement (PBLI)** – Students must demonstrate the ability to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
6. **Systems-Based Practice (SBP)** - Students must demonstrate an awareness of and responsiveness to the system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

How can we develop WUSOM physician demonstrating all those 6 competences?

We at WUSOM address competencies at all 3 instructional levels (i.e. goal - objective, teaching - learning activities & evaluation – feedback) while designing a particular course.

We have a structured method of evaluation of competencies for each course.

Competency Gradesheet (Subject: _____)								
Drs.			Post This Assessment method	Post This Assessment method	Post This Assessment method	Post This Assessment method	Post This Assessment method	Post This Assessment method
			Block MCQs	Block MCQs	Block MCQs	1.Direct Observation 2.Formative assessment during small group sessions	1.Direct Observation 2.Formative Assessment during Student Seminars 3.Formative assessment during small group sessions	1 on 1 discussion/MCQ bases reexem if necessary
Last Name	**First Name**	**Roll No**	**Patient Care (S/U)**	**Problem Based Learning & Improvementl**	**Medical Knowledge (S/U)**	**Professionalism (S/U)**	**Interpersonal & communication skills (S/U)**	**Remediation (Y/N)**
[redacted]			U	S	S	S	S	Y
			S	S	S	S	S	
				U	S	S	S	Y
			U	U	U	U	U	
			U	U	U	U	U	
			U	U	U	U	U	
			U	U	U	U	U	
			U	S	S	S	S	Y
			U	U	S	S	S	Y
			S	S	S	S	S	
			S	U	S	S	S	Y
			S	S	S	S	S	
			U	S	S	S	S	Y
			S	U	S	S	S	Y
			S	S	S	S	S	
			S	S	S	S	S	
			S	S	S	S	S	
			U	S	S	S	S	Y
			S	S	S	S	S	
			S	S	S	S	S	
			U	U	U	U	U	

“GLIMPSES OF AMSA EVENTS”


A
B
AMERICAN MEDICAL STUDENT ASSOCIATION
WINDSOR UNIVERSITY CHAPTER


HANS POLSTER CONFERENCE ROOM

Windsor University Promotions Policy – A Brief Oversight

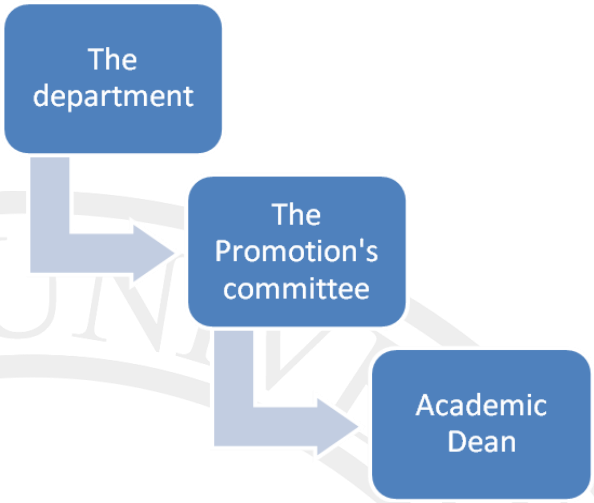
By Vivek Joshi

Windsor University School of Medicine (WUSOM) is committed to high academic and professional standards for its curriculum, faculty and students. Policies and procedures for student promotion guide the faculty and students in achieving their educational goals throughout the MD program. The Curriculum at Windsor University School of Medicine leads to the completion of the MD degree in four consecutive years, which includes two years of basic science courses and two years of clinical rotations. The evaluation system provides a formal record of a student's accomplishments during this program.

The evaluations and promotions of medical students operate at different levels which include the following:

1. Course/Departmental level
2. The Promotions Committee

Office of the Academic Dean



The first step of student evaluation is done by the course director or the chair of the department where student's level of achievement in the subject as well as the professional characteristics are measured and graded. The second step in the evaluation process is promotion, which is initiated and conducted by the Promotions Committee. This is an advisory committee responsible for reviewing and analyzing student performances in all courses and for making recommendations to the Academic Dean regarding the progress of student throughout the medical curriculum. The final authority for the student's promotion resides with the Office of Academic Dean.

Policies for Medical School Courses:

The minimum passing grade for each subject is 65%.This includes the grades from block examinations, internal assessment and subject NBME/ Final examination. Any student missing an exam due to excused or unexcused absence has to appeal to the Promotions Committee. The committee then discusses the individual cases and votes on their decision. Once approved by a majority vote the student is allowed to write a makeup exam within a 1 week of the missed examination. Make up exams subsequently given to such students will have a different set of questions but with equivalent difficulty.

Students are considered for promotion at the end of each academic level. To qualify for recommendation for promotion to the next academic level, a student must complete all the requirements specified by the Promotions Committee as well as maintain a satisfactory level of professional behavior and attitude which includes a mandatory 80% attendance record during the entire semester. Every student is required to pass all major courses offered during the particular semester to be promoted to the next academic level. Conditional promotion is recommended for students who fail one major subject course at the end of the semester. These students are required to pass a retake exam held in the first week of the next semester. If the student fails the retake exam he/she is recommended by the Promotions Committee to shift to the Extended Track MD program.

The transition from Basic Sciences to Clinical Rotations is governed by the NBME Comprehensive Basic Science Exam (CBSE). Every student at Windsor is required to pass this examination with a minimum score of 60%.

The Clinical Science years include core and elective rotations, which may vary in duration from 6 to 12 weeks. These rotations are conducted at various clinical sites in US and Caribbean. Every rotation has certain requirements to be fulfilled in order to be promoted to the next clinical rotation. These include - clinical preceptor evaluation, subject NBME, clinical logs and OSCE practical examination. After successfully completing all the clinical rotations the student is then sponsored for NBME written and practical Exit examination. This is the final step to attain a graduate degree from Windsor University School of Medicine. For a detailed description of the Promotion's policy please refer to the student handbook.

Tribute and Honor to the Silent Teachers

(A Ceremony of Gratitude)

By Safeer Khan

They were mothers, fathers, husbands, wives, brothers and sisters. They loved and they were loved. "Utilize me, even after my death. Utilize me to make a difference. Cut me open, look inside and learn." they said. That's why we honor them by calling them **"SILENT TEACHERS".**

On September 20th, 2016, the Department of Anatomy conducted a Ceremony to honor the **silent teachers of anatomy**.

During the ceremony, Dr. Andy Vaithilingam, the Academic Dean, expressed his gratitude and appreciation to all the body donors. He encouraged the students to express their gratitude, to show utmost respect and to utilize the bodies as a precious gift from the donors. The Chair of Anatomy, Dr. Sreekanth Thota, and the Director of Anatomy Lab, Mr. Safeer Khan encouraged and advised the students to maintain proper decorum and discipline in the anatomy laboratory and to appreciate their silent teachers and first patients. Dr. Venkatesh Bheemaiah, Dean of Student Affairs, Dr. Donna Patey, Dr. Pushparaj Shetty, and Mr. Ramesh Mulkanoor, Chief Administrative Officer also attended the ceremony to give their tributes.

In the second half of the ceremony, Father Emanuel performed a heartwarming prayer for the departed souls. Dr. Stella Ebere-Shepherd concluded the ceremony with a vote of thanks.

Students expressed their respect, appreciation and gratitude towards the body donors. Here are some of their messages:-

"Thank you for giving your body for us to improve our learning of anatomy." Jennifer Okpara.

"I will be thanking you always for expanding our learning, all the good we do as physicians in the future will come back to you." Abdulhammed.

"Thank you for the opportunity to learn and become future physician, you have done a difficult yet very admirable thing." Hani Issawi.

"As a medical student, I am thankful for the families and people who choose to donate their bodies for a better understanding of anatomy and allowing us to have a first-hand experience that will help us to become good doctors." Nafin Ashraf.