FINAL TEAM REPORT
OF THE
SURVEY OF

UNIVERSITY OF CONNECTICUT SCHOOL OF MEDICINE

Farmington, Connecticut

January 24-27, 2010

PREPARED BY AN *AD HOC* SURVEY TEAM

FOR THE

LIAISON COMMITTEE ON MEDICAL EDUCATION

LCME

LIAISON COMMITTEE ON MEDICAL EDUCATION

www.lcme.org

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June 9, 2010

Dr. Philip Austin
Office of the President
University of Connecticut
Gulley Hall, Unit 2048
352 Mansfield Road
Storrs, CT 06269-2086

Dear President Austin:

The purpose of this letter of accreditation is to inform you of the action taken by the Liaison Committee on Medical Education (LCME) at its meeting on June 1-3, 2010 regarding the accreditation status of the educational program leading to the MD degree at the University of Connecticut School of Medicine and to transmit to you the report (enclosed) of the LCME survey team that conducted a full survey visit to the school of medicine on January 24-27, 2010.

After reviewing the report of the survey team, including the relevant sections of the Medical Education Database and Institutional Self-study as contained in the report appendix, the LCME voted to place the medical education program leading to the MD degree on "warning of probation." This action of the LCME indicates that there are areas of noncompliance with accreditation standards that will, if not corrected promptly, seriously compromise the ability of the school to conduct a quality medical education program. While not an adverse action, warning of probation indicates that, if sufficient progress toward compliance with the listed accreditation standards and resolution of the areas in transition are not made within 12 months, probation will be imposed. Warning of probation is not subject to appeal and is held confidential by the LCME.

The LCME identified the following areas of partial or substantial noncompliance with accreditation standards. The standards cited below are quoted from the June 2010 edition of *Functions and Structure of a Medical School*, which is available on the LCME web site at www.lcme.org/standard.htm.

1) IS-11. The administration of an institution that offers a medical education program should include such associate or assistant deans, department chairs, leaders of other organizational units, and staff as are necessary to accomplish its mission(s).

Finding. At the time of the survey visit, there were four vacant department chair positions, with one position vacant for four years and another for two and one-half years. These latter two vacancies exceed the two-year limit specified in the bylaws of the school of medicine.

2) ED-8. The curriculum of a medical education program must include comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.

Finding: There is not an institutionalized method for assessing comparability of students' clinical experiences in the Phase 2 curriculum that is systematically and consistently applied across the multiple clinical sites. Comparability of clinical experiences is left to the individual clerkships to monitor. Not all clerkships in the Phase 2 curriculum have been effective in assuring comparability. This is especially the case in the surgery clerkship.

3) ED-30. The directors of all courses and clerkships (or, in Canada, clerkship rotations) in a medical education program must design and implement a system of fair and timely formative and summative assessment of medical student achievement in each course and clerkship/clerkship rotation.

Finding: Formative feedback is delayed in the Correlated Medicine Problem Solving component. Summative evaluations from the Student Continuity Practice component of the Clinical Medicine course are frequently late, resulting in students receiving grades of "incomplete." Clerkship grades were noted to be delayed in a number of clerkships, most especially in the surgery clerkship.

4) ED-32. A narrative description of medical student performance in a medical education program, including non-cognitive achievement, should be included as a component of the assessment in each required course and clerkship (or, in Canada, clerkship rotation) whenever teacher-student interaction permits this form of assessment.

Finding: There are no narrative evaluations provided in the Human Systems course, which includes a large number of hours of small group instruction. This lack is reported as being due to the lack of continuity in small group instruction facilitators. Narrative evaluations also are not consistently provided in each required clinical clerkship.

5) ED-33. There must be integrated institutional responsibility in a medical education program for the overall design, management, and evaluation of a coherent and coordinated curriculum.

Finding: The curriculum management system is complex, and the scope of responsibility of each of the several existing committees is not clear. For example, several committees appear to have responsibility for setting curriculum policy and conducting evaluations of

courses and clerkships. Course and clerkship directors possess excessive autonomy in course administration, leading to an erosion of central authority for the curriculum.

6) ED-35. The objectives, content, and pedagogy of each segment of a medical education program's curriculum, as well as of the curriculum as a whole, must be designed by and subject to periodic review and revision by the program's faculty.

Finding: The lack of a standardized format for mandated triennial reviews of courses allows for inconsistency. While individual courses and clerkships are reviewed periodically, curriculum years or phases have not been reviewed. Recently, an analysis of the curriculum as a whole was completed for the first time in 15 years.

7) ED-36. The chief academic officer of a medical education program must have sufficient resources and authority to fulfill his or her responsibility for the management and evaluation of the curriculum.
FA-2. A medical education program must have a sufficient number of faculty members in the subjects basic to medicine and in the clinical disciplines to meet the needs and missions of the program.

Finding: The number of basic science faculty members has been decreasing for five years. Recent retirements in response to a retirement incentive program have had an adverse effect. Limitations on financial resources and restrictions on rehiring retired faculty members are limitations on the ability to secure an adequate number of faculty to deliver the curriculum. There is a heavy reliance on volunteer faculty, which affects the ability to assure consistency and quality. Department chairs and faculty confirm that the number of faculty is inadequate to support the curricular structure. Announced retirements contribute to concerns about the adequacy of faculty numbers.

8) MS-19. A medical education program must have an effective system in place to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

Finding: A structured career counseling program is lacking for students in the first and second years of the curriculum. This results in a lack of knowledge on the part of these students of the steps that should be taken early in their medical education to prepare them for application to residency.

9) MS-23. A medical education program must provide its medical students with effective financial aid and debt management counseling.

Finding: Financial aid services and debt management counseling continue to be reported by students as inadequate; noncompliance with this area was cited in the previous full survey. Insufficient staffing in the Office of Financial Aid may contribute to the problem.

10) MS-27-A. The health professionals at a medical education program who provide psychiatric/psychological counseling or other sensitive health services to a medical student must have no involvement in the academic assessment or promotion of the medical student receiving those services.

Finding: Students bear the burden of ensuring that faculty who provide sensitive medical care are not in a position to evaluate them academically. Students are uncomfortable seeking mental health services because they are not provided in a manner that assures confidentiality. Some mental health services are provided in the medical school outpatient psychiatric clinic, which serves as an educational site during the psychiatry clerkship.

11) MS-37. A medical education program should ensure that its medical students have adequate study space, lounge areas, and personal lockers or other secure storage facilities at each instructional site.

Finding: Student lounge space is inadequate; this was cited as an area of noncompliance at the time of the previous full survey. Implementation of the plans to address this continues to be postponed.

12) ER-2. The present and anticipated financial resources of a medical education program must be adequate to sustain a sound program of medical education and to accomplish other programmatic and institutional goals.

Finding: There have been significant funding deficits for the past three years. A structural change to the state allocation methodology has allowed the school of medicine to report a current break-even budget in the year-to-date. However, the replacement of faculty losses sustained over the past five years and the need for necessary facilities enhancements require substantial additional resources.

13) ER-7. Each hospital or other clinical facility of a medical education program that serves as a major instructional site for medical student education must have appropriate instructional facilities and information resources.

Finding: Student call rooms at Hartford Hospital are not functionally useful for students on required clerkships. Students are unaware of the availability of any call rooms at that hospital.

14) ER-9. A medical education program must have written and signed affiliation agreements in place with its clinical affiliates that define, at a minimum, the responsibilities of each party related to the educational program for medical students.

Finding: Of the 10 facilities used for the inpatient rotations of required clinical clerkships, five do not have current, signed affiliation agreements that meet LCME standards.

In addition, the LCME noted the following areas in transition whose outcomes could affect the school's ongoing compliance with accreditation standards.

1) In parallel with recent increases in tuition and fees, there has been an increase in the average indebtedness of graduates of the medical school. Over a five-year period, average indebtedness rose from approximately 25% below the national average to slightly above the national average. From 2003 to 2008, the average indebtedness almost doubled, from about $64,000 to about $126,000.

2) The medical school began an organized program for faculty development two weeks prior to the site survey. The effectiveness of this program is yet to be determined.

3) The recent development of a new faculty assessment tool (CREATE) has caused widespread confusion regarding the implementation of faculty policies on promotion, tenure and compensation. The undetermined impact of this tool and the recent faculty vote to establish a bargaining unit may further erode the stability of the faculty and educational resources.

4) With the proposed combination of John Dempsey Hospital and Hartford Hospital Center currently abandoned, clinical strategic planning remains very much a work in progress. Planning is aimed at assuring fiscal stability. The dean is currently actively engaged in the strategic planning process for replacement of the university clinical facilities.

The LCME requested that the school of medicine develop an action plan that describes the steps that have been and will be taken to bring the educational program into compliance with each of the listed areas of noncompliance. The action plan, which should be structured as indicated in the enclosed template, will be due to the LCME by December 15, 2010. The LCME will review the action plan at its February 2011 meeting. After the LCME's review and approval of the action plan, a limited accreditation survey will be scheduled to assess progress in implementing the action plan and to assess the outcomes that have been achieved. In order to assist the dean in developing the action plan, the LCME Secretariat will conduct a consultation visit to the school of medicine. Dr. Dan Hunt will contact Dean Laurencin to schedule this visit.

Accreditation is awarded to a medical education program based on a judgment of appropriate balance between student enrollment and the total resources of an institution, including faculty, physical facilities, and the operating budget. If there are plans to significantly modify the

educational program, or if there is to be a substantial change in student enrollment or in the resources of the institution so that the balance is distorted, the LCME expects to receive prior notice of the proposed change. Substantial changes may lead to re-evaluation of the program's accreditation status by the LCME.

The report of the survey team is held confidential by the LCME. A copy of the final report also is being sent to Dean Cato Laurencin. The report is for the use of the school of medicine and the university, and any public dissemination or distribution of its contents is at the discretion of institutional officials.

Sincerely,

Barbara Barzansky, PhD, MHPE
LCME Secretary, 2009-2010

enc: Report of the full survey visit
Action plan template

cc. Cato T. Laurencin, MD, PhD, Dean, University of Connecticut School of Medicine
Dan Hunt, MD, MBA, LCME Secretary, 2010-2011

TEMPLATE FOR ACTION PLAN

[Copy this page for each area of noncompliance. Include action steps (specific tasks) that will lead to the desired outcome.]

STANDARD:

TASKS (Steps to be taken that will lead to the desired outcome)	INDIVIDUALS/ GROUPS RESPONSIBLE FOR EACH TASK	INDICATORS THAT THE TASK HAS BEEN ACCOMPLISHED	EXPECTED DATE OF ACCOMPLISHMENT OF THE TASK	DESIRED OUTCOME THAT ILLUSTRATES COMPLIANCE WITH THE STANDARD

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TO: Liaison Committee on Medical Education

FROM: The Secretary of the *ad hoc* Survey Team That Visited the University of Connecticut School of Medicine on January 24-27, 2010

RE: Report of the Survey Team

On behalf of the *ad hoc* LCME survey team that visited the University of Connecticut School of Medicine on January 24-27, 2010, the following report of the team's findings and conclusions is provided.

Respectfully,

David Seiden

David Seiden, Ph.D., Secretary

INTRODUCTION

A survey of the University of Connecticut School of Medicine was conducted on January 24-27, 2010, by the following *ad hoc* team representing the Liaison Committee on Medical Education (LCME):

Chair:	Jeffrey P. Gold, M.D. Team Chair Dean University of Toledo College of Medicine Toledo, OH	Surgery
Secretary:	David Seiden, Ph.D. Team Secretary Associate Dean for Student Affairs UMDNJ-Robert Wood Johnson Medical School Piscataway, NJ	Anatomy
Member:	C. Nanette Clare, M.D. Team Member. Senior Associate Dean and Associate Dean for Academic Affairs University of Texas Medical School at San Antonio San Antonio, TX	Anatomic/Clinical Pathology
Member:	Barbara A. Schindler,M.D. Team Member Vice Dean, Educational and Academic Affairs Drexel University College of Medicine Philadelphia, PA	Psychiatry
LCME Faculty Fellow:	Larry Reimer, M.D. Faculty Fellow Assistant Dean for Curriculum and GME University of Utah School of Medicine Salt Lake City, UT	Internal Medicine, Pathology

The team expresses its sincere appreciation to Dean Cato T. Laurencin and the staff, faculty, and students of University of Connecticut School of Medicine for their many courtesies and accommodations during the site visit. Dr. Mary Casey Jacob, Dr. Bruce Koeppen and Ms. Lynn E. Donatelli merit special recognition and commendation for their thoughtful visit preparations and generous support during the conduct of the survey.

A copy of the survey visit schedule is included in the Appendix.

SUMMARY OF SURVEY TEAM FINDINGS

DISCLAIMER: This report summarizes the findings and professional judgments of the *ad hoc* survey team that visited the University of Connecticut School of Medicine from January 24-27, 2010, based on the information provided by the school and its representatives before and during the accreditation survey, and by the LCME. The LCME may come to differing conclusions when it reviews the team's report and any related information.

Institutional Strengths

The team identified the following areas of institutional strength:

- The medical school benefits from a mature and articulate student body that is exceptionally happy with, loyal to and supportive of their school.

- The principles espoused in the "Teacher-Learner Compact" are reflected in the culture and environment of the school. The learning environment is exceptionally conducive to student learning. Professionalism is espoused throughout the curriculum and the students feel that they are studying in a safe environment.

- The longitudinal continuity care experience provides contextual learning for the basic science curriculum and thereafter.

- There is substantial student research involvement including the required ambulatory quality improvement project which has been recognized by the National Board of Medical Examiners.

Areas of Partial or Substantial Noncompliance

The survey team also noted the following items where it believes the school is not in full compliance with accreditation standards:

IS-11: **"The medical school administration should include such associate or assistant deans, department chairs, leaders of other organizational units, and staff as are necessary to accomplish the missions of the medical school"**

Finding: There are currently four department chair positions that are vacant with one of them vacant for four years and another for 2.5 years, exceeding the two year limit of the medical school's by-laws.

ED-8: **"There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline"**

Finding: There is not an institutionalized systematic and consistent method for assessing comparability of the educational experience in the Phase 2 curricuum across multiple clinical sites. This is left to the individual clerkships to monitor. Not all clerkships in the Phase 2 curriculum are effective in having maintained comparability, with the Surgery clerkship being especially deficient in this regard.

ED-30: **"The directors of all courses and clerkships must design and implement a system of formative and summative evaluation of student achievement in each course and clerkship"**

Finding: Evaluations from the Student Continuity Practice (SCP) component of the Clinical Medicine Course are frequently late resulting in a grade of Incomplete, requiring students to contact their preceptors to get the evaluation submitted. Interim evaluations in Correlated Medical Problem Solving (CMPS) are reported to be quite slow. Phase 2 evaluations are also reported to be unacceptably delayed. Surgery is most deficient in this regard.

ED-32: **"Narrative descriptions of student performance and of non-cognitive achievement should be included as part of evaluations in all required courses and clerkships where teacher-student interaction permits this form of assessment."**

Finding: The Human Systems course, which includes a large number of hours of small group contact, does not provide written narrative evaluations. This is reportedly due to the lack of continuity of faculty leadership of small group exercises. Not all clinical clerkships provide narrative evaluations.

ED-33: **"There must be integrated institutional responsibility for the overall design, management, and evaluation of a coherent and coordinated curriculum."**

Finding: Several committees are in place to set curriculum policy and review individual courses. This highly complex curriculum management structure lacks clarity of scope of responsibility of the respective committees. Course and clerkship directors retain excessive curricular autonomy in course administration such that there is an erosion of the central curriculum authority.

ED-35: **"The objectives, content, and pedagogy of each segment of the curriculum, as well as for the curriculum as a whole, must be subject to periodic review and revision by the faculty"**

Finding: The lack of a standard format for the mandated triennial review of courses allows for inconsistency in these reviews. Individual courses and clerkships have been reviewed periodically by the Course and Curriculum Evaluation Committee however, segments of the curriculum, such as an entire year or phase, have not been reviewed. An analysis of the curriculum as a whole was recently completed for the first time in fifteen years.

ED-36: **"The chief academic officer must have sufficient resources and authority to fulfill the responsibility for the management and evaluation of the curriculum."**

and

FA-2: **"There must be sufficient number of faculty members in the subjects basic to medicine and in the clinical disciplines to meet the needs of the educational program and the other missions of the medical school."**

Finding: Limitations on financial resources and restrictions on the rehiring of retired faculty are limiting factors in securing adequate numbers of faculty to deliver the curriculum. Recent retirements, in response to a retirement incentive program, have had an adverse impact. There is currently a heavy reliance on volunteer faculty which makes it difficult to maintain consistency and quality. Department chairs and course directors confirm that there is an inadequate number of faculty to support the current curricular structure. Concerns about announced future retirements do not bode well for a resolution to this problem. The number of basic science faculty has been consistently decreasing for 5 years.

MS-19: **"There must be a system to assist students in career choice and application to residency programs and to guide students in choosing elective courses."**

Finding: Although career counseling is available to third and fourth year students, a structured

program for students in years one and two is lacking. This results in a lack of knowledge and understanding by students of steps that should be taken early in their medical school careers, to prepare for their residency applications.

MS-23: **"A medical school must provide students with effective financial aid and debt management counseling"**

Finding: Financial aid services and debt counseling continues to be reported as inadequate. This may be contributed to by insufficient staffing in the Office of Financial Aid. Noncompliance with this standard was cited in the previous survey.

MS-27A: **"The health professionals who provide psychiatric/psychological counseling or other sensitive health services to medical students must have no involvement in the academic evaluation or promotion of the students receiving these services"**

Finding: Students are uncomfortable seeking mental health services because they are not provided in a confidential environment. In addition, the student bears the burden of ensuring that faculty who provide their sensitive medical care are not in a position to evaluate them academically.

MS-37: **"Schools should assure that students have adequate study space, lounge areas, and personal lockers or other secure storage facilities"**

Finding: Student lounge space is inadequate and has been for a long time. Implementation of the plans to address this continues to be postponed. Noncompliance with this standard was cited in the previous survey.

ER-2: **"The present and anticipated financial resources of a medical school must be adequate to sustain a sound program of medical education and to accomplish other institutional goals."**

Findings: There have been significant deficits for the past three years. A structural change to the state allocation methodology has allowed the medical school to report a current break-even budget year-to-date. However, the need to replace faculty losses sustained over the past five years and make necessary facilities enhancements require substantial additional resources.

ER-7: **"A hospital or other clinical facility that serves as a major site for medical student education must have appropriate instructional facilities and information resources."**

Finding: Student call rooms at Hartford Hospital are not functionally useful for students on required clerkships. There is consistent lack of knowledge by students of the availability of any call room facilities at Hartford Hospital.

ER-9: **"There must be written and signed affiliation agreements between the medical school and its clinical affiliates that define, at a minimum, the responsibilities of each party related to the educational program for medical students."**

Findings: There are ten inpatient facilities at which medical students take required clinical rotations. Five of these clinical sites do not have current, signed affiliation agreements that meet LCME standards.

Areas in Transition

The following items that were in transition at the time of the survey visit have the potential to impact future compliance with accreditation standards:

- Student indebtedness has been rising significantly in recent years. In parallel with recent increases in tuition and fees, there has been an increase in the average indebtedness of UCONN graduates. Over a five year period, average indebtedness has risen from approximately 25% below the national average to slightly above the national average. From 2003 to 2008, the average indebtedness almost doubled, from about $64,000 to about $126,000. This trend should be monitored to assure that compliance with standards is not compromised.

- The medical school began an organized program for faculty development two weeks prior to the site survey. It remains to be seen how effective this program will be.

- The recent development of a new faculty assessment tool (CREATE) has caused widespread confusion regarding the implementation of faculty policies on promotion, tenure and compensation. The undetermined impact of this tool and the recent faculty vote to establish a bargaining unit may further erode the stability of the faculty and educational resources.

- With the proposed combination of John Dempsey Hospital with Hartford Hospital Center currently abandoned, clinical strategic planning remains very much a work in progress aimed at fiscal stability, as well as, the overall delivery of clinical services in a proposed new hospital for the school of medicine. The Dean is currently actively engaged in the "Plan B" strategic planning process for replacement of the university clinical facilities. The outcome of this planning will have important implications for the future of the school of medicine.

PRIOR ACCREDITATION SURVEY

The last full survey of the University of Connecticut School of Medicine occurred on January 26-29, 2003. The LCME identified the following institutional strengths:

- The school has implemented an innovative curriculum thanks to the leadership provided by the Dean for Academic Affairs and Education and a committed group of educational program administrators.
- The Student Continuity Practice experience affords an uncommon opportunity for the school's students to gain in-depth understanding of community-based longitudinal health care, and advancing their clinical skills as they apply to modern primary care practice.
- The commitment and dedication of the school's faculty, especially volunteer physician faculty throughout the region, are greatly appreciated and valued by the medical students.
- A comprehensive and well-articulated system of clinical skills assessment that provides both formative and summative evaluation assures that University of Connecticut students are amply prepared for this essential component of patient care.
- With rare exceptions, the school has enjoyed noteworthy success in recruiting and retaining a diverse student body through its multifaceted outreach program for minority groups.

The LCME also identified the following areas of partial or substantial noncompliance with accreditation standards:

- **Standard IS-4: The manner in which the medical school is organized, including the responsibilities and privileges of administrative officers, faculty students and committees must be promulgated in medical school or university bylaws.**

  Finding: Existing bylaws as expressed in the "Guidelines for the Operation of the School of Medicine" are acknowledged to be very obsolete and ignored, generating concern about the role of department chairs and faculty leadership in medical school decision-making.

- **Standard MS-23: A medical school must provide students with effective financial aid and debt management counseling.**

  Finding: Medical students report that they receive little structured counseling that helps them understand and manage their debt portfolio, which is expected to accelerate significantly because of contemplated large tuition increases in at least the next two years.

- **Standard MS-37: Schools should assure that their students have adequate study space, lounge areas and personal lockers or other secure storage facilities.**

  Finding: The student lounge, which serves dental students as well as medical students, is small for the population that uses it. Study space is scarce, and space available for that purpose in the library is less accessible because of cutbacks in hours, and undesirable because of the lack of restrooms.

- **Standard FA-1: The recruitment and development of a medical school's faculty should take into account its mission, the diversity of its student body, and the population that it serves.**

  Finding: The self-study notes that faculty diversity is not optimal in terms of institutional goals. Recommendations to address the issue have been developed by a university committee but no actions have been taken to date. An institutional commitment to faculty diversity is not apparent in the pattern of recent faculty recruitments.

- **Standard FA-12: The dean and a committee of the faculty should determine medical school policies.**

  Finding: While a Dean's Advisory Committee and the School of Medicine Council exist and meet periodically, they are perceived as ineffective for providing appropriate input into organizational decision-making.

The LCME noted the following areas that were in transition, whose outcome could affect the school's ongoing compliance with accreditation standards:

- **Creation of a Board of Directors for the Health Center**. The impact of the newly created Board of Directors for the University of Connecticut Health Center has yet to be ascertained, and follow-up is warranted to determine its role and responsibilities regarding oversight and planning related to the medical school.

- **Department restructuring**. Substantial reorganization of the school's departmental structure took place during the just completed accreditation cycle, and additional modifications are nearing implementation. The changes commend monitoring to assess the effectiveness of the involved departments in achieving their own and school-wide missions and goals.

- **Expanded role of information technology in medical education**. A variety of initiatives have been set in motion to exploit information technology as a tool for enhancing medical education. Their impact on student learning and the cost of medical education merits assessment as the initiatives take effect.

- **Capital Projects**. The school expects to be able to address many of its facilities needs with funding support from a bond issue that will provide $300 million for capital expenditures over a ten-year period. The plans and timetable for addressing the school's facilities needs through this mechanism require additional reporting.

- **Financial stability**. The Health Center endured significant budgetary shortfalls between 1998 and 2000. Cost controls and supplemental state appropriations balanced the budget in 2001, but with an attendant reduction in funding for support or development of medical school programs. Further monitoring is desirable to determine how the school and the Health Center are weathering changes in the financial environment.

- **Faculty compensation mechanisms**. The various compensation and incentive plans available to faculty are confusing and poorly understood. The self-study notes a concern that compensation activities intended to strengthen research and patient care activities may dilute the faculty's continued commitment to education.

The LCME voted to continue accreditation of the educational program leading to the M.D. degree for a seven year term and requested that the dean submit a written status report to the LCME secretaries by January 1, 2005 on the following issues:

- A description of any additional modifications to the school's Guidelines for Operation of the Medical School or related documents, as they relate to faculty governance and institutional decision-making.
- A four-year summary of student educational indebtedness, and the results of the most recent AAMC Graduation Questionnaire regarding financial aid and debt management counseling and services.
- A description of any renovations or expansions in student lounge and study space available to the medical students, and a comparison of library hours of operation to those prevailing at the time of the accreditation survey. Relevant sections of the AAMC Graduation Questionnaire regarding study space and library facilities should also be included.
- A table showing the distribution of full-time faculty members by race, ethnicity, and gender, along with a summary of the racial, ethnic, and gender distribution of full-time faculty who have been hired since the time of the accreditation survey.
- A description of any changes made to the structure or operation of the Dean's Advisory Committee or the Medical School Council to enhance their contributions to organizational decision-making.
- A narrative summary of the impact and effectiveness of the Board of Directors of the medical school's planning and operations.
- A table describing faculty strength, funding, and space available for departments that have been reorganized since the time of the accreditation survey, and where possible, a comparison of this information with corresponding measures for their predecessors.
- A narrative description of the impact of laptop requirements, use of handheld devices in clinical clerkships, and other information technology initiatives on teaching and learning, and any increases in student debt attributable to such activities (for example, laptop purchases).

- A summary of funding from the bond issue assigned to medical school facilities improvements, and a description of any renovations or construction projects enabled by that funding.
- A copy of the school's LCME Part I-A Annual Financial Questionnaires for fiscal years 2002-03 and 2003-04.
- A description of the impact of faculty compensation and incentive plans on their research and clinical productivity, and evidence that the faculty has sustained its commitment to medical education.

STATUS REPORT, December 21, 2004

Dean Peter J. Deckers reported on the

- planned changes in the medical school's governance structure;
- recent trends in tuition and fees, financial aid support, and student indebtedness, and changes in financial aid and debt management counseling and services;
- short-term and long-range programs to enhance student lounge and study space and provide more extensive student access to the library;
- recent successes in diversification of the faculty;
- planned replacement of the Dean's Advisory Group and the School of Medicine Council with alternative governance groups that broaden input into organizational decision-making processes;
- replacement of the Health Affairs Committee of the Board of Trustees with a board of Directors whose membership includes greater expertise in health affairs;
- merger of the former Departments of Biochemistry and Microbiology, and discussions about reorganization of the Department of Pathology and creation of a Department of Immunology;
- the academic and financial impact of increased use information technology in the medical education program;
- projects funded through the 21st Century UConn program;
- data and projections regarding the school's and health center's financial status and prospects; and
- increases in the clinical and research productivity of the faculty, and modifications to the Compensation Plan to sustain and enhance faculty commitment to medical education.

The LCME accepted this status report and asked for an additional status report due by January 1, 2006 providing:

- an update on the approval process for new Guidelines of the School of Medicine ("bylaws") with a description of any successes or challenges that may have arisen in conjunction with replacement of the Dean's Advisory Committee and School of Medicine Council with other governance groups;
- an update for academic year 2004-05 on student educational indebtedness and financial aid support, an assessment of the recent changes implemented in the financial aid office and the services it provides;
- a narrative update on progress in the construction and renovation of student study and lounge space and modifications to the library and library services;
- an update on the gender and demographic profile of new faculty recruited in the past year, and summary data for the basic and clinical sciences in terms of their gender, race, and ethnicity;
- an update on any changes in medical school organization or operations resulting from actions of the Board of Directors;

- a description of any further changes in departmental structure, net changes in faculty numbers resulting from reorganization, and the impact of the impact of the new departments, if any, on the school's ability to achieve its academic missions;
- an update on the status of construction, renovation, and other capital investments resulting from the financial support received via the 21st Century Uconn program; and
- a narrative summary of the school's financial status and prospects, including progress toward reaching the break-even point with the faculty practice plan.

STATUS REPORT, December 28, 2005

Dean Peter J. Deckers reported on the

- administrative oversight of the school and increased participation in institutional decision-making;
- financial aid and student indebtedness;
- facilities for students and library renovations;
- faculty diversity;
- effectiveness of the new Board of Directors;
- reorganization of departments;
- modernizations funded by the 21st Century UConn program; and
- finances of the medical school.

The LCME accepted this status report and asked for an additional status report due by January 1, 2007 providing:

- plans to expand the departments of immunology and pathology and laboratory medicine; and
- plans of the anticipated consolidation of the departments of cell biology and pharmacology

STATUS REPORT, January 1, 2007

Dean Peter J. Deckers reported on:

- the appointment of a new faculty member in the Department of Immunology and the appointment of a chair for the Department of Pathology and Laboratory Medicine; and
- plans to disband the Department of Pharmacology and relocate its faculty to other academic departments.

The LCME accepted this report and instructed the present survey team to pay close attention to the quality of pharmacology instruction subsequent to the departmental restructuring.

THE MEDICAL EDUCATION DATABASE AND INSTITUTIONAL SELF-STUDY

(See Appendix for a summary of the self-study findings and composition of self-study committees.)

The medical education database was comprehensive and useful to the survey team. Updates were provided prior to the visit and during the visit. The institutional self-study had wide participation of administrators, faculty and students. The student survey provided appropriate information, and it tended to corroborate information in other parts of the database and the AAMC Graduation Questionnaire. The response rates for the LCME Student Surveys were 71% for first and second year students and 73% for third and fourth year students. These response rates made these data useful although perhaps not as reliable as may have been hoped for. On the other hand, the AAMC Graduation Questionnaire had a response rate of about 90%.

HISTORY AND SETTING OF THE SCHOOL

The University of Connecticut was founded as the Storrs Agricultural School by act of the Connecticut General Assembly in 1881. After several name changes, the school assumed its current name in 1939. The first PhD degree was awarded in 1949. Currently, the university consists of 14 schools and colleges on 8 campuses located throughout the state. The university offers 8 undergraduate degrees, 17 graduate degrees and 6 professional degrees. A total of about 29,400 students are enrolled.

The University of Connecticut Health Center was founded on the Farmington campus in 1961 and construction began in 1966. The Health Center is composed of the School of Medicine, School of Dental Medicine, the John Dempsey Hospital (204 general acute care beds and 20 nursery beds) and associated medical and dental groups. A major addition to the hospital was dedicated in 1994 and the Academic Research Building opened in 1999. The Medical Arts and Research Building (MARB) was opened in 2005. The Health Center consists of 39 buildings totaling over 2 million square feet and occupies a 206 acre campus that is about 38 miles from the main campus in Storrs and about 8 miles from the state capital in Hartford. The School of Medicine admitted its first class in 1968 and granted its first degrees in 1972. To date, 2,819 students have received their M.D. degrees.

(See Appendix for campus map)

The following table compares selected data from the time of the last survey visit to information provided for the current accreditation survey.

	Previous Survey 2002-03	Current Survey 2008-09
Entering class size	80	89
Total enrollment	335	329
Residents and fellows	590	583
Full-time basic science faculty	155	128
Full-time clinical faculty	640	766
($ in Millions)		
Tuition and fees	5,781,600	10,665,700
State appropriations	59,085,800	72,902,800
Research/training grants, direct	56,159,000	59,738,700
Indirect cost recoveries	15,406,800	18,546,700
Practice plan income	63,568,000	80,919,900
Revenue from clinical affiliates	28,029,000	35,499,900
Other revenues	7,191,500	7,219,000
Gifts and endowment	3,084,500	3,710,600
Total revenues	246,441,000	301,187,300

I. INSTITUTIONAL SETTING

See Appendix for the following documents:

- Current entry in AAMC *Directory of American Medical Education*
- List of changes in *Directory*
- Organizational charts showing relationship of health center and medical school to university
- Organizational chart for dean's office
- Dean's brief resumé
- Table showing enrollment in graduate programs in basic sciences 2002-2009
- Table showing total number of house offices 2002-2009
- Table showing number of house officers by specialty

Medical School Mission and Planning

The primary mission of the University of Connecticut School of Medicine is education at the undergraduate, graduate, and professional levels for practitioners, teachers, and researchers, conducted in an environment of exemplary patient care, research, and public service. The school of medicine's mission is reflected in its programs, which incorporate four basic interrelated goals:

- to provide educational opportunities for Connecticut residents pursuing careers in the patient care professions, education, public health, biomedical and/or behavioral sciences;
- to advance knowledge through basic, biomedical, clinical, behavioral, and social research;
- to develop, demonstrate, and deliver health care services based on effectiveness, efficiency, and the application of the latest advances in clinical and health care research;
- to help health care professionals maintain their competence through continuing education programs.

The institutional self-study revealed that the school of medicine was developing an academic strategic plan, which was in its third draft. This draft was being discussed with the education, research, public issues and dean's councils for final review, stakeholder input and adoption. The "School of Medicine Academic Plan 2009-2014" has been finalized as of the time of the site survey and was distributed to the survey team for review. It appears to be/a thoughtfully written education strategic plan with appropriate outcomes and metrics.

The clinical strategic planning is very much in the hands of the John Dempsey Hospital and the practice plan leadership. With the proposed combination with Hartford Hospital currently abandoned, this also remains very much a work in progress aimed at fiscal stability, as well as, the overall delivery of clinical services in a proposed new hospital for the school of medicine. The input of the school of medicine into the clinical site strategic planning is through the clinical department chairs, particularly the Chair of Orthopedics, who chairs the practice plan group.

The dean is currently actively engaged in the "Plan B" strategic planning process for replacement of the university clinical facilities. Given the recent direction change with the Hartford Hospital, this element of clinical strategic planning is currently the focus of considerable attention

A. Governance and Administration

The University of Connecticut is accredited by the New England Association of Colleges and Schools, with the next regional accreditation survey scheduled in 2017. The University of Connecticut School of Medicine is one of fourteen schools in the University of Connecticut system. The University of Connecticut Board of Trustees has delegated authority to the University of Connecticut Health Center

Board of Directors. The Board of Directors includes two appointed members from the University Board of Trustees and the chairman of the Board of Directors becomes an *ex-officio* member of the Board of Trustees. This organizational change occurred just prior to the 2003 LCME full survey. Although the data base indicated that the Health Center Board of Directors does not have an approved written policy specifically directed to the Board regarding conflict of interest, such a policy was adopted in January, 2010, a few weeks prior to the survey visit, and became effective immediately. It is of note that the University of Connecticut Health Center was working with the Hartford Healthcare Corporation for more than one year regarding a proposed partnership whereby the Hartford Healthcare Corporation would assume management responsibility for many or all aspects of the current clinical enterprises. This would likely have included changes in the corporate structure of the physician practice, the hospital, and other functions. At the time of the writing of the self-study, the proposal was complete and was dependent on approval by the Connecticut General Assembly for the construction of a new university hospital on the Health Center Campus. At the time of the visit, the proposed partnership discussions had been terminated and the University was planning to independently secure state appropriations (~$450MM) for a new 250-bed University Hospital on the Health Center Campus.

The president of the University of Connecticut is Mr. Michael J. Hogan, who has served in that role since 2007. The current dean of the school of medicine, Cato T. Laurencin, M.D., Ph.D., serves in the role of Dean of the School of Medicine and as Vice President for Health Affairs for the university since his appointment in October 2008. A combination of these two positions resolved the leadership ambiguity cited by the earlier LCME survey team in 2003. The decanal role has a reporting relationship to the University of Connecticut Provost for all academic matters and the Vice Presidential role has a reporting relationship to the University of Connecticut President for health system delivery matters (see Appendix for tables of organization).

Dr. Laurencin is a graduate in chemical engineering from Princeton University and received his medical degree from Harvard Medical School. He has also earned a Ph.D. in biochemical engineering from the Massachusetts Institute of Technology. He is a board certified orthopedic surgeon who still retains an active clinical practice in the New England Musculoskeletal Institute along with his myriad administrative and academic responsibilities (see Appendix for brief resumé).

There are nineteen department chairs and eleven center directors described at the time of the self-study. The department chairs have been appointed in a range from 1997 through the October 2009 appointment of an interim chair of the Department of Surgery. The surgery chair search was initiated in November of 2009. It is of note that the chair of cell biology has been an interim appointment since March 2006 without active, ongoing search or internal appointment. There are four departments without a permanent chair at the time of the self-study, including cell biology, medicine, immunology, and surgery. The institutional policy limits interim appointments to two years. Two interim chairs have exceeded this limit.

The dean's office is served through either the full or part-time support of fifteen associate and assistant deans, including a highly experienced dean for academic affairs (see Appendix for table of organization). The associate and assistant deans have been appointed from September 1986 through January 2010, with percent efforts ranging from five to one hundred percent. They are well organized and highly focused. The AAMC Graduation Questionnaire indicates that the students view the dean's office as accessible, aware of and responsive to student concerns at levels well above the national norms.

There has been considerable succession within the school of medicine administration since the time of the last site visit. The new dean was appointed in October 2008 and there has been reduction from 22 to 15 associate/assistant dean positions within the ranks of the academic offices of the medical school. With an average tenure of 7.5 years for the associate and assistant deans, they believe that they ably conduct the business of the school and are adequately responsive to students and faculty. The assistant dean for

admissions has been the subject of a recent search, which has been completed. The dean of students has announced retirement at the end of the current academic year, prior to his annual task of completion of the MSPE's. A national search is about to be initiated for this position.

It is also of note that the total number of academic departments has decreased from 21 to 19 since the time of the last survey with combinations of multiple departments, as well as the creation of a new Department of Immunology. There has been the renaming of the Department of Physiology as the Department of Cell Biology. There have been nine new department chairs since the 2003 survey and four serving in an interim capacity.

Review of the self-study of the basic science departments reveals understanding and ongoing contribution by the basic science to the school's mission and goals, as well as reasonable resources including financial, faculty, and facilities. There has been a continued reduction in the size of the basic science faculty from 155 to 128 full-time faculty members over a five-year interval. Updated information provided at the time of the site survey demonstrates that the basic science faculty continues to decrease in all categories (full time-126, part time-31 and volunteer-70). The volunteer faculty is, for the most part, used as instructional work force to make up for full time faculty losses. This overall attrition has been based upon early retirement programs, inability to "hire back" retired faculty, and loss of such faculty lines. There is also significant concern voiced about the implications of the planned hospital merger and the implementation of a new faculty productivity assessment instrument (CREATE). There is a widely held feeling that the number of teaching faculty, particularly for the Phase 1 curriculum, is below the necessary threshold to maintain the quality of the programs in this particularly intense curriculum structure in years one and two.

The clinical faculty has been stable since 2005 after increasing, predominantly in the full time category.. This is somewhat department specific, with noted shortages in surgery, radiology and several other specialty areas. Review of the self-study of the clinical departments reveals full understanding and an ongoing contribution to the school's mission and goals. There has been an increase from 640 to 769 full-time clinical faculty members over the same five-year interval.

One of the major changes described in the self-study relates to the recent efforts begun in June 2009 by the AAUP, to organize the faculty into a collective bargaining unit. This included a card campaign and a petition to the Connecticut State Labor Board, calling for an election. In September, the University of Connecticut Health Center Faculty Association filed a petition with the state Labor Board calling for an election. The results of this faculty election, supporting the formation of the collective bargaining unit by two votes, became known in November 2009. At the time of the site survey, it was widely understood that the AAUP organization will proceed based upon this two-vote (~0.4%) majority, with the faculty attempting to write a constitution and soon to begin formal contract negotiations. There remains considerable division and concern by the faculty between the two roughly equal visions regarding the role of a collective bargaining unit. The academic and fiscal impact of this organizing movement (if any) is therefore unclear at the time of the visit.

B. Academic Environment

There are multiple graduate degrees offered at the University of Connecticut Health Center in combination with the College of Medicine. The fields of graduate study (MS and PhD) are now organized consistent with the areas of concentration rather than being departmentally based. They include studies in biomedical science, public health, clinical and translational research, and business administration (as part of a joint degree program). Areas of concentration (AoC) of the biomedical sciences individually reviewed on a seven year cycle. Each AoC conducts a self-study and then a combination of external and internal review team members participate in a site visit and then generate a

report on the AoC. The new Masters in Translational Research currently enrolls six students, three of whom are faculty, and will markedly enhance the research experience of this small group. Currently, jointly enrolled students in graduate programs receive a tuition waiver and all others pay tuition, including the university full time faculty. The thirty enrolled MD-PhD students receive a tuition waiver and stipend for all years of the program. This program has received 102-139 applications annually over the past five years from which four or five are selected each year.

During the time period from 2003 through 2008, the number of master students in biomedical science has risen from zero to, most recently, 167, and the number of biosciences doctoral students has risen from 143 to 166 at the time of the self study and 170 at the time of the site survey. The Ph.D. programs in biomedical sciences fall into six areas of concentration, which include cell biology, developmental biology, genetics, molecular biology and biochemistry, immunology, neuroscience, and skeletal cranial facial and oral biology. Of the166 students enrolled at the time of the self-study in the biomedical science Ph.D. program, 25 were medical students in a dual M.D./Ph.D. program. The Masters in Public Health Program accredited by the National Council on Education for Public Health (NCEPH) currently has 120 students enrolled (see Appendix for enrollments).

The Master of Dental Sciences Program is run predominantly by the dental school and currently has 47 students enrolled. There are a number of dual degree programs serving to accomplish degrees in less than the usual time period. These include the MD/PhD, DMD/PhD, MD/MPH, MD/MBA, PhD/MBA and MD/MCTR programs. It is of note that the graduate programs at the University of Connecticut Health Sciences Center are under the governance of the graduate school at the University of Connecticut. The associate dean of the graduate school oversees these programs and reports jointly to the dean of the graduate school and the dean of academic affairs at the school of medicine. The institution currently provides a budget of approximately $2.45 million, predominantly devoted to assistantships. The assistantships are currently funded at $27,000, including health insurance and a full tuition waiver. This is a fair market stipend, with the exception of a relatively expensive health insurance program.

The doctoral programs in Public Health currently have 10 students enrolled, who are divided into two areas of concentration (social and behavioral sciences, occupational and environmental health). This is a relatively new program, which draws faculty from both the University of Connecticut Health Center and the Storrs Campus of the university. In 2007 a new program entitled "Master of Science in Clinical and Translational Research" was created. This was meant to provide healthcare professionals with both academic and research skills that may be needed for independent research. The goal is for students to conduct independent clinical and translational research. Currently there are 11 students enrolled in the program with numerous professional terminal degrees. There are no certificate programs at the time of the self study and visit, although the graduate school is considering such opportunities.

At the time of completion of the self-study, the School of Medicine sponsored 45 ACGME (or equivalent) programs with a total of 586 residents (see Appendix). The entire system is approximately 40 to 45 residents over CMS cap each year, which is funded by the hospital or hospital partner affiliates. The most recent institutional review by the ACGME in March 2008 resulted in reaccreditation for four years. Since the time of the last survey, four new programs have been added in Dermatology, Child and Adolescent Psychiatry, Hospice and Palliative Care Medicine, Interventional Cardiology, with the closure of six other programs including Medicine, Psychiatry, Medicine Pediatrics, Nuclear Medicine, and Anesthesia Critical Care. There are no sponsored programs on probation. All of the residents are involved in the learning environment programs and all have signed the teacher/learner compact as part of their educational programs and responsibilities. There are resident as educator programs centrally available and within most departmental programs.

Funding from the university for research faculty has not been well sustained since the time of the last survey, with 20% attrition in faculty members who are more than 75% research intensive. During the same period, external funding of research has remained fairly flat. There is little change in the clinical faculty research productivity since the time of the last LCME review. In addition, the level of biostatistics support has reportedly fallen off greatly. Recruitment is currently underway to replace one or more of the biostatistics positions. The health science campus is currently somewhat dependent upon main campus resources for biostatistics support.

Work is underway to apply for a federal CTSA designation (C-CATS) with resources backed by the University of Connecticut. Intramural research support, as measured by the budget for intramural research grant awards, has been reduced by 28% since the 2003 LCME visit.

Plans are currently underway to renovate one of the research buildings of approximately 117K sq ft. Given the decrease in the number of faculty who are truly research intensive, there appears to be no significant research space shortage at this time. There is concern for the amount of unrenovated (vintage 1972) research space and the state of HVAC and other FFE. State funds to support this research building renovation (and all other proposed and not yet begun state bond financed projects) were being held at the time of the site survey. Research space allocations are handled at the departmental level, although there does exist a central "Research Space Committee".

This research focus has resulted in multiple research opportunities for medical students from basic science laboratory experiences through clinical and community health experiences. In 2006, 62% of the graduates reported doing research with medical school faculty. This has risen over the intervening years and in 2009 approximately 87% of the graduating students reported doing such research. The ability of the school to fund students during periods of summer research and other equivalent experiences has somewhat fallen, which has resulted in what is described as a "perceived loss of value for research in the medical curriculum." Excellent web-based resources describe various student research programs that allow students to understand the types of clinical, basic science and community-based research programs that are available for them to participate in. The research experience remains optional, however, the large majority of the class does participate, many through the Phase 3 "Selective" rotation. The required student research program in patient safety resulted in a competitive poster presentation, and has been recently recognized by the NBME and awarded a continuation grant (~$30K).

The medical school encourages and supports medical student participation in service-learning activities. All medical students are required to complete 15 hours of health related community service, and the average service given is closer to 80 hours. The community service requirement grew out of a tradition of community service involvement by University of Connecticut medical students and a desire to provide institutional support for these activities. General goals for this experience include incorporating clinical skills into community settings, augmenting professional education through experience with community activities, and contributing needed services to the community. Students may choose to work with an agency in their practice community or with one of the many ongoing service projects in the Greater Hartford area. Activities include health promotion, intervention, and clinical care. Student-operated community service projects include health education and mentoring in Hartford schools, free clinics serving pregnant, homeless, migrant, and adolescent populations, and a health education program with the American School for the Deaf. With the addition of the Urban Service Track in FY2008, many of these opportunities now include students from UConn's Schools of Nursing and Pharmacy.

The University of Connecticut Health Center adopted a diversity vision statement in 2006, although not formally a part of their mission statement. This is a full and wide-ranging statement, articulating their values regarding diversity in the faculty and student body, care for patients, and the relationships pertaining thereto. While the Health Center considers diversity very broadly, the strategic plan for

diversity focuses on diversity that involves race and ethnicity. There are statements in the Teacher/Learner Compact which both students and faculty sign regarding a commitment to embracing the higher standards of medical professionalism and diversity. The Health Careers Opportunity Program plays a key role in the recruitment and retention of the diversity of the student body, which has been increasing over the past several years. For the past five years, African-American students have ranged between 10% and 14% of the medical student body and Hispanic-Latino students have comprised 1% to 3% of the student body. This is somewhat reflective of the demographics of the state of Connecticut. There are numerous curricular elements focusing on cultural competency and healthcare disparities, going through virtually all phases of the pre-clinical and clinical curriculum. There has been a substantial lack of diversity in the faculty and this was cited as an area of non-compliance in 2003. As of the end of the most recent academic year, 3% of the paid faculty were African American and 2% were Hispanic. Steps have been taken in an attempt to recruit and retain, as well as to promote, faculty members across a broad spectrum of diversity with a renewed focus of the dean's office. There is also limited diversity represented in the staff of the medical school. Among the non-faculty medical school employees, approximately 3% are African American and 3% are Hispanic. Although this is somewhat reflective of the demographics of the state of Connecticut; the diversity is less than would be predicted by this alone. These challenges are recognized by the leadership of the school of medicine.

II. EDUCATIONAL PROGRAM FOR THE MD DEGREE

See Appendix for the following documents:

- Educational program objectives
- A schematic showing the placement of courses and clerkships within each academic period
- A table indicating the presence in the curriculum and the amount of structured teaching time devoted to subjects required for accreditation
- An organizational chart for management of the curriculum
- USMLE Steps 1, 2 and 3 performance data [number examined, percent passing, mean total score, mean national total score] for first-time takers for the three most recently-available years

A. Educational Program Objectives

The University of Connecticut School of Medicine revised its curriculum in 1995. In 2002 the SOM Council recommended revision of learning objectives and this was accomplished in 2004. The school has 63 school-wide educational objectives, organized according to the six ACGME competencies (see Appendix). Based on the six competencies these objectives reflect general physician competencies specifically suggested by the ACGME.

The types of patients seen by students in each clinical experience are determined a priori based on the school objectives and national standards. The required patient experiences are disseminated to the multidisciplinary ambulatory experience section directors, and inpatient clerkship section directors. These objectives were presented to the curriculum oversight committee when they were first created, but they have not received consistent review by this committee since. Students express some concern that the case mixture is too heavily focused on primary care patients rather than specialty care problems, particularly in neurology and radiology. The level of student responsibility is stated for both inpatient and ambulatory care experiences in both the third and fourth years.

Students maintain an electronic log of all patient encounters by PDA. The log includes places to report the student's level of involvement in the history, physical exam, visit note, and oral presentation, whether or not the student was observed and whether or not they received feedback. Diagnoses and procedures are automatically linked to the requirements for each rotation, and the student can generate rotation specific requirement progress reports at any time. However, it does not appear that this happens on a consistent basis. Students are to review their progress reports with preceptors at the mid-rotation and end of rotations. However, students report that this feedback does not uniformly occur. Site directors are responsible to ensure the required experiences are available and have been met. Site directors report to the course directors if there is any pattern of difficulty. Site directors also serve on course committees to review overall aspects of the courses and monitor aggregate student performance. The system of feedback works at the level of course or clerkship director and site directors, but the feedback is not consistently transmitted to the Curriculum Operating Committee (COC).

If there are gaps in clinical experiences, students may be assigned to different preceptors or different locations. For pediatrics, students review computer based cases or work one on one with the clerkship directors. Rarely, they may have to spend additional time on the clerkship.

The medical students receive the school's objectives on the school's curriculum webpage. The dean for academic affairs presents this document to the students during a Dean's hour at the beginning of the first year, to second year students on the first day of class, and to 3rd and 4th year students at their introductions

to each year. The students are aware that these exist. All Course Directors are asked to post the material on the Blackboard sites for each course and clerkship. In Human Development and Health and the Clinical Medicine Course, the students are shown how the course objectives relate to the school's goals, objectives and competencies. In most clerkships, the objectives are clearly organized by the school's goals, objectives and competencies.

The school objectives serve as a foundation for the curriculum's design and provide overall guidance in the development of course objectives. All course directors review the curriculum objectives annually and indicate which are addressed and assessed in their courses. These objectives are disseminated to section and site directors. Although it is stated that periodic review of each course is conducted by the Course and Curriculum Evaluation Committee (CCEC) and the COC, this has not occurred at all for some courses, consistently for others, and did not occur at all for an entire year. There has been only 1 complete review of the entire curriculum in the last 15 years.

B. Structure of the Educational Program

1. General Design

The curriculum to obtain an M.D. degree consists of a total of 164 weeks, with 38 scheduled weeks in year one, 38 weeks in year two, 48 weeks in year three and 40 weeks in year four. The curriculum is organized into three phases. Phase 1 extends through the first two years and consists of a total of six courses. There are 1029 scheduled hours in first year and 1038 in second year, which includes the required elective hours. In the first year of Phase 1, students spend 657 hours in the Human Systems course. This is an integrated course that covers the normal structure and function of the human body and includes such basic science topics as anatomy, physiology, biochemistry, histology, biostatistics and cell and molecular physiology. It is taught concurrently with Correlated Medical Problem Solving (CMPS) and Principles of Clinical Medicine (PCM), both of these latter courses extend through year 2 of Phase 1. CMPS consists of weekly problem-based learning sessions to integrate topics of the week with clinical problems. The PCM course covers patient communication and physical examination skills with standardized patients in the clinical skills center and by attendance at a continuity clinic that extends for three years. Human Development and Health begins in the second year of Phase 1 and covers health care systems, health care law, human behavior, biostatistics and epidemiology. Mechanisms of Disease is the major course of second year occupying 512 hours of instruction and integrates pathophysiology, pathology, pharmacology, and infectious disease in organ systems format. In Phase 1, students must also accomplish the elective courses.

Phase 2 is a clinical year with two courses: Multidisciplinary Ambulatory Experiences (MAX) and Inpatient. The MAX consists of two-sixteen week rotations in ambulatory care and Inpatient consists of 16 weeks of inpatient care. MAX subsumes clerkships in the clinical disciplines of Family Medicine, Medicine, Ob/Gyn, Orthopaedics, Otolaryngology, Psychiatry, Pediatrics and Surgery. Inpatient subsumes clerkships in the clinical disciplines of Medicine, Pediatrics, Psychiatry and Surgery. Students take these clerkships in many different sequences. Their exposure to any given discipline's inpatient and outpatient experiences may be separated by many weeks and may be in either sequence. Students also continue the experience in the continuity clinics that were initiated in first year. Students come together three times in Phase 2 for Home Weeks that provide enhancement of knowledge and skills. Phase 3 is the fourth year that consists of three elements. The first element is a three month Advanced Clinical Experience (ACE) where students accomplish a rotation in emergency medicine, a rotation in a critical care unit and an advanced inpatient care rotation in either family medicine, internal medicine, pediatrics or surgery. The second element is called Selective, which is an eight week capstone project. Students develop and carry out a project with the guidance of a faculty advisor. The third element of Phase 3 is five months of elective work (see Appendix for curriculum schematic).

While contact hours in Phase 1 are relatively high, the curriculum provides multiple opportunities for active learning and independent study. The Correlated Medical Problem Solving (CMPS) course extends through the first two years and consists of small group problem solving. In the Human Development and Health course of the second year, students do research and report on a topic of their choosing. Students also have to accomplish a report in Home Week. Several courses devote time to assessing evidence: CMPS, biostatistics in Human Systems, and epidemiology in Human Development and Health. In the MAX clerkships students must assess their own strengths and weaknesses.

Skills of lifelong learning are fostered by the student self-assessments, problem solving sessions and the required written and verbal reports. Results of these experiences are evaluated within the courses and experiences in which they participate.

There is no central authority for a systematic and consistent method of assessing comparability in the various clinical sites. The clerkship directors are completely responsible to make certain the educational experiences are equivalent. Not all clerkships in Phase 2 are effective in monitoring, with the Surgery clerkship being especially deficient in this regard. Clerkship directors utilize the Blackboard system to distribute the same objectives and goals. Students receive orientation centrally when beginning a clerkship.

The last major curriculum reform was in1995, before the last site visit, and the curriculum has been stable since that time. Minor changes are planned for 2010-2011, including addition of a mandatory 2-week rotation in neurology in the third year and a mandatory 2-week experience in radiology in the fourth year.

2. Content

All of the subjects required for accreditation included in the curriculum and the coverage of these subjects is sufficient to meet accreditation standards (see Appendix).

Years One and Two

A. METHODS OF INSTRUCTION

YEAR ONE

Formal instructional hours

Course	Lecture	Lab	Small groups*	Patient contact	Other†	Total
Human Systems	323	192	108	0	34	657
Clinical Medicine	--	--	--	--	--	278
Principles of Clinical Medicine 1	25	4	99	0	14	142
Student Continuity Practice 1	0	0	0	136	0	136
Correlated Medical Problem Solving	0	0	94	0	0	94
TOTAL**	348	196	321	136	48	1029**

* Includes case-based or problem solving sessions

† Describe

Human Systems "Other" = Exams

Principles of Clinical Medicine 1 "Other" = standardized patients

**plus elective hours

YEAR TWO

Formal instructional hours

Course	Lecture	Lab	Small groups*	Patient contact	Other†	Total
Human Development & Health	90	0	34	0	8	132
Mechanisms of Disease	295	58	141	0	18	512
Clinical Medicine	--	--	--	--	--	303
Principles of Clinical Medicine 2	26	4	64	27	30	151
Student Continuity Practice 2	0	0	0	152	0	152
Correlated Medical Problem Solving	2	0	89	0	0	91
TOTAL**	413	62	328	179	56	1038**

* Includes case-based or problem solving sessions

† Describe

Human Development and "Other" = 2 exams of 4 hours each
Mechanisms of Disease "Other" = 4 exams of 4.5 hours each
Principles of Clinical Medicine 2 "Other" = standardized patients

**plus elective hours

Clinical Medicine Course 1 and 2 has participants from fifteen different school of medicine clinical departments and ten allied health departments. There is no lead department. This course extends through the entire first and second years. Currently, there are sufficient numbers of faculty to participate. Written objectives are available for the course and these are, for the most part, in outcomes based terms. Generally, this course helps students to develop the knowledge, skills, values and attitudes required to interact with patients, families and other members of the health care team. There is a focus on interviewing and communication skills, data collections, the physical examination, data organization, clinical reasoning, behavioral counseling and personal and professional development. Goals for the course are well defined and distributed to students and faculty. The course objectives are reviewed at the annual faculty retreat early in the academic year and are posted on Blackboard. Preceptors receive periodic reminders regarding these objectives. In addition, there are periodic faculty meetings scheduled to discuss course progress and address problems that arise. Residents and fellows involved in teaching small group workshops are sent a copy of the goals and objectives for the section they are teaching, as well as supplemental readings and material. The section leader reinforces this information verbally with the resident/fellow before the session commences. The course has two primary components: the Student Continuity Practice (SCP) which occurs ½ day per week during years 1, 2 and 3 and the Principles of Clinical Medicine (PCM) which occurs ½ day per week during years 1 and 2. Students are placed in the same internal medicine, family medicine or pediatric practice for the first 3 years of medical school with the option of staying in that practice in their fourth year as well.

SCP faculty are located in practices all over the state of Connecticut. Course directors meet with each

new faculty member to orient them to the course. Several faculty development sessions are offered to prepare faculty for their roles. Faculty are given the Learning Contract. Space in the clinical practices is now deemed adequate but had been problematic in the past.

The course is appropriately positioned in the curriculum, as the first year portion of the course develops students to a level necessary for second year and the second year develops them for third year.

The course appropriately uses predominantly small group sessions (lecture is only 18%) for the Principles of Clinical Medicine portion and 100% clinical experience for the Student Continuity Practice. This longitudinal experience provides contextual learning for the basic science curriculum and thereafter. Formative feedback occurs with clinical skills assessments with standardized patients. Evaluations from the SCP are frequently late resulting in a grade of "Incomplete," requiring students to contact their preceptors to get the evaluation submitted.

The Student Independent Analysis reflects general satisfaction with the course with 69% agreeing that the course was successful and valuable, and 94% of respondents rated it good-to-excellent on the 2009 AAMC Graduation Questionnaire. Students are overwhelmingly positive about the Student Continuity Practice.

Students perform well on the USMLE Step 2CS exam which is seen as a major success of the course. Challenges continue to have a sufficient number of faculty and preceptors.

Correlated Medical Problem Solving 1 and 2 (CPMS) is designed to complement and reinforce the didactic portion of Phase 1 of the curriculum, namely Human Systems, Human Development and Health and Mechanisms of Disease. CPMS consists of small group (8-9 students) problem based learning experiences scheduled ½ day per week with two faculty facilitators (a basic scientist and a clinician) throughout the first and second year. Students are expected to analyze clinical cases, which are correlated with the didactic curriculum being presented, develop leaning objectives, do the required research and formulate appropriate hypotheses regarding the nature, pathophysiology and treatment of the patient's disorder utilizing concept mapping. The last 10 weeks of the 4th semester of CMPS is called Clinical Reasoning. Students are expected to evaluate complex disorders, develop a problem list, and differential diagnoses and give an oral presentation. The overall course promotes small group, problem based, self directed learning (PBL). Student evaluation utilizes student generated weekly summaries of learning issues and at least 4 concept maps/semester as well as a case based take home examination which is graded using the pass-fail system. A multiple choice examination is being planned at the end of each semester to evaluate self-directed learning.

Success of the course is the promotion of problem based, self directed group learning and clinical reasoning. Challenges include the recruitment of adequate numbers of faculty and the variability in the quality of the facilitators. Recently retired faculty members have been recruited to meet this need.

It is expected that students be provided with oral and written formative (mid-course) and summative feedback but the formative feedback is frequently delayed. There is no narrative assessment provided in this small group format, despite the regular weekly direct contact with faculty facilitators. This is attributed to the lack of continuity of faculty leadership of these small group exercises.

The Student Independent Analysis rated both year 1 and 2 of the CMPS course highly with 83% and 60% of respondents agreeing that the year 1 and year 2 courses respectively were successful and valuable, with the clinical reasoning portion of the course as the strongest component.

Human Development and Health is an integrated course with faculty participating from multiple departments and there is no lead department. There are faculty participants from nine different departments, as well as from the state attorney general's office, oral health, social work and staff from patient education.

Currently, there are sufficient faculty to teach this course. There is, however, increasing difficulty retaining sufficient numbers of faculty for the small group teaching.

There are written objectives for the course, which are written in out-come based terms. There are five main sections to the course: 1. health and health care systems, 2. health and behavior across the lifespan, 3. health law and ethics, 4. clinical epidemiology and 5. biopsychosocial perspective.

This course occupies the first eight weeks of the second year in the Phase 1 curriculum. The length is appropriate as is the position in the curriculum. There is approximately 27% of the course taught in small group sessions with the remainder in lecture format. Resources for this course are adequate.

Students participate in small groups for the epidemiology portion and health law and ethics portion. In these groups, discussions include cases similar to what they will have on the exam.

This course is successful in covering many required topics of becoming a physician that do not naturally fit in other areas of the curriculum. Challenges include having faculty, who only lecture for one hour, understand the entire course and keep their lectures in appropriate context. Although the Student Independent Analysis does not address this course specifically, the topics included in this course are reported to be covered successfully by approximately 57% of respondents.

Human Systems is a large multidisciplinary course that occupies 657 hours (64%) of the first year curriculum. The course is managed by a course director and a "Human Systems Management Group." which is comprised of the several section leaders and the primary teaching faculty. Each of the four sections of the course is overseen by one or more section heads who report to the course director. Faculty members from 19 different departments participate in the teaching of this course, along with some use of graduate students and medical and dental residents and significant contributions from volunteer retired physicians.

The course is divided into four sections: Human Biology (which, in turn is divided into three units) and Organ Systems 1, 2 and 3. The objectives of the Human Biology section is to have the students learn the fundamental principles and topics deemed essential to proper understanding of organ systems. The topics subsumed in this section of the course include metabolism, tissue biology, general genetics, molecular and cell biology, general physiology, immunology and basic hematology. The three Organ System (OS) sections address the body systems. OS-1 includes the anatomy and physiology of the Central Nervous System which is integrated with head and neck anatomy. OS-2 covers cardiovascular, respiratory and renal biology and is integrated with thoracic anatomy. Biostatistics is also included in this section. OS-3 covers gastrointestinal physiology and endocrine and reproductive biology and is integrated with abdominal and pelvic anatomy. Throughout the Human Systems, where it is deemed beneficial to the understanding of the normal condition, pathological processes and disease are used to reinforce understanding of normal tissue and organ systems.

The course presentation is approximately one-half lecture-based, 30% laboratory based with the remainder being small group case-based exercises. Student assessment is based upon 13 internal examinations which include written multiple-choice, short answer and essay questions as well as

laboratory practical questions. NBME subject examinations are not used. Narrative evaluations are not included in the evaluation process. This is reportedly due to the lack of continuity of faculty leadership of small group sessions. Physical facilities and technology support for this course is appropriate. Faculty resources for this large course are probably barely adequate at this time, although there is significant reliance on volunteer retired physician to cover the laboratory sessions and reported shortages in faculty to precept small group sessions and to integrate radiology with anatomy. The faculty shortage is reportedly the reason that the inconsistent leadership of small groups does not allow for narrative evaluations. There is concern about the ability to maintain an appropriate level of faculty coverage as experienced faculty reach retirement and the more junior faculty have limited expertise in areas relevant to biomedical education.

The Student Independent Analysis indicated that the Human Systems course is well regarded by the students and has been consistently so over the years. The students rated the individual discipline components of the course and these rating reveal that the Anatomy, Physiology and Biochemistry components are very well regarded, while Neuroscience and Histology are less well regarded. In response to the question of whether each component was successful and valuable, the percentages who strongly agreed or agreed were 94.6%, 88.7% and 86.0% for Anatomy, Physiology and Biochemistry, respectively. For Neuroscience and Histology the similar responses were 78.7% and 75.6% respectively. The AAMC Graduation Questionnaire, in which the format requires that responses be discipline based, reveals that ratings for how well this course prepares students for clinical clerkships is above the national average for physiology, at about the national average for anatomy, histology and biochemistry and significantly below the national average for neuroscience. The evaluation of Neuroscience has been consistently low for the past five years, albeit with a slight improvement in the most recent year. The opinion offered during the site survey was that this relates to a desire for a more clinically oriented Neuroscience course. Opinions obtained from students during the site survey were very supportive of this large, integrated course in the first year curriculum.

Mechanism of Disease has participating faculty from 19 different departments and there is no lead department. A total of 128 different faculty participate and there seems to be sufficient numbers. There are objectives for this course written primarily in outcome based terms. This course integrates basic science disciplines within the context of the study of disease processes. It is designed to provide the scientific basis for understanding disease. There are nine main sections of the course: 1. General pathology, immunology and general pharmacology, 2. Infectious diseases, 3. Diseases affecting homeostasis, 4. Oncology, 5. Diseases affecting metabolism, 6. Diseases of the nervous system, 7. diseases of the immune system, connective tissue, skin and joints, 8. Diseases of the reproductive system, and 9. Clinical pathologic conferences.

This is the major course of the second year of Phase 1 curriculum and has a total of 512 contact hours. It is appropriately placed in the second year. It consists of approximately 60% lecture and 40% lab and small group exercises.

Formative feedback is by way of mini-quizzes, practice questions and experiential unknown exercises in histo-pathology. The resources available are currently sufficient for the success of the course. The course is successful in the integration of pathology, pharmacology, and pathophysiology across the organ systems. The main challenge is to keep a sufficient number of faculty, particularly in the areas of microbiology and infectious disease.

Students are generally satisfied with the course, however the pharmacology section is the most poorly rated. On the 2009 AAMC Graduation Questionnaire, 68% report satisfaction with the pharmacology education while 93% report satisfaction with immunology and 90% with pathology.

All students are required to take 12 credits worth of **Electives** during phase 1. There are 23 separate offerings available from which students may choose. Eleven of these can only be taken by second year students, three only to first year students, and 9 by either. Electives are offered by a variety of departments and include a range of topics from basic sciences, clinical medicine, and the medical arts. Each course has been assigned an allocation of credits based mostly on the amount of contact time it requires from students. The courses average 4 credits each, and most students complete 3 electives total. Each course is independent and has an independent set of objectives, and learning and evaluation strategies. With small numbers of students taking each, there is no direct feedback information on the electives individually. The objectives of the electives are supportive of the overall school objectives.

Years Three and Four

YEAR THREE

Clerkship	Total wks	% Amb.	# Sites used* in/out patient	Typical hrs/wk formal instruct.**	Clinical Encounter Criteria† (Y/N)	Patient Log (Y/N)
In-patient clerkships:			**IN**			
Beginning to End	2	0%	4	6-12***	Y	N
In-patient Medicine	4	0%	4	16-18	Y	Y
In-patient Pediatrics	2	0%	1	20	Y	Y
In-patient Psychiatry	4	0%	3	25	Y	Y
In-patient Surgery	4	0%	5	5	Y	Y
Out-patient clerkships (MAX):			**OUT**			
Family Medicine	6	100%	38	5	Y	Y
Medicine	6	100%	8	4-6	Y	Y
OBGYN	6	50%	4	10	Y	Y
Orthopaedics	1	100 %	4	4	Y	N
Otolaryngology	1	100%	7	6	Y	N
MAX Psychiatry	½ day x 14 weeks	100%	20-25	1.5	Y	Y
Pediatrics	6	100%	10	4-6	Y	Y
Surgery	3	100%	15	4	Y	Y

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: # inpatient/ # outpatient

* *Sum of lectures, conferences, and teaching rounds; show the range of hours if there is significant variation across sites

***depends on the week, not the site

† Have criteria for the kinds of patients, clinical conditions, or procedural skills been defined?

Course	Lecture	Lab	Small groups *	Patient contact	Other†	Total
Clinical Medicine – Student Continuity Practice 3	0	0	12	152	0	164
Home Weeks	19	0	40	17	0	76

* Includes case-based or problem solving sessions

† Describe

YEAR FOUR

	Total wks	% Amb.	# Sites used*	Typical hrs/wk formal instruct.**	Clinical Encounter Criteria† (Y/N)	Patient Log (Y/N)
Advanced Clinical Experience						
Advanced In-patient Experience- Medicine	4	0	6	15-20	Y	Y
Advanced In-patient Experience-Pediatrics	4	0	1	15-20	Y	Y
Advanced In-patient Experience-Family Medicine	4	0	2	15-20	Y	Y
Advanced In-patient Experience- Surgery	4	0	4	6-10	Y	Y
Critical Care	4	0	7	20	Y	Y
Emergency Medicine	4	0	7	7.5	Y	Y

*Include the number of sites used for inpatient teaching and the number of sites used for outpatient teaching in the clerkship in the following format: # inpatient/ # outpatient

* *Sum of lectures, conferences, and teaching rounds; show the range of hours if there is significant variation across sites

† Have criteria for the kinds of patients, clinical conditions, or procedural skills been defined?

Beginning to End (BTE), a third year 2 week course, is a component of the Inpatient Course. It is designed to expose students to the systems based issues related to patient care. Topics include: 1) the role of and coordination of counsel from consultants in the care of the hospitalized patient; 2) coordination of care and role of non-physician members of the team (e.g. care coordinators, social workers, physical therapists, nutritionists, etc); 3) quality of care issues that may impact a patient's hospital stay; and 4) the role of end of life care and hospice. Objectives for the course were developed by a medical school committee. The goals and objectives are crafted in ACGME competency language.

Students identify patients in the Emergency Department and are expected to "follow" individual patients throughout their entire hospital stay, independent of assigned medical service. This allows the student to work across specialties, view in real time the role of the consultant, have access to non-physician provider input, and be an advocate for the patient. Students discuss their experiences with preceptors with whom they meet at least three times weekly. During the preceptor sessions, the clinical experiences are

reviewed and discussed. There is a course director and section leader for the BTE course. The section leader for BTE meets with each of the site directors and discusses the objectives and evaluations with them. In addition, information is posted on the "Blackboard" portal for faculty to review. Students are evaluated during BTE based on their patient presentations to faculty preceptors approximately three times per week. Their "write ups" are also reviewed. This provides one-on-one learning between a student and a faculty member. Students are given mid-course feedback and, if sub-optimal, a plan of action is developed. Narrative evaluations are provided.

Educational space, computer equipment and support personnel are considered adequate. Faculty are described as competent and interested in teaching, but may be pre-occupied with their clinical demands. There are adequate numbers and types of patients for students. Students provide feedback after completing the BTE rotation which is reviewed by the course director and section leaders. Recurrent problems are brought to the Inpatient Section Leaders meeting. Students have consistently noted on course evaluations the variability of preceptors, lack of course rigor and "too much down time." Faculty report that they are aware of these concerns. The Student Independent Analysis indentified the strength of the course as "an opportunity to experience the quality and patient perspective of health care in a hospital setting." Weaknesses included "lack of educational value with poor direction and organization." Students felt the goals of the course were already met through other clinical rotations.

Family Medicine

The **MAX-Family Medicine clerkship** is an outpatient experience in Family Medicine in addition to the ongoing continuity clinic experience all students have during the first 3 years of medical school. The MAX-Family Medicine clerkship uses goals and objectives written by the school of medicine. The objectives are given to students at the beginning of each rotation. Students maintain an electronic log of patients seen on PDAs. The log is reviewed at mid-clerkship to determine that students are seeing appropriate patients. Students spend 6 weeks in a single family practice office location. The clerkship uses 38 separate office sites. During the clerkship students also spend 4 hours doing a single home hospice visit, and 4 hours doing another home visit. They have 3½ days of didactic teaching, all at the school of medicine home site. There is a section leader for the clerkship who is responsible for consistency among the training sites. Supervision at these sites is by both practicing family physicians and residents in the family medicine program. Student comments do not identify any problems with variability between training sites. Residents receive goals and objectives for the rotation several times during the year to attempt to achieve consistency. Residents receive 2 hours of didactic training in how to teach prior to their participation. Supervision by faculty across training sites is evaluated by students as strong. According the AAMC Graduation Questionnaire, 89.8% of graduates agree that they were observed taking a patient history and 88.4% agree that they were observed performing a physical exam during family medicine training. These are above the national averages. There were no reported concerns or comments by students about workload or excessive hours. Overall this clerkship is well received by students. The only negative feedback is that the clerkship may be too long given the other outpatient and continuity experiences the students have in their curriculum. In the Graduation Questionnaire, 95.6% of students felt their training in family medicine was adequate. This is much better than the national average of 88.4%. The major success of this clerkship is the high rating of faculty by students. The challenges include maintaining consistency across training sites, the need to identify new or alternative training sites as needed, and keeping pace with increasing student computer literacy requiring ongoing innovation in interactive mock case discussions.

The **Advanced Inpatient-Family Medicine clerkship** is a new subinternship in Family Medicine introduced in 2009. In the past two years an effort has been made to try, as much as possible, to create consistency between the Advanced Inpatient experiences in Family Medicine and Internal Medicine. The

purpose on these two rotations is to teach students how to diagnose and manage common problems in inpatient medicine. The eight case conferences developed for the Internal Medicine AIE have been incorporated in the Family Medicine experience and the students in both rotations take the same final exam. The clerkship uses goals and objectives written by the school of medicine. The objectives are given to students at the beginning of their rotation. Students maintain an electronic log of patients seen on PDAs. The log is reviewed at midclerkship to determine that students are seeing the appropriate patients. Students spend 4 weeks in one of two hospitals used for the rotation. There is a course director for the clerkship who is responsible for consistency between the training sites. Supervision at these sites is by a site leader, practicing family physicians, and residents in the family medicine program. Residents receive goals and objectives for the rotation several times during the year to achieve consistency. Residents receive two 45 minute training sessions yearly on how to teach. There are no data on student feedback for this clerkship. The challenges of this clerkship are creating consistency between this and the Advanced Inpatient Internal Medicine rotation, and ensuring that students have appropriate supervision by attending and resident physicians.

Internal Medicine

The **Inpatient Medicine clerkship** is one component of the M3 experience in internal medicine. Internal medicine training in the third year is divided between the Inpatient Medicine clerkship and the outpatient MAX-Medicine course. These courses are taught separately without direct coordination between the 2 experiences. However, required patient encounters in internal medicine may be accomplished in either rotation. During the Inpatient Medicine clerkship, students see only hospitalized patients. The clerkship uses objectives created from the school of medicine's goals and objectives with modifications based on the Clerkship Directors in Internal Medicine Association. The objectives are given to students at the beginning of each rotation. Students maintain an electronic log of patients seen. Students spend 4 weeks in a single rotation at one of four hospital sites: St Francis, The Hospital of Central Connecticut, Brownstone/Hartford Hospital, or John Dempsey Hospital. The students spend 4-5 days per week at the hospital site and ½ day in the week starting in week 2 in their continuity clinic that continues from phase 1. Each week ½ day is spent at the school of medicine for didactic lectures with all formal lecture material delivered at the same time at this site. There is a site director at each of the hospitals who works with the clerkship director to maintain consistency among the training sites. Students report some differences in the mixture of patients seen depending on the site. There are also different proportions of students receiving honors at each of the trainings sites. These two issues suggest that there may not be a uniform experience at all sites. Residents receive goals and objectives for the rotation several times during the year to attempt to achieve consistency. Student comments suggest that residency teaching is a weak component of this clerkship. Supervision by faculty across training sites is evaluated by students as very strong. According the AAMC Graduation Questionnaire, 66.7% of graduates agree that they were observed taking a patient history and 65.2% agree that they were observed performing a physical exam during the Internal Medicine training. This is not tabulated in a way to know how much observation occurs on the inpatient clerkship versus the ambulatory care rotation. The overall percentages are below those nationally. There were no reported concerns or comments by students about workload or excessive hours. In the Graduation Questionnaire 89.8% of students felt their training in internal medicine was adequate. This is identical to the national average. Students have performed at the national average in this content area on NBME 2 CK. The major success of this clerkship is the high level of satisfaction with the faculty by students and the comprehensive patient mix that is required and documented. The challenges include standardizing the experience across training sites, giving students a meaningful role in patient care, rapid transfer or discharge of patients that limits the time students have to interact and synthesize clinical information, electronic order entry that is not student friendly, rotating shifts of residents not coinciding with student rotations, and inability to completely identify procedural goals for students.

The **MAX-Medicine clerkship** is the required third year outpatient internal medicine rotation. It uses goals and objectives created by the school of medicine and adapted from the Society of General Internal Medicine/clerkship Directors of Internal Medicine Core Medicine Clerkship Curriculum Guide. The objectives are given to students at the beginning of each rotation. Students maintain an electronic log of patients seen on PDAs. The log is reviewed at the end of the rotation to determine that students have seen the appropriate patients. Students spend 6 weeks in an internal medicine office. There are 8 established sites including outpatient clinics at the four hospitals that also participate in the inpatient medicine experience. In addition, the students spend ½ day per week in geriatrics, and ½ day per week in a case based conference at the school of medicine. They also participate in a CQI project under the auspices of a faculty member at their training site. There is a section leader for the clerkship who is responsible for consistency among the training sites. Supervision at these sites is by internal medicine faculty and medical residents. Some students report lower numbers of patients or a lack of variety of patients at some training sites, but the student logs reviewed by the section director show that students all meet the patient requirements for the rotation. Supervision by faculty across training sites is evaluated by students as strong. There were no reported concerns or comments by students about workload or excessive hours. Overall Internal Medicine training is well received by students except for their feeling that the amount of time spent on the outpatient rotation is excessive compared to inpatient medicine given the 3 year continuity clinic experience. The major successes of this clerkship are strong faculty ratings by students, and a centralized interactive case conference. The challenges include maintaining consistency across training sites, maintaining direct observation of students in clinics, improving the volume of patients at some sites, assuring that students see the appropriate mixture of patients at all training sites, and identifying new or alternative training sites.

The **Advanced Inpatient Medicine clerkship** is the fourth year subinternship in Internal Medicine. It uses objectives created from the school of medicine's goals and objectives except the medical knowledge objectives are modified from the Clerkship Directors in Internal Medicine objectives. All objectives are given to students at the beginning of each rotation. Students maintain an electronic log of patients seen on PDAs. The log is reviewed at mid-clerkship to determine that students are seeing the appropriate patients. Students spend 6 weeks in a single rotation at one of six hospital sites. The students receive all clinical and didactic teaching at that site. There is a site director at each of these hospitals who works with the course director to maintain consistency among the training sites. Residents receive goals and objectives for the rotation and carry a pocket card explaining their role and the expectations for the students. Student feedback has only been formalized for the last year. Comments suggest that resident enthusiasm for teaching at one site and by faculty at another is a weak component of this clerkship. The successes of this clerkship are the case based conferences that teach core topics in Internal Medicine and an internal exam that tests them. The major challenges include maintaining consistency across training sites, coordination with the new family medicine subinternship, and assuring that students are directly supervised by attending and resident physicians.

Obstetrics and Gynecology

Max Obstetrics and Gynecology is the only clerkship experience in the third year that has a contiguous experience, not separated into inpatient and outpatient rotations. It consists of a total of six weeks, with rotations in outpatient clinic, labor and delivery, gynecological surgery and subspecialty exposure. Learning objectives are partially in outcome-based terms and were developed from the Association of Professors of Gynecology and Obstetrics (APGO) list of learning objectives. The objectives are distributed to all faculty and residents who teach in the clerkship. Students access the objectives on the Blackboard system. Required clinical encounters were determined after a review of common and important topics and procedures, learning objectives, and other requirements. Students complete an encounter log that is reviewed by site directors at mid-clerkship and at the end of the clerkship. When the logs are reviewed at mid-clerkship, if there are areas lacking, the site directors help coordinate

experiences for the remainder of the rotation so that students will be successful in accomplishing the clinical requirements.

Students spend two weeks in the outpatient clinics, two weeks in labor and delivery, one week on gynecological surgery and one week in subspecialty exposure. There is a core set of lectures covering most of the required material. Consistency of instruction across sites is the responsibility of the clerkship director to monitor. Residents at the beginning of the year receive instructions from site directors on the role of the medical educator, strategies, and components of the clerkship and receive the clerkship objectives. There is also a general resident orientation session on being a medical educator. Evaluations by residents are reviewed and students evaluate the residents as teachers.

There are four sites utilized for student rotations and these are all adequate. Students are well supervised and must have six direct observation forms completed, documenting that the student has been observed performing core clinical skills.

Students report having received mid-clerkship evaluations and the 2009 AAMC Graduation Questionnaire reports that 81% received sufficient feedback from faculty. Students do not take night call on this clerkship and there have been no reports of concerns about violations of the duty hours policy. This clerkship is very effective in teaching and the 2009 Graduation Questionnaire reports that 90% of students had a good-to-excellent educational experience. The NBME subject examination is used and scores are good compared to national standards. Successes include the addition of a fourth clinical site, a centralized orientation, and direct observation of procedural skills.

Orthopaedics

The **MAX-Orthopedics clerkship** is a one week clerkship comprised of nine half days of participation in one of several ambulatory clinical sites. Most of these are at the John Dempsey Hospital; however, use of private group practice sites does occur. There are approximately four hours of didactics covering seven classical orthopedic subspecialty areas. There are written objectives for the clerkship, for this experience in outpatient orthopedics to expose each student to the common musculoskeletal scale of diseases that are typically encountered. There is some exposure to the operating room, as well as a daily didactic session. There is an end of rotation survey, which asks students about the number and diversity of patients that were encountered. There is no student evaluation for this one-week period, either based on formative, summative, or narrative types of assessment. There are a large number of faculty and clinical resources in orthopedic specialties that appear to be ample to continue to deliver this MAX-Orthopedics clerkship.

The LCME Student Independent Analysis and the AAMC Graduation Questionnaire comment that there is minimal autonomy and opportunity to see patients on their own with much shadowing. They also indicate that sometimes lectures are not conducted or are conducted off schedule. There are comments that the rotation is too brief, and that they would have appreciated a more in-depth exposure. They comment that many of the orthopedic practices are sub specialty-based, i.e. in scoliosis, foot and ankle or other orthopedic sub specialties, therefore limiting the clinical faculty practice diversity available to the students during the rotation. Overall, the students found the experience welcoming and productive, and appreciated the opportunity to gain exposure to common orthopedic ailments. The students would appreciate more faculty consistency and formative and/or summative feedback.

Otolaryngology

The **MAX-Otolaryngology clerkship** is a one-week, seven half day ambulatory clinical experience which includes didactics in five specific areas, including the approach to the neck mass, introduction to voice disorders, nasal and sinus disorders, hearing and balance disorders, and audiology. There are

extensive learning objectives for this clerkship, which is described largely as observational, allowing the students to obtain superficial, but broad exposure to the practice of ambulatory otolaryngology. At the end of the clerkship there is a "problem solving case conference" in which the students' clinical experience is assessed by a senior faculty member. There is no student evaluation, either based on formative, summative, or narrative types of assessment. The faculty do not deem there to be any current "problems" and that they believe this to be an important contribution to the student experience.

Site survey feedback and the evaluation of the LCME Student Independent Analysis and Graduation Questionnaire reveals that the students believe the faculty and residents are welcoming and that this was a solid introduction to ambulatory otolaryngology. Many commented on the positive exposure and the usefulness to plan some of their fourth year electives and in career selection. In the view of several students, only a minimal opportunity was provided for any independent physical exam skills with significant amount of faculty and resident shadowing. There was a tremendous variability in experience depending upon the site of assignment, be it that of an adult, pediatric, or subspecialty otolaryngology clinic. In addition, there was a concern that there was little or no exposure to any otolaryngology inpatient operating experience. Many students commented that the rotation was too short to be a meaningful experience in important areas related to otolaryngology.

Pediatrics

The **Inpatient Pediatrics Clerkship** is a 2-week segment of the Inpatient Experience of the third year curriculum. The Connecticut Children's Medical Center, a tertiary care free-standing children's hospital with approximately 85 beds, is the only site at which this clerkship is offered. Students spend approximately 60 hours per week on the inpatient wards. The objectives of the clerkship are based on those established by the Council on Medical Student Education in Pediatrics. There are four kinds of patients or patient conditions that must be seen during the rotation. Conditions must include medical issues unique to adolescents (e.g. anorexia nervosa, drug or alcohol overdose), to newborns/infants (e.g. newborn fever or hyperbilirubinemia), to chronic medical conditions in pediatrics (e.g. asthma, cystic fibrosis, sickle cell disease) and to emergent pediatric conditions (e.g. toxic shock, sepsis, dehydration). The clerkship director or a designee meets with students at the beginning of the rotation to review objectives and goals. Feedback is ongoing during this short rotation. There is a final feedback session to review that all requirements and assignment have been completed. Additional clinical cases can be reviewed using CLIPP cases and the clerkship director can work one-on-one with the student if specific difficulties have been identified. A resident may also be assigned to work with the student. Residents are informed during yearly orientation, at the start of the academic year, about the objectives for the medical student rotations. These objectives are again reviewed on the first day of each in-patient rotation block (monthly). Objectives are also on the residency Blackboard site. Residents are prepared for their teaching roles with a "residents as teachers" workshop each year of residency. Residents are taught how to give feedback, teach to a group, teaching in busy settings, etc. Teaching attendings evaluate students' core clinical skills on a daily basis. Communication skills, interpersonal skills, professionalism, critical thinking skills etc. are also evaluated on a daily basis. Interviewing skills and physical exam skills are mainly evaluated by senior residents or attending physicians. Feedback is given informally throughout the rotation and formally at the end of the rotation. 2 written admission notes are given to the teaching attending for the week for review. These notes document a complete history, physical exam, and show a thorough and well-thought out assessment/differential diagnosis and plan. Feedback is given on each written presentation. An observed history and physical exam is performed by each student and feedback is given by the attending. The final evaluation is determined by the faculty, residents, subspecialty attending staff, nurses and other staff who have worked with the student during the rotation and the observed history and physical exam exercise. There is no NBME subject exam administered in this clerkship. Student evaluation of the Pediatrics clerkship on the AAMC Graduation Questionnaire is at or above the national average in all domains. Of particular note is the very high agreement that faculty have

personally observed a history and physical exam and gave sufficient feedback during the clerkship. The LCME Student Independent Analysis gave significant praise to this clerkship and rated it as the best of the third year clerkships. The teaching and organization of the clerkship along with the treatment by residents were given special positive note. The only criticism from the students was that they felt that the two week duration of the inpatient pediatric experience was too short.

The **MAX Pediatrics** rotation is the outpatient component of the third year pediatric requirement. It is six weeks in duration. There are six ½ day sessions per week at a primary care site, one ½ day per week at a longitudinal specialty clinic and ½ or 1 day (depending on week) of clerkship conference. The clerkship objectives are based on the same national standard as cited above for the inpatient component. Thirty required clinical encounters must be completed during the clerkship. Most are with real patients but a select few may be filled in with simulated encounters from the CLIPP cases. Mid-clerkship feedback is held with each student to assess their progress in meeting clerkship requirements. This clerkship is almost entirely conducted with one-on-one faculty to student supervision with very limited or no resident supervision. Students are observed performing a history and physical exam at their primary care site as well as performing a physical exam in the newborn nursery. These observations contribute to the final evaluation. No NBME subject exam is used in this clerkship. Student evaluation of this clerkship on the Student Independent Analysis shows 75% of respondents rating this rotation as excellent.

The **Advanced Inpatient Experience in Pediatrics** is a fourth year sub-internship rotation which students may take. Typically 10-14 students per year enroll. Only 2 students per four-week block can be accommodated at the single site available for this rotation at The Connecticut Children's Medical Center.

Psychiatry

The **Inpatient Psychiatry clerkship**, a component of the Inpatient Course is a 4 week clerkship. It is separate from the MAX (outpatient) Psychiatry experience. There are core didactic lectures one half day per week and a two hour case conference. Clerkships objectives are taken in part from those outlined by the American Directors of Medical Student Education in Psychiatry (ADMSEP) as well as those of the medical school faculty. Objectives are competency based using the school format. Objectives focus on attainting competency in interviewing and assessment of a psychiatric patient (with particular emphasis on the mental status examination), gaining working knowledge of psychiatric disorders using the Diagnostic and Statistical Manual, constructing biopsychosocial treatment plans, gaining general knowledge of psychopharmacology, writing accurate and well structured progress notes, establishing a supportive alliance with the patient and good working relationships with treatment team, and gaining an ability to do a concise and appropriate presentation on a psychiatric patient. The objectives are reviewed during student orientation for the course as well as by the site directors. The objectives are handed to the students in written form and also are in the student "Passport" given at the start of the rotation.

Faculty have defined the number and types of patients students are expected to see during the clerkship. Students electronically log the patients they see during the rotation with diagnosis. Their logs are reviewed weekly by the clerkship director and administrative staff for the clerkship to ensure they are being completed contemporaneous with the rotation weeks. Their progress is monitored and feedback given by residents and faculty attendings at multiple points in the clerkship. The clerkship director formally conducts a review of the student logs weekly, discusses objectives and goals with the students formally, and ensures students are meeting requirements. Should a student have difficulty with seeing appropriate patients or meeting clerkship objectives, the clerkship director reviews the issues with the student and preceptor and switches or modifies the site, if required.

Faculty across all sites receive a document with information about the role of being a medical educator, the components of the Psychiatry Inpatient rotation, and the learning objectives. They also receive their

own copy of a student Passport for reference. Faculty are deemed adequate and there are more than adequate patients. Residents review clerkship objectives before each rotation with the clerkship director. This is supplemented with online material on preparing for the teaching role. Students give feedback on the residents at the completion of the rotation. This feedback is used to encourage and/or direct the development of the resident's educational skills. If a resident receives a poor review the information is automatically sent the residency training director by the overall Inpatient course director, and the training director addresses the issue with the resident.

Student performance is evaluated using several tools. Each student is required to have one structured clinical observation (SCOS) per week by an attending physician documenting that the students have been observed and demonstrated appropriate clinical skills. Students must hand in their signed SCOS forms in order to sit their final NBME subject examinations. Feedback evaluations are solicited from attending and resident physicians. Site directors and clerkship director review the direct observations, patient requirements and the evaluation summary with the student at mid-point and again at the completion of the rotation. A written narrative summary is provided to the student. Grades are usually reported in a timely manner.

Student feedback about the Inpatient Psychiatry clerkship has shown steady improvement and has been positive, both on the AAMC Graduation Questionnaire and the LCME Student Independent Analysis. The Graduation Questionnaire reports that in 2005, 62.3% of respondents rated the quality of their experience in psychiatry as good or excellent. The percentage has steadily increased during the past few years. In 2009 87.0% reported that their experience was good or excellent. The Student Independent Analysis had 72% of respondents agreeing that their inpatient psychiatry experience was excellent. Concerns about the separation of the Inpatient Psychiatry Clerkship and the MAX Outpatient Psychiatry clerkship have been raised. Faculty attrition in Psychiatry was noted by the department chair. Concerns about the ability of the faculty to manage a potential increased class size have been raised.

The **MAX Psychiatry** clerkship is an ambulatory 14 week long experience for one half day per week in a mental health clinic or private practice (20-25 different sites), integrated into the Pediatric MAX experience. It is separate from the 4 week Inpatient Psychiatry Clerkship. Some students have their MAX Psychiatry clerkship before the Inpatient Psychiatry Clerkship. There is a 12 hour didactic session that covers core psychiatry disorders. The objectives are taken in part from those outlined by the American Directors of Medical Student Education in Psychiatry (ADMSEP) as well as those of the faculty using the school competency based format. Objectives are the same as those defined for the Inpatient Psychiatry Clerkship. The objectives focus on attainting competency in interviewing and assessment of a psychiatric patient (with particular emphasis on the mental status examination), gaining working knowledge of psychiatric disorders using the Diagnostic and Statistical Manual, constructing biopsychosocial treatment plans, gaining general knowledge of psychopharmacology, writing accurate and well structured progress notes, establishing a supportive alliance with the patient and good working relationships with treatment team, and gaining an ability to do a concise and appropriate presentation on a psychiatric patient. The objectives are reviewed during student orientation for the course as well as by the site directors. The objectives are handed to the students in written form and also are in the student "Passport" given at the start of the rotation.

The patient types and numbers requirements for the MAX Psychiatry Clerkship were drawn from the following sources: review of other program's requirements nationally, the school of medicine learning objectives, and a review of critical topics and diagnoses derived based on Psychiatry literature. The site directors review the students' patient logs with the students at midpoint and again at completion of the course. Students are not able to complete the rotation if they have not fulfilled these requirements. Students who have difficulty seeing appropriate patients or meeting clerkship objectives will review this with their faculty preceptor and clerkship director who may switch or modify the site if required. Faculty

across clinical sites receive a document with information about the role of being a medical educator, the components of the Psychiatry MAX rotation, and the learning objectives. They also receive their own copy of a student Passport for reference. Some of the MAX Psychiatry sites have residents, others do not. The residents review clerkship objectives before each rotation with the residency-training director. The residents are educated about how students are prepared for clinical rotations and have access to online educational material.

Students are evaluated with six structured clinical observations (SCOS) over the course of the rotation by an attending physician. The SCOS documents that students have been observed and demonstrated appropriate clinical skills. The students must hand in their signed SCOS forms in order to sit their final NBME examinations which they take following the completion of the Inpatient Psychiatry Clerkship. Attending faculty and residents provide feedback on student clinical skills. The site directors and clerkship director review the direct observations, the clerkship patient requirements and the evaluation summary with the student at mid-point and again at the completion of the rotation. A narrative evaluation is provided at the end of the clerkship.

There are adequate faculty and patients for this clerkship. Ensuring comparability across the 20-25 sites used for this clerkship has been a challenge for the clerkship director. Student feedback for the MAX Psychiatry Clerkship is less positive than for the Inpatient Psychiatry Clerkship. Students raised concern about the discontinuity between Inpatient Psychiatry, the timing (Monday evenings) of the lecture series, repetitiveness and quality of the lecture series and the fragmented, observership nature of the clinical experience for some students. In an effort to address student concerns, additional sites were added to dovetail specific interests (e.g. Geriatric Psychiatry, Neuropsychiatry, Child Psychiatry). Students are assigned based on preference and recent feedback has been generally positive.

Surgery

The **Inpatient Surgery** clerkship is a required four-week rotation delivered at one of the five participating hospital inpatient surgery services. It consists of 3½ days per week at one of the five clinical sites, and a full day per week at the medical school, pursuing formal didactic and case presentation materials.

The clerkship curriculum is based upon the core competencies as defined by the school of medicine, presented to the students in a formal orientation session and are included in the Blackboard materials. During the course of the clerkship, the students become part of the inpatient teams and function as a "junior intern" learning skills of day-to-day management under the supervision of faculty, midlevel and senior level surgical residents. During this four-week period, there are five in-house calls which allow the student to take the next day off following morning sign-off rounds.

This surgical clerkship includes participation in surgical procedures, as well as in the day-to-day floor management of surgical patients and other operating room/aseptic technique. There are designated site directors at each of the five sites who are responsible for the coordination and monitoring of the experience for each individual student during the clerkship rotation. Given the relatively short duration of the clerkship, mid-clerkship formative evaluation typically does not allow a substantial amount of time to make up any shortages in cases or procedural experiences that may be lacking. The residents are heavily involved and formally meet with the site directors and clerkship course directors one to two times each year outlining the goals and objectives, as well as the expectations for the teaching assessment and feedback during the clerkship. Mid-clerkship evaluations of the various aspects including history & physicals, professional behavior and knowledge, as well as procedural experience are provided to the students in a timely fashion. NBME subject examinations are used and have hovered around 70th %-tile over the last three years. There is no narrative component of the summative grade.

The self-study as well as multiple discussions during the visit, the LCME Student Independent Analysis and the AAMC Graduation Questionnaire indicate that there is very variable evaluation of the quality of the inpatient surgery clerkship which has been attributed to the "students' interest" in a surgical career. Concerns regarding the inconsistency of a formal orientation have been at least somewhat resolved by the course director who currently takes responsibility across all of the sites. It is continually reported that some of the basic surgical skills are not adequately taught, including basic suturing, insertion of venous access, arterial blood gases, bladder catheterization and others. The fall off in student access to surgical procedures has been attributed to the work hour requirements for residents, as well as preferences of patients. There is no comment about the use of simulation to successfully make up for some or all of the procedural and skill deficiencies. The AAMC Graduation Questionnaire reveals that 34.8% of respondents agreed that they were observed taking a patient history during their surgery rotation and 39.1% were observed performing a physical examination. These are well below the national data of 46.3% and 50.7% respectively. There are some negative comments relating to the quality and consistency of the full day didactic sessions, the comfort of the call rooms at the different hospitals, the overall contact with attending surgeons outside of the operating room in ambulatory settings, and for purposes of mentorship, career guidance. In addition, the students are critical of the short length of the clerkship, as well as the lack of topics and inconsistency covered by the formal Friday lectures. There are also comments regarding excessive work hours relating to the four to five in-house calls that they take during this four-week clerkship block. Several of these issues relate to the fact that this clerkship is being delivered across five different busy surgical sites with diverse patient populations and different sets of UCONN SOM surgical faculty. This is at least in part due to the small full time Department of Surgery.
Review of the LCME Student Independent Analysis and the AAMC Graduation Questionnaire, specific to this inpatient surgical clerkship, reveals similar concerns about access to attending faculty, and indeed, some questions regarding objectivity in grading and demeanor of some of the private practice surgical faculty. In the comment sections, students indicate that "faculty frequently did not show up for lectures that they were scheduled to deliver, as well as concerns about objectivity of grading, demeanor of faculty and residents, and limited hands-on procedural experience".

The combination of the multiple clinical sites, the inconsistency of experiences (didactic and clinical), as well as, the documented concerns about faculty and resident teaching, grading, behaviors and attitudes raise significant concerns for this clerkship. The students clearly recognize the surgery experiences, particularly this specific Phase 2 aspect, as one of the weakest components of the clinical curriculum.
The clerkship director, in place for the last nine months, is working with the interim department chair, in place for three months, to meet with all of the clinical surgery faculty and attempt to enhance uniformity of the didactic, clinical and grading experiences. The interim Chair of the Department of Surgery, is aware on several levels of the Phase 2 and Phase 3 challenges, and is working with the clerkship directors to improve the consistency and quality of the courses. There is a national search to identify a permanent chair of the Department of Surgery.

The **MAX-Surgery clerkship** is a one-to-one student to faculty (possibly small faculty group) focusing on general surgical care in the outpatient (ambulatory) setting. The concept is that students will work with assigned surgical faculty to see patients in physicians' offices, allowing them to participate in the care of myriad typical outpatient surgical problems. There are written goals and objectives for this clerkship, based upon the core competencies defined by the school of medicine. These objectives are stated in the students' Blackboard site, and are also formally described to them during orientation conducted by the course director at the start of each rotation. Students are required to see patients in each of six major categories, and report upon them in their computer log system. The preceptors and local site directors are responsible for the completeness of each student's three-week experience. Should there be inability to fulfill all six components of the experience, the students will be assigned to an inpatient experience elsewhere in the curriculum to compensate for this deficiency. There are no residents

involved in the MAX-Surgery course; however, there are formal scheduled didactic programs for the attending faculty. The assessments include participation by the preceptor and the site director and are based at least to some extent on a written examination, employing some of the clinical scenario that the students have encountered during the clerkship. There is no narrative evaluation of student performance that is used as part of this clerkship.

The self-study indicates that the school is having increasing difficulty in finding "true general surgeons" given the continued restriction of scope of practice that has occurred by sub-specialization in the surgical field. This has required them to rely on increasingly large numbers of multispecialty surgical groups, rather than individual single surgeons or single specialty groups with a broad clinical practice. It indicated that they continue to change clerkship sites, based upon the changing nature of the clinical practices. The students are somewhat critical of the lack of single preceptor settings, as they prefer to develop a relationship with a single physician during this three-week interval, rather than with an ongoing and changing number of subspecialists. As the number of physicians in the sub specialty distribution increase, the hands-on technical experience goes down as the relationship clearly suffers. It is stated that it is "difficult to enroll enough local surgeons whose practices fulfill the required learning goals" which unquestionably produces a concerning challenge to continue to deliver this outpatient clerkship. Complaints regarding the full day didactic lecture series of unexpected cancellations, changes in sequence, and inconsistent focus on appropriate levels of learning are articulated in the LCME Student Independent Analysis and the reflected AAMC Graduation Questionnaire.

Students who demonstrate or articulate interest in surgical careers have seemed to form mentorship relationships and are grateful for the experiences derived from this outpatient clerkship component. Many students are concerned, as is the faculty, about the stability of the teaching sites, the spectrum of clinical and didactic experience, as well as the focus of the private practice/volunteer faculty on medical student teaching. The ability to assess the individual sites and teaching faculty, as well as monitor the need to either reassign students or to change sites remains unclear and needs to be defined if this component of the outpatient experience is to be sustained and enhanced in the curriculum.

The **Advanced Inpatient Experience - Surgery** is a fourth year offering structured to provide immersion as a junior surgical house officer into one of the four affiliated hospital systems, which includes a combination of didactic and clinical experiences. Students join an inpatient resident team which takes responsibility for all case presentations, teaching rounds, weekly conferences, and of course, clinical care. The M4 students are assigned to a specific attending surgeon who meets with them weekly at the individual site to oversee the delivery of the curriculum, the overall experience, and take responsibility for the assessment. The students are required to adhere to the 80-hour workweek. There are written objectives for the clerkship based upon the school's goals, objectives, and competencies and identifying benchmarks in eight specific surgical areas which reflect many of those taught in the M3 MAX-Surgery rotation. The learning objectives are built around the six ACGME competencies including a clear definition of the knowledge, skills, attitudes and benchmarks for each of the six competencies. There is great dependence upon resident teaching in this clerkship. The surgical residents actively participate in each of the competencies with the fourth year students as well as guide them through the diversity of clinical experiences necessary to meet the objectives of the clerkship. The clerkship director who coordinates the mid-clerkship feedback and progress monitoring oversees all this. The residents involved are required to participate in a "resident as teacher workshop" where issues such as medical student teaching, feedback, group leadership, assessment, etc. are dealt with on an annual basis. It is unclear how resident performance is monitored and enhanced.

A composite evaluation of the M4 student is constructed at the end of each clerkship, using the "myevaluation.com" internet-based tool. The use of this technology was implemented immediately prior

to the completion of the self-study, and hence is very much "a work in progress at this time." There are also end of clerkship oral and written examinations based on the material delivered in the clerkship. There is a narrative evaluation that is completed for each of the students that accompanies their final clerkship grade.

The faculty believes that there are an adequate number of individual faculty members, resources and sites to deliver this clerkship when distributed across the academic year. Because of the strong desire of most of the students to have this in the first portion of the fourth year as they prepare for residency applications, audition for residency positions and form mentorship relationships with surgical faculty, the system is somewhat stressed for capacity in the early part of the year. The need for enhanced access to letters of recommendation, as well as, the limited availability of surgical faculty mentorship is derivative to these desires.

The students comment on the variability and inconsistency of case material from site to site, as well as the differences in the faculty time and focus on medical student teaching. They also indicate that due to relatively low surgical volumes in some of the sites, their overall clinical experience is not uniform in scope and quality. The ability to monitor and track the overall experience from site to site is of some concern, as it is for several of the clinical teaching sites. Overall this component of the curriculum appears to be a generally stable, effective and well received fourth year clerkship students.

Home Weeks is a component of the MAX Clerkship during the third year. Students return to the school of medicine on three separate occasions for one week each to address a variety of topics including advanced patient communication skills and advanced physical examination skills, as well as multidisciplinary topics. Participating faculty include basic and clinical scientists representing multiple departments. There are written course objectives for each week. A description of each activity is described in correspondence to the students. Each Home week has a specific theme, e.g. Home Week 1: Advanced Clinical Skills, Home Week 2: Immunology/Transplantation, Home Week 3: Neuroscience. There are didactic presentations as well as case presentations and journal clubs. Topics covered include advanced history taking, medical informatics, evidence based medicine, radiology, complementary and alternative medicine, pain management, transplantation, nutrition, neurologic examination. Neuroscience is considered essential as there is no currently required Neurology clerkship. Students are expected to do a PowerPoint presentation on a topic in ambulatory medicine that is evaluated by faculty and provided to the associate dean for student affairs for potential inclusion in the MSPE.

Students receive narrative verbal and written feedback from their preceptors and on their PowerPoint presentation. There are no written examinations. This is a pass-fail course. Space is deemed adequate. The library staff help in making themselves and special rooms available to students. Obtaining enough faculty for some of the small group sessions can be difficult, i.e. journal clubs. Utilizing graduate students and post doctoral fellows for some of these activities has helped.

Students provide regular feedback on the course and changes have been made in response to that feedback. Students did not comment on this course in the LCME Student Independent Analysis and it is not included in the AAMC Graduation Questionnaire.

The **ACE Emergency Medicine** course uses objectives that are a combination of the school of medicine's goals and objectives based on the Task Force on National Fourth Year Medical Student EM Curriculum and the American College of Emergency Medicine. These include procedural skills that students must perform under observation. The objectives are given to students at the beginning of their rotation and are posted electronically. Students maintain an electronic log of patients seen on PDAs. The

log is reviewed at midclerkship to determine that students are seeing the appropriate patients. Students spend 4 weeks in a single rotation at one of seven hospital sites. The students receive all clinical and didactic teaching at that site. They participate in fourteen 8-10 hours shifts, and 3.5 days of didactic teaching. There is a site director at each site who works with the clerkship director to maintain consistency. Residents receive goals and objectives at the beginning of the year. Student feedback is very positive for this rotation highlighting the ability to actually perform procedures and to receive feedback about them. In the 2009 AAMC Graduation Questionnaire 84.1% of students felt their training in emergency medicine was adequate. These are lower responses than in the preceding 3 years, but, overall, this is much better than the national average of 57.1%. The major success of this course is the opportunity of students to have direct patient experiences, do procedures, and to utilize SimMan as a tool for teaching and evaluation. The challenges include maintaining an appropriate volume of patients at all training sites and the need to substitute didactic teaching or simulation at some sites.

The **ACE Critical Care** course is a 4 week required course in the fourth year. Each student must choose a rotation in medicine, surgery, pediatrics, or neonatology. The course uses objectives based on the school of medicine's goals and objectives. The objectives are given to students at the beginning of their rotation and are posted electronically. Students maintain an electronic log on PDAs of patients seen. The log is reviewed at midclerkship by the course director to determine that students are seeing the appropriate mixture of patients. Students spend 4 weeks in a single rotation at one of seven hospital sites in one critical care unit. The students receive all clinical and didactic teaching at that site. There is a site director at each site who works with the clerkship director to maintain consistency among the training sites. Residents receive goals and objectives at the beginning of the year. Student feedback is grouped in discipline specific categories. It is generally positive for all, but some comments suggest an insufficient number or mixture of patients at some sites in medicine and pediatrics. The major success of this course is positive feedback about the faculty. The challenges include maintaining consistency and an adequate number of patients across training sites.

Elective Courses

Fourth year medical students are allowed 20 weeks of elective time, four weeks of which can be used as vacation. The fourth year catalog lists more than 100 elective courses, several being the same topic at multiple training sites. About 80 distinct elective types exist across subspecialty areas of medicine, surgery, pediatrics, ob/gyn, psychiatry, and family medicine, and additional advanced experiences in anesthesiology, emergency medicine, laboratory medicine and pathology, neurology, and radiology. Students can create a special elective in collaboration with a faculty advisor to meet individual needs. Students are allowed to take all fourth year electives at other institutions. Only 30% of students spend any elective time away from the University of Connecticut. Students rate the fourth year electives as very positive, but, in the LCME Student Independent Analysis, the availability of electives that benefit future career choices was rated lower than other aspects of the fourth year curriculum.

3. Separate Educational Tracks

There are two separate educational tracks: The Urban Service Track and the Oral Maxillofacial Surgery/MD Track (OMFS). The Urban Service Track began in 2007 and the purpose is to produce health care professionals committed to serving the urban underserved populations. Competencies expected to develop include culture, linguistics, population health, health policy, advocacy, health care financing, community resources, and others. In addition to the required curriculum, these students participate in inter-professional learning experiences and clinical training is in federally qualified clinics. The Urban Service Track requires that scholars participate in quarterly learning retreats that focus on 11 competency areas and vulnerable populations living in urban communities and include care of migrant workers and

care of the homeless. The retreats are four hours in length and held off campus at facilities/agencies in urban communities. Scholars are expected to read the required pre-assignments in preparation of each retreat. In addition to attending the quarterly learning retreats, Urban Health Scholars are expected to volunteer for two community service activities providing care/outreach to the underserved. These volunteer activities are arranged by the Urban Service Track Program and require participation as interdisciplinary team. The total number of volunteer hours required is approximately 12 per semester. There are three to four medical student per year who are joined by a similar number of students from the schools of nursing, dental medicine and public health.

The OMFS track is available only to individuals who are graduates of dental school. It is a combined program with the UConn School of Dentistry and OMFS residency program. Students are granted entrance into medical school with advanced standing. They participate in the PCM course, take Step 1 and advance to Phase 2.

4. Summary of Curriculum Structure

In summary, the curriculum established in 1995 accompanied by ACGME competency-based educational objectives written in 2004 appears to be successful. The presence of a three year longitudinal primary care experience is unique and the extensive outpatient component of the third year curriculum fosters future career choices in primary care. There is some concern, however, that this focus on primary care comes at the expense of student exposure to specialty training and the ability to choose a specialty career. The school states that its curriculum is designed to be totally integrated, yet students are still very aware of and evaluate curriculum content along traditional basic science lines. The school states it has a strong focus on self-directed learning, but students are heavily scheduled with in-class activities. Further, student survey ratings raise questions about the adequacy of the guidance they get both via curriculum content and career counseling concerning making effective career choices. The increasing need for part time and volunteer faculty to teach basic science courses and to provide enough clinical settings for outpatient experiences is a challenge that is not currently being met. Comments during the site survey indicate that there are not enough faculty to adequately and consistently conduct small group activities. The objectives are well written and appropriately guide the education that is delivered. The use of information technology with student logbooks both aids learning objectives and helps assure appropriate student outcomes, but the central control of clinical learning activities distributed among multiple different training sites is not adequate, and needs to be addressed. In the 2009 AAMC Graduation Questionnaire, 94.2% of respondents reported that they were satisfied with the quality of their education compared with 86.6% nationally.

C. Teaching and Evaluation

YEARS ONE AND TWO

		Contribute to Grade (Check all that apply)						
Course	# of Exams	Internal Exams	Lab or practical Exams	NBME Subject Exams	Faculty/ Resident Rating*	OSCE/SP Exam	Paper or Oral Pres.	Other†
Human Systems	13	✓	✓					
Clinical Medicine (yrs 1 & 2) Principles of Clinical Medicine Student Continuity Practice					✓ ✓	✓		
Correlated Medical Problem Solving (yrs 1&2)	2 per yr**				✓			
Electives (yrs 1&2)					✓		✓	
Human Development & Health	2				✓		✓	
Mechanisms of Disease	8	✓	✓					

* Include evaluations by faculty members or residents in clinical experiences and also in small group sessions (for example, a facilitator evaluation in small group or case-based teaching)

† Describe the specifics in the report narrative

**take home exams

YEARS THREE AND FOUR

	Contribute to Grade (Check all that apply)							
Course or Clerkship	NBME Subject Exams	Internal Written Exams	Oral Exam or Pres.	Faculty/ Resident Rating	OSCE/ SP Exams	Other*	Clinical Skills Observed (Y/N)†	Mid-Course Feedback (Y/N)
Beginning to End			✓	✓			N	Y
HomeWeeks				✓			Y	N/A
MAX Family Medicine		✓		✓		✓	Y	Y
MAX Surgery		✓		✓		✓	Y	Y
In-patient Surgery	✓		✓	✓			Y	Y
MAX Medicine		✓		✓	✓		Y	Y
In-patient Medicine		✓	✓	✓			Y	Y
MAX OBGYN	✓			✓			Y	Y
MAX Orthopaedics							N	N
MAX Otolaryngology							N	N
MAX Pediatrics		✓		✓		30 CLIPP Cases	Y	Y
In-patient Pediatrics				✓		Observed H/P, 3 written H/P	Y	N
MAX Psychiatry		✓		✓			Y	Y
In patient Psychiatry	✓			✓			Y	Y

Selectives			✓	✓		Paper in journal article form		
Clinical Medicine Course- Student Continuity Practice 3				✓				
Advanced Clinical Experience (ACE)								
AIE Medicine		✓		✓			Y	Y
AIE Pediatrics				✓		✓	Y	Y
AIE Family Medicine		✓	✓	✓			Y	Y
AIE Surgery		✓	✓	✓			Y	Y
Critical Care		✓		✓	✓		Y	N
Emergency Medicine		✓	✓	✓		✓	N	Y

* Describe the specifics in the report narrative

† Are all students observed performing core clinical skills? (yes or no)

Family Medicine "other"= a home visit and a write-up of the experience. The write up is evaluated by faculty and graded and becomes part of the overall grade on which honors is based.

MAX Surgery "Other" = Students take their NBME Subject Exam after they have completed both the MAX Surgery and the Inpatient Surgery rotations and not before

ACE Emergency Medicine "other": students are given feedback during more than half the shifts worked.

The responsibility for supervision of medical students during required clinical experiences is delegated to the clerkship site directors by the medical school clerkship director. Clerkship directors have final responsibility and are expected to ensure that there is comparability of educational experiences at all sites, including appropriate supervision and teaching of medical students by faculty and residents. All clerkships, except those that are primarily observerships (Beginning-to-End, Otolaryngology and Orthopedics), require direct observation of student clinical skills by a faculty member or senior resident, however the frequency with which this occurs is variable among clerkships. Pediatrics, Psychiatry and Family Medicine are especially adherent to this requirement while Medicine and Surgery are less successful in this regard. Clerkship directors and site directors also review the Student Experience Logs which document all patient encounters as well as supervisions and feedback, and the post-rotation electronic feedback from students. Students are also expected to monitor their patient encounters to ensure they see the appropriate, defined patients on the clerkship. Graduate students do not participate as teachers routinely in the medical student educational program.

All clerkship directors and site directors are school of medicine faculty members, as are other physicians who supervise students on the clerkships and other clinical educational experiences. Students are supervised and evaluated by residents on their clerkship. There are mandatory orientations for residents and fellows that address their roles as teachers and evaluators of medical students. Basic information regarding curriculum goals and objectives is presented to residents at the start of the academic year and in many residencies on an ongoing basis as part of their didactic curriculum. Residents receive formal assessment of their teaching through student surveys on MyEvaluations.com although the feedback they receive is not always timely. The Blackboard site for the Graduate Medical Education Programs contains a link to an online course, "Residents as Teachers," a curriculum based on one developed by the Alliance for Academic Internal Medicine. Individual GME programs also provide curriculum as part of their

program didactics. Residents in the Capital Area Health Consortium provide feedback on the effectiveness of their education on teaching. Only 2% rated it as "Ineffective." Medical students evaluate their resident teaching and that feedback is used in resident evaluations.

Residents as Teachers Curriculum	**Clerkship Objectives Provided to Residents**	**Required as part of Orientation**	**Blackboard (available, not required)**	**Program Didactics**
Anesthesiology	X	X	X	
Dermatology	X	X	X	
Emergency Medicine	X	X	X	X
Family Medicine	X	X	X	X
Internal Medicine	X	X	X	X
Neurology	X	X	X	
Obstetrics/Gynecology	X	X	X	X
Orthopedic Surgery	X	X	X	
Otolaryngology	X	X	X	
Pediatrics	X	X	X	X
Primary Care Internal Medicine	X	X	X	
Psychiatry	X	X	X	
Radiology	X	X	X	X
Surgery	X	X	X	X
Urology	X	X	X	

There are limited centralized faculty development programs to prepare basic science and clinical faculty for their roles as teachers. Faculty are provided with course and clerkship objectives and student feedback on their role as educators. In Phase 1 of the curriculum, course directors and section leaders provide feedback to faculty on their teaching skills and provide informal interventions in teaching skills. Faculty can decide whether their student feedback data will be used by their department chairs in their annual evaluations.

The medical school began an organized program for faculty development two weeks prior to the site survey. A faculty member with responsibility for faculty development has been recently appointed 30% time to direct the program in conjunction with the Faculty Affairs Office. An Academy of Distinguished Educators consisting of outstanding educators was appointed in the fall of 2009 and will support the Faculty Affairs Office in developing academic enrichment workshops. Planning for a school wide mentoring program, including faculty roles as educators is expected to begin in February 2010. These programs are not mandatory. The effectiveness of this program remains to be seen given the very recent implementation. Junior faculty report significant variability in access to faculty development opportunities, and depend, in large part, on support of their individual department chairs.

There are multiple evaluation measures in place that are effective in evaluating student performance. Course and clerkship faculty decide on the assessment tools used for their discipline. There is limited inter-course or clerkship or central curriculum collaboration in assessment. All courses and clerkships are expected to provide both mid-block (formative) and summative feedback, both verbal and written. Narrative assessments occur on most but not all clerkships including the 4th year Selective Project. The Surgery Clerkship provides narrative feedback inconsistently. Among the preclinical courses, although extensive small group interaction is scheduled into the curriculum such that narrative evaluation should be possible, it generally does not occur.

Clinical skills, including communication skills and physical examination skills, are evaluated on clerkships by direct observations and there are multiple OSCE's for both formative and summative feedback in Principles of Clinical Medicine and the Medicine clerkship. There is a strong educational experience, Correlated Medical Problem Solving, in Years 1 and 2 that promotes problem solving and clinical reason. Behaviors and attitudes are also documented in multiple courses and on clinical clerkships. Knowledge is most commonly evaluated using multiple choice examinations. Student grading is on a pass-fail system. In the third year, select students may be given "honors' in specific disciplines once all clerkship grades are available.

Students report that there are significant delays in specific reporting of formative feedback (Clinical Medical Problem Solving) and summative feedback (Surgery and Student Continuity Practice). Other clerkships have been noted to be delayed as well, e.g. Critical Care, Ob-Gyn, Pediatrics, Internal Medicine. Clinical students expressed significant concern about how the faculty decisions to assign "Honors" grades for clerkships following the third year were made and students feel those decisions are arbitrary despite posting of criteria on Blackboard.

D. Curriculum Management

1. Roles and Responsibilities

Responsibilities for curriculum management are held by the Education Council (EC), Committee on Undergraduate Medical Education (CUME), the Curriculum Operating Committee (COC), and the Course and Curriculum Evaluation Committee (CCEC) (see Appendix for schematic of curriculum management). The EC reports to the Dean's Council and is responsible for policies and plans for all educational activities of the school of medicine, including undergraduate education, graduate medical education and continuing medical education. The CUME is a subcommittee of the EC and is the primary educational policy making body for the undergraduate medical curriculum. It develops policies for all aspects of the undergraduate curriculum. The policies cover creation or elimination of courses, modification of objectives, criteria for student evaluation, and changes in requirements for promotion and graduation. The COC handles operational issues of the curriculum, including academic calendars, integration of material, suggesting policy changes to CUME, piloting innovations, and conducting periodic review of content, allocation of time, and elimination of redundancies. The Course and Curriculum Evaluation Committee (CCEC) is a standing committee of the CUME. The CCEC has the responsibility of conducting regular reviews of courses and assessing overall effectiveness of the education program. The CCEC makes recommendations to the CUME, COC, and individual course directors.

Membership in these committees consists of a combination of academic deans, faculty and students. The EC does not have student membership and the CUME does not have course director membership. The permanent chair of the CUME and COC is the dean for academic affairs. The chair of the EC is an elected position and is currently occupied by the dean for academic affairs.

The curriculum management system as described above is highly complex and it is difficult to determine the lines of responsibility. Course/clerkship directors and department chairs do not have a clear understanding of which committee is responsible for various aspects of the curriculum. Course directors and particularly clerkship directors retain a level of autonomy such that there is an erosion of the central curriculum authority. It is unclear as to which changes in courses and clerkships must be taken to the CUME.

The CECC is responsible for evaluation of courses and has a schedule of accomplishing this on a three year rotational basis. There is no standard format for this review allowing for inconsistency. While the courses have been reviewed periodically, there is no review of segments of the curriculum such as a year or phase as a whole. Review of the courses was suspended in 2008-09 as the entire four-year curriculum was reviewed for the first time in 15 years. The results of the course reviews and resultant recommendations by the CECC are submitted to the CUME, COC, and individual course directors, so that is it not clear which entity has the authority to decide which recommendations should be enacted. It is the responsibility of the dean for academic affairs to follow the implementation of the enacted recommendations.

Curricular content is monitored by the COC. Several members of the COC teach in courses across the three years. A curriculum database was developed in early 2009. It is based on categories and terminology from the USMLE content outlines for Step 1 and Step 2. The database is on a spreadsheet and each course is responsible for checking the topics covered in their specific courses. This will be reviewed for completeness and redundancy on an annual basis. It is questionable whether this is an effective method for assessing the curriculum for horizontal and vertical integration and possible areas of redundancies or gaps.

Clerkships are expected to evaluate comparability of educational experiences across all clinical sites. There is not an institutionalized systematic and consistent method for assessing comparability of the educational experience in the Phase 2 curriculum across multiple clinical sites. The responsibility for collecting these data, monitoring the data and making necessary changes is the responsibility of the clerkship directors alone. Not all clerkships in the Phase 2 curriculum are effective in maintaining comparability with the Surgery Clerkship being especially deficient in this regard. Data from the clerkship comparability evaluations is not routinely presented to curriculum management committees.

In the Phase 1 curriculum student workload is monitored by the CUME and by course directors. Students have 1029 scheduled hours in year 1 and 1038 scheduled hours in year 2, with 3.5 to 4 weeks between the end of second year and the beginning of third year in which to prepare for and take the USMLE Step 1 and have vacation. There is a well published policy for student duty hours and there are only rare reports of violation. The clerkships are responsible for monitoring compliance with this policy.

The chief academic officer does not have sufficient resources for the curriculum. Limitations on financial resources and restrictions on the rehiring of retired faculty are limiting factors in securing adequate numbers of faculty to deliver the curriculum. Recent retirements, in response to a retirement incentive program, have had an adverse impact. There is currently heavy reliance on volunteer faculty which makes it difficult to maintain consistency and quality. Department chairs and course directors confirm that there are not enough faculty members to support the current curricular structure. Concerns about announced future retirements do not predict a resolution to this problem. The classrooms are just adequate in size and number for the current number of students.

2. Geographically Separate Programs (if applicable)

Not Applicable

E. Evaluation of Program Effectiveness

A variety of outcome measures are utilized to evaluate student achievement of the medical school educational objectives. Both national assessment tools, e.g. NBME examinations and internal tools, e.g. faculty designed examinations, are used, including student course and clerkship feedback on their educational experiences. Tools for the assessment of student performance are determined by individual course directors, section heads and clerkship directors, linked to the goals and objectives being evaluated.

Medical school departments are not directly involved. No central curriculum governance group determines methods of evaluation, although the Course and Curriculum Evaluation Committee (CCEC) which has no course/clerkship directors as members, does consider if competencies and objectives are being assessed.

The Course and Curriculum Evaluation Committee reviews individual courses on a triennial basis. However, the lack of a standard format for this triennial review allows for inconsistency in these reviews. While these individual courses and clerkships reviews occur routinely, segments of the curriculum, such as an entire year or phase, have not been reviewed. An analysis of the curriculum as a whole was recently completed for the first time in fifteen years.

Student feedback is expected on all courses and clerkships. Feedback is anonymous and web-based. Grades are withheld until students complete their evaluations so the participation rate is over 90%. Data are collected by individual course and clerkship directors and shared with the dean of academic affairs. A few Phase 1 courses offer peer evaluation to teaching faculty.

Additional assessment tools include student advancement and graduation rates, the AAMC Graduation Questionnaire, performance on NMBE Step 1, 2 (CK & CS) &3 and subject examinations, residency match results and specialty choices, feedback from residency training directors, Medical Board sanctions of graduates and the UConn Graduate Survey. USMLE Step 1 and Steps 2 CK and CS are required for graduation (see Appendix for USMLE scores). These measures all indicate recent strong student performance on the NBME examinations, strong residency match results and high student satisfaction with their medical education reported on the AAMC Graduation Questionnaire. For the past 7 years that are reported in the database, over 90% of every graduating class reported satisfaction with the quality of their medical education at the UConn School of Medicine. In the most recent year reported (2008-2009), 94.2% reported satisfaction.

Despite the complex nature of the curriculum and the multiple curriculum related committees, reporting of evaluation data is not centralized. Primary reporting of data is to the course and clerkship directors rather than any centralized curriculum committee. Student performance data on internal assessments is reported to the appropriate course and clerkship directors as well as the dean for academic affairs and associate dean for student affairs. External evaluation data are reported to the dean of academic affairs and associate dean for student affairs. Student feedback data are reported to course and clerkship directors. Results of teaching surveys are given to course and clerkship leaders as well as the faculty members or residents themselves. All data are considered in planning the course or clerkship for the following year. Individual faculty evaluations by students are reported to the faculty involved, but not to their department chairs unless requested by the faculty member. USMLE performance data are reported to the Curriculum Operating Committee (COC). The dean for academic affairs shares all performance data with the Curriculum Operating Committee, Committee on Undergraduate Medical Education, the Course and Curriculum Evaluation Committee and the Educational Council on an annual basis. These committees utilize the data to review and revise the curriculum, if indicated.

These data were recently considered by the Course and Curriculum Evaluation Committee when it performed an evaluation of the curriculum in September 2009 which confirmed the strength of the current curriculum and resulted in minimal recommendations for curricular change. This 2009 evaluation of the curriculum was the first done in 15 years. There has been no standard format for the mandated and well defined triennial evaluation of the courses and clerkships resulting in inconsistencies in curricular reviews. Individual course and clerkships have been reviewed periodically by the Course and Curriculum Evaluation Committee; however, segments of the curriculum, such as an entire year or phase, have not been reviewed.

III. MEDICAL STUDENTS

See Appendix for the following documents:

- Student enrollment by class year
- Mean MCAT scores and premedical GPAs for past seven entering classes
- Gender, racial, and ethnic distribution of medical students
- Table of students who left school, exhibited academic difficulty, or took leave of absence
- Sample Medical Student Performance Evaluation ("dean's letter")
- Tables of financial aid support
- Executive Summary section of narrative section of Student Independent Analysis and data from student questionnaire

A. Admissions

1. Premedical Requirements

Requirements for admission include a baccalaureate degree which is considered a prerequisite for admission. Although exceptions are theoretically permitted to allow admission with three years of college work this is reported to not occur. The MCAT is required and must be taken no later than August of the year preceding the expected matriculation date. Required undergraduate courses include one year of biology or zoology including laboratory, two years of chemistry with laboratories including organic chemistry, one year of physics including laboratory and one year of English composition and literature The English requirement may be satisfied with other writing-intensive humanities courses. Courses that are recommended but not required include biochemistry, genetics and physiology. Preference is given to Connecticut residents, however out-of-state residents are accepted as are international students. Applicants must submit an AMCAS application, an $85 application fee and supplemental statement within 4 weeks of acknowledgement of receipt of the AMCAS application, and letters of recommendation within 8 weeks of acknowledgement of the AMCAS application. The selection criteria are publicized in the university bulletin, on the university website, and in the AAMC MSAR. The selection criteria for admission, which include college grades, MCAT score, rigor of the curriculum, recommendations, work and volunteer experiences are published criteria and are consistent with those typical of other medical school and appropriate for a state-supported medical school.

The medical school has adopted and published technical standards. The standards are published in the admissions brochure and are posted on-line. When applicants are asked to submits a secondary application they are provided information about the standards and invited to contact the school is they have questions. During the interview day, applicants are again informed about the standards and information is sent to accepted applicants.

2. Selection

The admissions office calculates an "academic strength index." The index takes into account the overall academic performance, MCATs, and selectivity of the candidate's academic program.

All applicants with scores above a certain cutoff level are processed for the rating of additional file elements and interview unless there is some information in the file that suggests a candidate is not suitable for admission. The cutoff level represents the Admission Committee's judgment of the academic ability and achievement which a "typical" applicant should demonstrate to warrant consideration of the other pertinent selection criteria. The files for all candidates that fall below the cutoff level are also

carefully reviewed and some warrant further consideration. Special attention is given to the following subsets of applicants: underrepresented minorities, disadvantaged candidates, candidates who might add a unique dimension to a class, post-baccalaureate candidates, those applying to dual degree programs, those with grade trends, those with discrepancies between the GPA and the MCAT, and those especially strong in any one area. State residents and non-residents are dealt with as distinct pools handled in parallel. The typical academic strength index expected for non-residents is higher than for residents. Over half of the Connecticut residents are selected for interview and further review and less than 10% of out of state residents are selected.

Applicants selected for further consideration are interviewed by at least two interviewers. When the interview is completed, the interviewer writes a narrative report on the applicant and gives an interview score. Following the interviews, the applications are reviewed and rated by the Admissions Committee on the basis of all factors including academic strength, letters of recommendation, interviewers scores and comments, academic extras such as awards, honors work and advanced study, non-academic extras such as volunteer or paid work and activities providing evidence of initiative, responsibility and leadership, and the MCAT writing sample. A final composite score is created using these variables and the GPA and MCAT scores. While these summary ratings are given to the Admissions Committee, the Committee is free to select the best overall candidates regardless of the formula score rank.

The Admissions Committee is composed of 15 voting faculty members, including the chair. The assistant dean for admissions, the associate dean for student affairs and the director of the Health Careers Opportunity Program serve as ex-officio members without vote. There are four student members on the committee, three of whom vote on a rotating basis. Three of these students are second year students and the fourth is a third year student who was a member the previous year. Committee members are appointed by the dean of the medical school and the dean for academic affairs. Students serve terms of one year and faculty members serve terms of three to five years.

The Admissions Committee typically meets twice monthly from September through March. Early Decision candidates are considered in September. Starting in late September, regular decision candidates are considered. Each interviewed applicant file is assigned to at least three Admissions Committee members. Committee reviewers carefully read and evaluate the entire file, and assess the accuracy of all ratings. A recommended action is proposed for each interviewed candidate being considered at any given meeting. If all reviewers are in agreement with a proposed recommendation, block votes may be taken to accept, deny, or list proposed candidates as alternates.

When reviewers do not all agree, candidates are presented by the reviewers, and the full committee considers these candidates. When a candidate is voted on, the committee makes one of the following decisions:

1. Accept - offer a position
2. Acceptable/Alternate - hold on the acceptable list at this time
3. Hold - for further information or consideration
4. Reject - not suitable for admission

Following an initial classification as "Acceptable/Alternate", an applicant may be brought back to the Committee, at the Committee's request. Importantly, while the rank order represents the Committee's judgment of the importance of the various selection criteria, in some cases a higher ranked applicant is not accepted because of a weak element in the file or a poor interview evaluation, and a lower ranked applicant may be accepted because of a strong element in the file along with excellent interview evaluations.

A rank-ordered alternate list is established, usually in March/April. The Admissions Office works off this list in rank-order as withdrawals are received. Occasionally, an alternate list applicant is reevaluated if there is strong evidence that might alter the applicant's rank order.

Decisions of the Admissions Committee are final and not subject to review. Offers of acceptance are signed by the Chair of the Admissions Committee.

The applicant pool seems to be ample to allow the admission of a high quality class. There have been over 2900 applicants per year in the past two years to matriculate approximately 85 students. There have been some very preliminary discussions about the possibility of increasing the class size to 105. The school believes that the applicant pool is sufficient to accommodate such an increase because many well qualified applicants are currently left on the alternate list. The academic credentials of the matriculating class, as measured by GPA and MCAT scores, are at about the national average (see Appendix). There is a "Combined Program in Medicine" which is a baccalaureate/MD program in conjunction with the undergraduate campus at Storrs. Students admitted though this program are included in the 85 students admitted to the first year.

The school of medicine has a robust and multi-pronged set of programs aimed at preparing and recruiting minority and disadvantaged students for college educations and careers in science and medicine. Programs are aimed at college level students, pre-college students and post-baccalaureate students. Programs include summer programs and academic year programs. Much of this effort is supported by a Health Careers Opportunity Program grant. These efforts have resulted in a reasonably diverse student body (see Appendix). Data are collected to track the success of these programs as measured by enrollment in college, enrollment in medical school and enrollment in UCONN-SOM. These data reveal substantial variability in the success of these programs, as would be expected. In some cases, program participants have enrolled in college and professional schools in substantial numbers and in other cases outcomes are much less successful.

3. Visiting and Transfer Students

The procedures for verifying the credentials of enrolling visiting students are thorough and appropriate. Very limited numbers of transfer students with advanced standing are admitted. In the past three years, only one student has been admitted to the third year class. Available spaces are based upon attrition. Only students from LCME-accredited medical schools are eligible for transfer admission. No students are accepted for transfer into the fourth year. All students transferring into the third year must have passed the USMLE Step 1 with scores above the mean of UCONN students and must present suitable and equivalent preparation in history taking and physical exam skills consistent with the level of preparation of UCONN students

At present, the physical resources of the medical school for both preclinical and clinical education are sufficient to meet the needs of the current enrollment, although research space is constricted. The size of the faculty, particularly the basic science faculty is marginal to meet the educational needs of the present enrollment. The number of basic science faculty has been consistently decreasing for 5 years. If plans to increase class size are to proceed, an increase in faculty will likely be necessary.

B. Student Services

1. Academic and Career Counseling

a. Academic Counseling

Students experiencing academic difficulty are identified by monitoring performance on exams and small group performance. Small group leaders are asked to give formative feedback to weak performers and to alert course directors to any problems. Course directors reach out to students who underperform and offer assistance. In addition to counseling students whose performance appears to be sub par, they may also refer students, through the associate dean for student affairs for tutoring available from more senior students. The course directors also refer students to expert faculty who teach the topic in the course for one-on-one tutoring.

The dean for academic affairs and the associate dean for student affairs receive notification of students who have failed any individual exam so that overall progress can be monitored and corrective action taken early. Students with academic difficulties may self-refer to the associate dean for student affairs. Occasionally, course directors refer students to the associate dean for student affairs if they suspect non-academic issues are contributing to academic performance. The associate dean for student affairs then facilitates appropriate counseling, medical/personal leaves of absence, etc. Additionally, the Office of Health Career Opportunities Programs (HCOP) also offers support and advice to students from underrepresented minorities. There is close cooperation between the Office of Student Affairs and the HCOP office.

In the clinical curriculum, the site director at each location serves as the first line in detecting problems or providing enrichment activities. In addition, the overall course directors of both the ambulatory and the inpatient experiences are highly visible and available to students. The associate dean for student affairs stays in close touch with course directors in order to closely monitor student performance and to detect the need for remediation or support. Mid-way through the 3rd year, each student selects a clinical advisor to review his/her performance, and to begin to plan the fourth year curriculum which is flexible and individualized. Resources similar to those available in the preclinical years are available to clinical students. In addition, there is an elaborate clinical skills program with programmed patient instructors who may be used to more fully define and remediate difficulties in history taking, physical diagnosis, and patient interaction.

Through the Office of Student Affairs, there is an established program of formal testing when a concern is raised that a student may have a learning disability that is contributing to underperformance. These evaluations are done through the student health plan and are free of charge.

The database reported a very modest attrition rate which is well within the norms that are seen nationally (see Appendix).

b. Career Counseling

The school of medicine has concentrated its efforts in career advising on the 3rd and 4th year students. A structured program for students in first and second year is lacking. This has resulted in a lack of knowledge and understanding by students of steps that should be taken early in their medical school careers to prepare for residency applications. There is a plan for career advising for years one and two, but this will be implemented after the LCME site survey. Hence, the current third and fourth year students were somewhat disadvantaged by the lack of such information early in their enrollment..

In the 2009 AAMC Graduation Questionnaire, 46.4% of respondents report that they strongly agree or agree that they are satisfied with career preference assessment activities. This is a decrease since 2008

and compares with 52.3% nationally.

Currently, career advising begins in the second half of third year when students choose a clinical advisor. There are two large group meetings with the class in February and June to discuss information about planning electives and residency applications. The clinical advisor must sign-off on the student's elective schedule for fourth year. Students in third year are encouraged to use the Careers in Medicine website; however, in 2008-09 only 17 third year students and 2 fourth year students did so. In 2007-2008 it was 21 and 2 respectively.

Currently, students in years 1 and 2 have available to them shadowing experiences and interest groups in some of the specialty areas. They have been told about the Careers in Medicine website, but in 2008-09 only 24 first year students and 9 second year students registered on that site. A careers website for the school of medicine has recently been created to offer information about careers in medicine and timelines. This is now available for students in all four years.

The students have excellent results in the NRMP residency Match. For the past two years, 98% of the students in the match were initially successful without having to participate in the "scramble." The MSPE is written primarily by the associate dean for medical student affairs (ADMSA). The ADMSA meets with each student to discuss the contents of the letter and to review the students' specialty choice and fourth year schedule. It is noteworthy that the ADMSA is scheduled to retire prior to the writing of the MSPEs for the class of 2011. The pre-medical experience portion of the letter is written by the assistant dean for admissions, and the remainder is written by the ADMSA. Students are allowed to read the draft and offer corrections of factual information. The MSPE also includes narrative comments from the first four rotations in fourth year (see Appendix for sample MSPEs).

Students are allowed four weeks of vacation in the fourth year which they can use in any amount at any time. They are instructed to use at least a portion of the vacation time for residency interviews.

2. Financial Aid Counseling and Resources

Students receive financial aid services from the Financial Aid Office which is located within the medical school. This office is staffed by a full-time director, which is a university position and reports to the university Director of Enrollment Services. The director is assisted by a full-time Financial Aid Counselor and a half-time Administrative Assistant. The Financial Aid Office serves the students of the school of medicine as well as the school of dental medicine. It appears to the site survey team that this level of staffing may be insufficient to allow the full scope of financial aid and debt counseling services.

The office is open Monday through Friday, 8:00 am to 4:30 pm and has an open door policy which encourages students to "drop in." Students may also make contact staff members by telephone during normal business hours. The staff will accommodate students by appointment after hours if their schedules do not permit meeting during normal business hours. Information regarding financial aid, scholarship applications, financial literacy programs, etc. is e-mailed to students and is available on-line.

The physical facility in which financial aid services are provided were recently renovated to correct problems related to privacy and confidentiality. Walls replaced modular separation to limit the transfer of sound to allow for private conversations and barriers to handicap access were removed.

Financial Literacy programs are offered throughout the academic year and made available to all students through live programs and the availability of information on-line. All appropriate information regarding indebtedness, loan consolidation and deferment and loan repayment options is provided to fourth year students. The federally mandated Exit Loan Counseling Sessions are provided through either group

sessions or on-line. Students are encouraged to meet one-on-one with Financial Aid staff or a lender representative after completing the exit counseling session. Although all appropriate services are offered, it is questionable how well utilized they are by the students. The system utilized for the disbursement of refunds, which is through the bursar's office of the Health Center campus, imposes delays that are noted and criticized by the students. Direct deposit of these refunds is not available.

The AAMC Graduation Questionnaire reports that, for the past five years, students at UCONN have had a somewhat lower level of satisfaction than the national average with regard to financial aid services and a satisfaction level similar to the national average with regard to debt management counseling and the financial aid exit interview. In the most recent year 62% of students were satisfied or very satisfied with financial aid services (compared to a national average of 67%); 67% were satisfied or very satisfied with debt management counseling (compared to 59% nationally); and 68% were satisfied or very satisfied with the exit interview (compared to 57% nationally). The Student Independent Analysis indicated that the amount of financial aid counseling offered to students was the subject of "moderate criticism" by the respondents to the survey. In the prior LCME survey in 2003, it was also found that "students report that they receive little structured counseling that helps them understand and manage their debt portfolio." This led to a finding of noncompliance with standard MS-23 in the prior survey. Progress reports reported modest improvement in student perception of debt counseling and reported that the Director of Financial Aid had retired and was replaced with a new individual. It was also reported that financial aid staff received additional training. While the efforts implemented targeted an improvement of loan servicing, it appears that counseling services to students continue to need attention.

Medical school tuition and fees have shown an upward trend in recent years at a rate greater than the national rate of rise. In 2003-2004, the year subsequent to the last LCME review, the UCONN tuition and fees for in-state students was slightly (4.5%) above below the national average for state-supported schools ($17,140 vs $16,358). For out-of-state students, tuition and fees were 1% below the national average ($32,440 vs $32,762). In subsequent years the gap widened for in-state students and dramatically increased for out-of-state students. By 2008-2009, UCONN exceeded the national average for in-state students by 13.5% ($28,168 vs $24,809) and exceeded the national average for out-of-state students by 16.7% ($50,815 vs $43,543). The differential was greatest during this period in the 2007-2008 year when tuition and fees exceeded the national average by 16.7% for in-state students and by 19.4% for out-of-state students. The tuition and fees for in-state students for the current academic year (2009-2010) increased another 5% to $29,576. For out-of-state students, the increase was 3.55% to $52,621. The school of medicine has a published policy for tuition and fees refunds that is appropriate and equitable. There is a statutory requirement that tuition for in-state students be set at the 75th percentile of state medical schools and that the out-of-state tuition be at the 50th percentile. Bringing the medical school into compliance with this statute is reportedly the reason for the recent steep increase in tuition.

In parallel with the recent increase in tuition and fees, there has been an increase in the average indebtedness of the UCONN graduates. During the years 2003 through 2005, the average debt of UCONN graduates who had debt was well below the national average for public schools, ranging from 24% to 29% below the national averages. In 2007 and 2008, the average debt was 6% and 1% above the national averages, respectively. From 2003 to 2008, the average indebtedness almost doubled, from about $64,000 to about $126,000. This trend should be monitored to assure that compliance with standards is not compromised (see Appendix for Tables of Financial Aid).

Resources for scholarship aid have not kept pace with the increase in the cost of attendance leading to the increased indebtedness of UCONN students. The school reports that a total of $3,078,375 of grants were awarded in the current year. About $1.4 million of the total is from the HCOP grant and $220,143 is from military or NHSC scholarships. About $1.1 million is from the 15% tuition set-aside for scholarships. Grants from the UConn foundation totaled $63,750. The University of Connecticut has undertaken an

ambitious fundraising endeavor, "The Campaign for UConn." Its goal is to dramatically increase support for students, the faculty, academics, research and athletics. The campaign will seek to raise $600 million, with a goal of achieving 900 privately funded scholarships across the University by the campaign's conclusion in six years. It is unclear how much of these projected funds will be directed toward medical student scholarships and also unclear is what are the prospects for successfully achieving the campaign goal.

3. Personal Counseling and Health Services

All medical students have required health insurance coverage through the state of Connecticut and have the option to purchase insurance for dependents. The basic plan is entirely covered by annual student fees at a cost of $2,600/year. Students may purchase an optional plan with increased benefits. Students may also purchase optional dental coverage, under which dependents may also be eligible. All students are provided disability insurance without cost.

Required immunizations are all provided free of charge to students, as are TB testing and influenza shots and pre-matriculation physical examinations through the employee and student health service (Occupational Health) located on the school of medicine campus. This clinic is open from 8am to 5pm. In addition, students can access health care from a large number of available practitioners in their insurance network. Students felt their insurance coverage was adequate and reasonably priced and were comfortable with the panel of providers available to them. Some students wanted the ability to opt out of the medical school insurance coverage. Students were pleased with the options and availability of health services.

Students expressed concern that they were put in the position of bearing the burden of ensuring that faculty who provide their sensitive medical care are not in a position to evaluate them academically.

Wellness programs include a peer support program, a big-brother, big-sister program, alternate medicine stress management e.g. meditation, a mind-body-spirit elective, and a variety of student clubs and interest groups, e.g. outing clubs, LGBT. Students report satisfaction with these programs but view the need for a fitness center and an adequate student lounge as integral to a sound wellness program.

The medical school provides personal and mental health counseling for students including individual professional mental health counseling, peer counseling, small group discussions and some seminars/workshops on self care which is readily available. A .5 FTE mid-level mental health professional provides evaluations, treatment and triage at no cost to students. Psychiatrists and psychiatric residents are available for consultation. Students who seek mental health treatment elsewhere, but in-network, pay a $10/visit co-pay and $30/visit co-pay to providers out of the network. Some mental health services are provided in the medical school outpatient psychiatric clinic which serves as an educational site for medical students on their Psychiatry clerkship. Students are uncomfortable seeking mental health services at this site because they are not provided in a confidential environment. Students who require psychiatric hospitalization go to a facility other than John Dempsey. On the AAMC Graduation Questionnaire, 56.5% and 52.1% of students graduating in 2008 and 2009 respectively, stated that they were satisfied or very satisfied with mental health services; 37.7% and 42.1% were neutral. In the 2008 and 2009 graduation questionnaires 71% and 69 % of students respectively stated that they were satisfied or very satisfied with the personal counseling available to them as compared to 61% nationally.

The medical school has appropriate policies in place related to exposures to infectious or environmental hazards. During orientation all incoming first-year students attend a mandatory blood borne pathogen and TB control training program. They undergo fit testing with an N-95 TB respirator. Early in the PCM course, students receive further instruction on disposal of hazardous waste such as needles and syringes,

proper hand washing technique, and use of protective clothing in a clinical setting. Each student receives a risk assessment card with specific information on post-exposure procedures, prophylaxis and appropriate contact information for additional guidance and follow-up. Students are instructed to immediately contact the Occupation Health Clinical between the hours of 8AM and 5PM after a needle stick or other exposure. After hours, they are instructed to go to the hospital emergency room for assessment and prophylaxis if needed. Students reported a number of problems encountered in seeking treatment after hours at some of the clinical campuses, including bills for services. On the 2007-2009 AAMC Graduation Questionnaires, 100%, 100%, and 98.6% of students respectively reported being aware of procedures related to occupational exposure to infectious diseases.

C. The Learning Environment

After an extensive and broadly based developmental process a "Teacher-Learner Compact" was drafted, vetted by the Graduate Medical Education Committee and approved by the Education Council in 2006 (see Appendix). The Education Council adopted the Compact as policy for the school and all faculty who interact with students and faculty. The Compact is distributed to all students and new faculty, is contained in The Program Directors' Manual which is on Blackboard in the GME organization, and is reprinted in The Housestaff Policy Book which is available on-line. The faculty handbook also has a link to the Compact posted on line. The "Teacher-Learner Compact" seems to be well publicized and student awareness is high. The AAMC Graduation Questionnaire for the past three years reveals that student awareness of school policies related to student mistreatment is close to 100% and is well above the national norm. During this same period, the AAMC Graduation Questionnaire reports that the percentage of UCONN students who personally experienced mistreatment was significantly below the national average. In the most recent year, 13% of respondents reported mistreatment compared to 17% nationally.

One of the six competencies delineated by the Task Force for Curriculum Goals and Objectives described the desired professional attributes, including honesty, reliability, respect, compassion and several other appropriate attributes. The task force used many resources to develop this list, including reports from ABIM (Medical Professionalism Project), AAMC (Medical Student Objectives Project, Project on Clinical Education of Medical Students), IOM (Crossing Quality Chasm, Health Professions Education, Academic Health Centers), documents from other medical schools, review of literature for consensus statements/guidelines/opinions/studies. The goals and objectives were reviewed and discussed by all course directors, were approved by the Committee on Undergraduate Medical Education, and posted on school of medicine website.

The Steering Committee for the M1 and M2 Clinical Medicine Courses rewrote their course objectives based on the Curriculum Goals and Objectives. All faculty and students are directed to the course objectives which are posted on the Blackboard site. The evaluation of students and course are based on these objectives and formative feedback is provided midway in the year to reinforce the objectives and to allow course leadership, faculty and students to respond as indicated.

The Human Development and Health Course also posts the professionalism attributes that are expected of students. Students are made aware that demonstration of these attributes is expected, and is explicitly one criterion by which their small group evaluations are based.

Students undergo extensive orientation to the third year, once in the spring of their second year and then at the start of their third year. During this session the competencies that are expected of them are reviewed. Professionalism is highlighted and examples of professional and non-professional behavior are used. Particular emphasis is placed upon the difference in expectations that occur between the pre-clinical and clinical years. Students are also told that non-professional behavior on the part of their colleagues/teachers/other health care providers should not be tolerated and they are encouraged to report

this behavior to the dean of student affairs, dean of education, dean of academic affairs or course leaders. Confidential reporting to the Office of Diversity and Equity is also an available path for reporting In the MAX and In Patient courses, professionalism is evaluated as one of the major competencies students must achieve. Residents and faculty evaluate students in this domain. Evaluations are reviewed in "real time" thru an electronic system and unsatisfactory comments or scores are immediately flagged by electronic mail to the Course Director's for review. In this way, any pattern of poor scores or comments can be addressed in a timely manner.

Clearly delineated policies exist, are published and are well publicized that establish procedures for assignment of grades, remediation of inadequate performance, promotion and graduation. Established committees include the Course Grading Committees (each chaired by the relevant course director), Academic Advancement Committee (members and chair appointed by the dean for academic affairs) and Student Evaluation and Appeals Committee (members and chair appointed by dean of academic affairs). Appropriate due process is provided for and a clearly defined appeal process exists. Final decisions of the Student Evaluation and Review Committee are recommendations to the dean and the decision of the dean is final and not appealable within the school of medicine or the university.

Access to student records is very limited (on a need-to-know basis) and is accessible to students and appropriate designated faculty and staff. Students may give written permission for others to have access. An appropriate policy exists to allow students to challenge the accuracy of material in the record and may place into the record documents or statements related to any contested material. Records are maintained in a locked cabinet in the Registrar's Office for former students and in the Office of the Associate Dean for Student Affairs for currently enrolled students. There are no known impediments for students with respect to review and/or challenging of grades.

There seems to be ample availability of study space and lockers are available to students to store personal items. Student lounge and relaxation space has been an on-going problem and was cited in the previous LCME survey as not being in compliance with standards. The AAMC Graduation Questionnaire continues to report student dissatisfaction in this area. During the four year period from 2005-2008, the percentage of student reporting that they were dissatisfied or very dissatisfied with the availability of relaxation space ranged from 34.7% to 53.9%. In the most recent year (2009) 42% of graduates reported dissatisfaction, which continues to compare very unfavorably to the national average of 18.7%. During the site survey, students indicated that the use of the existing lounge by many groups, including graduate students and staff, the usefulness of this space for medical students is limited. Although plans have been developed for addressing this problem through new construction, financial limitations have prevented the implementation of these plans. Because of the plan for construction, renovation of the existing facilities has not been undertaken. The survey team reviewed the plans for the new student center but the time-line for this construction is unclear.

D. Student Perspective on the Medical School

The LCME Student Independent Analysis consists of a well-planned survey in which 72% of the students participated. Overall, the students are very satisfied with the educational experience as well as the learning environment. The smaller class size makes it easier to form friendships and professional relationships. From the 2009 AAMC Graduation Questionnaire, 94.2% strongly agree or agree with the statement "Overall, I am satisfied with the quality of my medical education," as opposed to 86.6% nationally. In fact, 57.7% responded strongly agree compared to 37.8% nationally. These feelings were verified by on-site discussions with students from all four years.

From the students' perspective, specific strengths include the integration of basic science teaching in years 1 and 2, clinical teaching in years 3 and 4, overall educational facilities, and relationships with

faculty and administration.

Some concerns mentioned include dissatisfaction with counseling on career options, lack of exposure to specialty fields in the clinical clerkships, lack of an adequate student lounge and exercise facilities, and concerns with the fourth year selectives project. From the 2009 AAMC Graduation Questionnaire, 46.4% of students are satisfied with career preference assessment activities. This is a decrease since 2008 and compares with 52.3% on a national level.

Students feel that faculty and administration listen to their concerns and are responsive to requests for changes and improvements. In the 2009 AAMC Graduation Questionnaire, 98.5% report satisfaction with the associate dean of students' accessibility and 94.2% satisfaction with his responsiveness to issues. Also, 75.4% report satisfaction with responsiveness of the academic dean to concerns, compared to 67% nationally. Students are very active on committees and 81% report satisfaction with their level of involvement on school committees, compared to 71% nationally (see Appendix for Student Independent Analysis).

IV. FACULTY

See Appendix for the following documents:

- Tables showing current numbers of full-time, part-time, and volunteer faculty members in the basic science and clinical disciplines, by department and total
- Tables of teaching responsibilities by department
- Table showing the major medical school faculty committees

A. Number, Qualifications, and Function

The number of full time faculty in the basic sciences departments has decreased from 172 in 2003 to 126 in 2009 while the number of part time faculty increased from 24 to 31. The number of volunteer basic science faculty remained essentially the same. During the same period the number of full time clinical faculty increased from 672 to 769 and the number of part time clinical faculty increased from 77 to 85 while the number of volunteer faculty remained constant. The total number of volunteer faculty is 70 for the basic sciences (31% of the total) and 1747 for the clinical departments (67% of the total)(see Appendix for tables of faculty numbers and teaching responsibilities). Comments during the site survey indicate that the total number of faculty is inadequate to teach in phase 1. The decreasing number of full time basic science faculty, and the reliance on volunteer faculty also raise concern about the consistency of the educational experience in small group and clinical settings. In the phase 1 curriculum many small group facilitators are recently retired faculty members that have been rehired for this responsibility with 1 year appointments and with reduced compensation. The state legislature is considering a bill to prevent state retirees from returning to work on a part-time basis. If this legislation passes, there will be an additional major reduction in the number of available faculty members for basic science small group learning activities.

There is no uniformly applied evaluation system of individual faculty members by students. A pilot program to survey students about individual faculty members in the Human Systems course in year 1 has been conducted the last 2 years, and is now in place for that course. There is a plan to implement an individual faculty evaluation survey in academic year 2009-2010 for all basic science teaching. Third and fourth year clinical faculty preceptors and residents are evaluated uniformly by students using myevaluation software using a comprehensive list of elements to be evaluated. The school has also relied on open comments on the course evaluation from students when they have specific suggestions concerning individual faculty members. Clinical faculty members receive their individual student survey

results at least annually, but basic science faculty are not all evaluated individually and can not all receive such feedback. Problems with individual faculty members are unevenly addressed by section or site leaders. Comprehensive faculty development was only implemented 2 weeks before this the site survey. The Office of Faculty Instructional Technology is available to informally help faculty with the use of technology in teaching activities. The university also has an Institute for Teaching and Learning; however, it has not been available to health science faculty. The senior associate dean for faculty affairs has worked informally with faculty members on their teaching skills, but no other formal program existed until recently. There is a newly appointed director of faculty development who is a faculty member in the department of Family Medicine. A monthly lecture series for health science faculty was just implemented with the first seminar taking place on 1/21/10. An Academy of Distinguished Educators was created in September 2009, but this academy appears designed to honor outstanding performance of established teachers, not to provide mentoring to junior faculty members. Efforts to train residents for their teaching role are conducted within courses and clerkships by course or section directors. These efforts generally consist of 1 or 2 training sessions in which residents are given the students' goals and objectives and an overview of their teaching responsibilities.

The faculty engage in ongoing scholarly activity with an extensive publication history, roles in national study sections and committees, journal editorships, and participation in extramural research grants. The productivity of the faculty has allowed for stable NIH funding despite a decrease in the number of research intensive faculty.

B. Personnel Policies

The medical school has specific personnel policies for appointment, promotion and tenure, faculty policies for conflict of interest, and faculty evaluation processes which are available to faculty on the web. Criteria for promotion have been established in teaching, research, patient care and other professional activities. Recent changes in the university reporting structures now leave final promotion and tenure decisions with the provost instead of the dean, consistent with the rest of the university. The school of medicine has made some recent changes to its promotion and tenure criteria, including an increase in the probationary period to tenure, a "stop the tenure clock" mechanism, and development of criteria for promotion and tenure for collaborative investigators. A post-tenure review process with strong faculty buy in was implemented in 2005, which links directly to the existing annual faculty review process using the CREAM model (Clinical, Research, Education, Administration, and Miscellaneous).

Faculty are notified of the terms and conditions of employment, including salary and compensation incentive plans, in their letters of offer. The hire letter refers the faculty member to the Human Resources benefits website, and the letter of appointment references the website for a range of policies including appointments, promotion and tenure as does a welcome letter from the Faculty Affairs office. There is a mandatory training for all new and existing faculty on the conflict of interest policies (Individual Conflict of Interest in Research, Conflict of Private Interests of Faculty/Staff with Academic Responsibilities [Consulting], Conflict of Interest in Commercial Support of Continuing Medical Education, and Institutional Conflict of Interest in Research), code of conduct, compliance, etc. Compliance with the conflict of interest policies is monitored annually. A multidisciplinary *ad hoc* committee is working on a policy for faculty and student interactions with industry. The Faculty Handbook is available on the website.

Faculty are assigned an academic track (Tenure, Non-Tenure, Affiliated, Community Based, Adjunct) at the time of appointment. They are assisted to understand their category options and make the choice of academic category once they have started in their faculty position. The categories are Investigator, Clinician-Investigator, Clinician Scholar, and Medical Educator.

The university and medical school bylaws require annual merit reviews by department chairs. The program to measure faculty productivity, the CREAM program, was implemented some time ago. Each faculty member is intended to have a CREAM profile defining his/her percent effort in the areas of Clinical, Research, Education, Administration and Miscellaneous. Two formal institutional mechanisms monitor a faculty member's activity in relation to his/her CREAM profile. The Academic Merit Plan, an annual merit review in place since 2000, evaluates the academic (non-clinical) aspects of a faculty member's work. Yearly, the faculty member completes a standard form to document academic accomplishments, educational contributions, and administrative and committee work. The form is reviewed during a required meeting with the department chair (and center director), and goals for the following year are negotiated. The chair rates the accomplishments in each of the CREAM domains, and overall, resulting in ratings of "superior, acceptable, marginal and unacceptable". The annual merit review system acknowledges teaching time and quality, but faculty can determine whether to include student evaluations of their teaching performance. Major teaching award winners and those identified as superior in the educational domain are eligible for financial rewards as are those who agree to teach in specified underserved areas of the curriculum. Departmental ratings are then reviewed by the Merit and Compensation Executive Committee consisting of elected faculty and Ex Officio administrators and can be appealed to the dean. During the site survey, faculty reported that use of the CREAM system as part of the annual review is variable. All chairs have an annual review by the dean but there is no departmental faculty input into that review. Junior faculty reported that the quality of the annual review process varied across departments.

Some junior faculty felt that their appointment letters were nonspecific about their time distribution and that some commitments in their appointment letters were not honored. There was no formal orientation to the medical school faculty policies and procedures but faculty felt that they understood the appointments and promotions/tenure processes. Twice yearly workshops offered by the Faculty Affairs office focused on academic advancement. Opportunities for faculty development and promotion were viewed as dependent on the mentorship of individual department chairs. Junior faculty with whom the survey team met, were clear in their enjoyment of teaching, did not feel that they are overloaded with teaching responsibilities and are willing to do more. Considering the reported shortage in faculty to teach in the Phase 1 curriculum, this is a resource that might be tapped. A recently revised system, known as the CREATE system, was recently developed by the Dean's Office and was received with "mixed reviews. Both junior and more senior faculty expressed considerable concerned about the tools used to evaluate faculty performance and productivity, especially the newly developed CREATE tool.

C. Governance

The institutional self-study reveals that the school of medicine has a reasonable set of standing committees (15) in which the voice of the faculty can be heard in administrative, educational, research and clinical areas (see Appendix for listing of faculty committees). In addition, faculty actively participates in strategic planning, budget development, space allocation and other school functions. Within these committees and councils, some of the members are ex-officio, some are appointed by the dean and some are elected by the faculty. These committees meet at reasonable intervals, representing full time and volunteer/community faculty (where appropriate). There have been several town hall meetings since the dean assumed responsibility, as well as with the provost and university president.

As noted above, the school of medicine faculty has voted by a close vote to organize under an AAUP collective bargaining agreement. This organization campaign was said to be based upon the concerns regarding the proposed Hartford Hospital partnership and proposed changes in faculty performance metrics. The leadership of the AAUP faculty collective bargaining unit has not begun the contract negotiation process with the administration. The impact of the organization campaign and contract are uncertain, however the faculty are highly engaged and focused on the quality educational programs.

V. EDUCATIONAL RESOURCES

See Appendix for the following documents:

- Four-year Revenue and Expenditure Summary and current Annual Financial Questionnaire
- Tables of teaching facilities
- Table of faculty offices and research labs
- Summary data and associated tables for each clinical teaching site
- Tables of library and information technology facilities, library holdings, and library/IT staff

A. Finances

MEDICAL SCHOOL REVENUE SOURCES
($ in Millions)

Source	FY2009	% of Total Revenues	% of Total Revenues/ all Public Schools*
Tuition and fees	$10,665,700	3.5%	3.1
Federal appropriations	$0	0%	0.6
Adjusted state, local, and parent support	$72,902,800	24.2%	12.4
Grants & contracts (direct)	$59,738,700	19.8%	21.9
Indirect cost recoveries	$18,546,700	6.1%	5.7
Practice plans	$80,919,900	26.9%	33.3
Hospitals	$47,483,900	15.8%	15.5
Gifts and endowments	$3,710,600	1.2%	3.2
Other revenues	$7,219,000	2.4%	4.3
Total revenue	$301,187,300		
Total expenses and transfers	$317,802,400		

* Fiscal year 2008 data

Operating Budget

The fiscal year operating budget 2008-2009 for the school of medicine totaled just under $300 million dollars in operating expenses. The revenue stream has been described as being relatively stable with 24% derived from state funds, 27% clinical (practice and hospital), 26% from direct and indirect research, 19% from contracts and endowments, and the remaining 4% from tuition and fees. The contributions to the operating budget from the state of Connecticut, in spite of the recent economic downturn, have been described as "stable" (see Appendix for revenues and expenses for past four years).

The total school of medicine operating revenue has increased from approximately $246 million to $299 million dollars per year over a five year time period with a $12 million dollar increase in state appropriations; a $4 million dollar increase in federal grants and contracts; a $17 million dollar increase in the medical practice plan revenue; and a $13 million dollar increase in revenue from the hospital systems.

During this same period of time, tuition and fees rose by approximately $5 million dollars as well. This is described in the context of state mandates that tuition and fees remain at the 75th percentile for in-state students and at the 50th percentile for out of state students.

In 2008/09, there was a budgeted projected loss of $11.5 million dollars, which ultimately produced a deficit of $22 million dollars, predominantly due to "structural issues related to the hospital status". This is attributed to the disproportionate number of under-reimbursed clinical programs related to the public mission and the excessive benefit costs of state employees benefit system born by the hospital system. The ability to make up these deficits and to remain cash flow positive in the budget is dependent upon the largesse of the state legislature and executive branch by supporting the Health Center programs at the end of the fiscal year.

In the 2009/10 operating budget, through a combination of increased base budget state appropriations, a system wide hospital based dean's tax, and a state employee benefit legislative "off set", the operating budget is balanced at a cash flow positive 0% margin. At the time of the site survey, the combination of the medical school, hospital and practice plan are slightly (~$400M) favorable to budget and the school believes that they will continue to perform as such in spite of the fact that the hospital and physician practice continue to lose large sums due to the multiple under-reimbursed state programs. The university is working to either eliminate these programs or enhance reimbursement. Thus, if the current projections are accurate, there will be a 0.33% (~$1MM) margin (all in) for the fiscal year. Given the five year reduction in faculty, salary reductions, furloughs, inability to fund deferred maintenance of the fiscal plant and other considerations, it is unlikely that the operating margin will remediate these challenges without the infusion of new state "base budget" resources or a major change in the structural operation of the clinical components of the health care delivery system.

The 2009-2013 School of Medicine Research Strategic Plan was developed and approved but the implementation was delayed for fiscal reasons at the time of submission of the database. The research faculty recruitment was initially deferred for fiscal reasons and not budget supported. This strategic plan calls for the hiring of approximately eight tenured/tenure-track faculty over the next three to five years. This has been implemented at the time of the site survey in the setting of the above-described ability to stabilize the budget gaps. Additional P30 awards were successfully earned to add another two research positions. The research faculty successfully submitted 33 grants under the American Recovery and Reinvestment Act, totaling $10.4 million for 2010, and $9 million for 2011. Review of the LCME Part 1A Overview (2008-2009) was significant for 53% facilities and administrative federal negotiated rate, which was effective through June 2011. All of these dollars were retained within the medical school and health sciences administration and health center research advisory committee. The medical school utilizes approximately 420K ft^2 of research space. Of this ~117K ft^2 is currently under construction and ~200k ft^2 of research space dates to 1972 and is in need of renovation. The state funds that will renovate one third of this "L Building" are currently frozen.

The school of medicine, in order to support the hospital, has initiated an "academic tax" spread across the affiliated hospitals. While initially structured at 7.5% of total GME program costs, in April 2009 it was increased to 15% of the GME costs in October of 2009, totaling what is budgeted to be $5.6 million dollars.

It is of note that over the last three years the total clinical operations loss has increased from $10.3 to $28.1 million dollars. In 2009, $11.5 million related to the hospital system and $16.6 million to the faculty practice. These numbers varied somewhat from schedule to schedule, representing overall consolidated Health Science Campus budgetary shortfall.

It was hoped that the proposed partnership with the Hartford Hospital Center would remedy some or all of these hospital losses, but it was unclear from the self-study materials how this will occur with or without this merger. In addition, the dean created a task force in August 2009 to review the functions and structure of the faculty practice plan with the hope of reorganization of the clinical compensation plan and improvement in the revenue cycle billing and coding, as well as a decrease in overhead. It is also anticipated that the practice plan might be converted to a more provider base clinical status, pending analysis of the associated finances. The determinations of this task force and the implementation of recommendations are unresolved at the time of the self-study writing.

Capital Budget

In the year 2000, the state of Connecticut legislated a $1 billion dollar program to rebuild and expand the university's infrastructure, spanning over the full decade. This was later added to in 2004, with an additional ten year $1.3 billion dollar building program to modernize facilities, some of which have renovated and expanded facilities in the health sciences campus and the school of medicine. The school of medicine is currently midway through a $300 million dollar ten year building program based upon the latter state of Connecticut bond financing. With the current fiscal pressure on the 2009 budget, the issuance of additional state bonds for the 2009-2010 fiscal year was deferred. This has resulted in the halt to several planned capital projects including renovation of the research building, a student recreation/activity center, the main lobby of the medical school and several other projects.

The database further indicates that there are no separate GAAP compliant financial statements for the medical school and that the medical school does not have its own bond rating separate from the parent university. The parent university does have Moody's and Standard & Poor's, external ratings. As an instrumentality of the state, all current health program capital financing is reported to be state bond funded. Upon further inquiry at the time of the site visit, the rating agencies have rated the main campus university debt at Aa3 and AA respectively. The health center entities cannot engage the capital markets at this time due to the inability to achieve a stable outlook rating or to use the umbrella of the main university.

The proposed partnership between the University of Connecticut Health Center and the Hartford Hospital Corporation (HHC) included a proposal for the construction of a modern 250-bed university hospital on the Farmington campus with an estimated cost of approximately $500 million. This hospital is still being planned. The state funds have yet to be identified for the construction of this facility. Some of these funds were to originate from the currently pending national health care reform legislation. As noted above, these plans have been altered as it has been determined at the time of the site survey that this merger with HHC will not go forward and that the university will independently pursue the necessary legislative appropriation and/or federal dollars to complete construction of the new university hospital.

Philanthropy

The University of Connecticut is currently engaged in a five year $600 million campaign, $150 million of which is targeted for the school of medicine. Of this, approximately $30 million has been raised (this is not confirmed on the 2008/09 consolidated balance statement). These funds are said to be designated for endowed faculty/chairs, student scholarships, and facilities (renovation and new construction) over this five-year period. The details of this campaign are currently being developed. The school of medicine reported just over $60 million dollars in current endowments and $660,000 in contributions for the current fiscal year. These endowments support over twenty named faculty positions and a number of other designated programs and facilities.

B. General Facilities

The facilities used for education of medical students are the original buildings, constructed in 1971. The auditoriums were refurbished in 2007 to include upgrades in comfort and technology. Classrooms for teaching consist of two auditoriums (seating for 154 each), 14 small classrooms (12-18 seats each), 5 lab/conference rooms (28-32 each) and 2 anatomy labs (64-68 each) (see Appendix).

These classrooms are used by the first, second and third year classes and is determined to be "just enough". The medical school has priority scheduling. Conflicts in schedules among the classes occur and occasionally conference rooms in the attached Health Center are utilized. The new facility for clinical skills training is in the main health center building and was constructed in 2007. There are 16 simulated examination rooms; equipment and technology is state of the art.

Research and office space for current faculty is considered to be "just enough" (see Appendix). However, research laboratory space is in need of major renovations. Organization and utilization of space is optimum and efficient.

There is currently no definitive plan for increased enrollment. If at sometime it is decided to increase the number of entering students, there will need to be major construction for teaching space.

Students feel that the educational space is sufficient. However, there is dissatisfaction with the lack of space for relaxation (student lounge) and recreation.

The University police department is responsible for campus security. This department is well equipped and has well-trained officers. In 2008 a campus wide security project was initiated including installation of video surveillance, access control systems and "blue light" emergency phones. Students are satisfied with security measures and they feel safe on campus.

C. Clinical Teaching Facilities

There are ten inpatient facilities and multiple outpatient clinics available for use by the school of medicine for clinical training of medical students (see Appendix). These include a mix of facilities owned by the medical school and not-for-profit private facilities and private physician offices. The facilities have sufficient resources for students' clinical training.

Facility: John Dempsey Hospital
Annual Admissions: 9,761
Outpatient Visits: 296,583
This facility is utilized for student education in internal medicine, Ob/Gyn, psychiatry and surgery. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. Accredited residencies programs are in place.

Facility: Hartford Hospital
Annual Admissions: 39,936
Outpatient Visits: 103,744
This facility is utilized for student education in internal medicine, Ob/Gyn, psychiatry and surgery. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Student call rooms are not functionally useful for students on required clerkships. There is lack of consistent knowledge by students of the availability of any student call room facilities at Hartford Hospital. Accredited residency programs are in place.

Facility: Hospital of Central Connecticut
Annual Admissions: 24,000
Outpatient Visits: 422,649
This facility is utilized for student education in internal medicine, Ob/Gyn and surgery. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. Accredited residency programs are in place.

Facility: St. Francis Hospital and Medical Center
Annual Admissions: 32,807
Outpatient Visits: 304,410
This facility is utilized for student education in family medicine, internal medicine, Ob/Gyn and surgery. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. Accredited residency programs are in place.

Facility: Connecticut Children's Medical Center
Annual Admissions: 7,381
Outpatient Visits: 100,000
This facility is utilized for student education in pediatrics. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. Accredited residency programs are in place.

Facility: Waterbury Hospital
Annual Admissions: 14,800
Outpatient Visits: 75,000
This facility is utilized for student education in psychiatry. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. An accredited residency program is in place for surgery.

Facility: Manchester Hospital
Annual Admissions: 9,109
Outpatient Visits: 351,115
This facility is utilized for student education in psychiatry. The educational resources available include library, conference rooms and computers for students' use. Call rooms are not necessary. There are no residency programs.

Facility: Middlesex Hospital
Annual Admissions: 14,201
Outpatient Visits: 468,896
This facility is utilized for student education in family medicine. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. An accredited residency program is in place for family medicine

Facility: Norwalk Hospital
Annual Admissions: 15,418
Outpatient Visits: 132,000
This facility is utilized for student education in internal medicine. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas.

Call rooms and lockers are available for students. An accredited residency program is in place for internal medicine.

Facility: St. Raphael's Hospital
Annual Admissions: 24,969
Outpatient Visits: 176,000
This facility is utilized for student education in internal medicine. There are adequate educational resources available, including library, conference rooms, computers for students' use and study areas. Call rooms and lockers are available for students. An accredited residency program is in place for internal medicine.

Affiliation agreements are up-to-date for five of the ten inpatient facilities that host students for required rotations. These agreements contain all the required elements. The following hospitals do not have current, signed affiliation agreements that contain required elements: Waterbury Hospital, Manchester Hospital, Middlesex Hospital, Norwalk Hospital and St. Raphael's Hospital. Service chiefs are appointed with the concurrence of the medical school for the specialties in which students are rotating.

The facilities share a collegial and professional relationship not only with the medical school but also among themselves. There is no negative impact of the teaching programs on the hospitals' operation or funding. Although the recent negotiations for merger between Hartford Hospital and the school of medicine did not end successfully, there appears to be no negative impact on the mutual relationship or on the student clinical education.

There are no adverse effects of declining hospital utilization, shorter stays or change in case mix.

D. Information Resources and Library Services

The library is conveniently located within the medical school and serves the health campus. The library director reports to the chief information officer. The library facility is very helpful to students. There were major renovations of space in 2005 and in 2008. There is seating for 240, and there are 14 small group study rooms, 18 public workstations and 3 computer classrooms. Students are satisfied with the facility. The holdings are more than adequate and faculty and students can access these from any site with internet connections. There are 13 professional staff librarians (see Appendix). The library is open for a total of 94 hours per week; however students would prefer somewhat longer hours. The study rooms are available 24/7.

The library has excellent automated databases, bibliographic search capabilities and computer and audiovisual capabilities.

The library is adequately funded and in fact the budget has increased over the past three years. There are several avenues for faculty and student input on library policy and procedures. Post-course surveys completed by students include evaluation questions about library services. The library monitors responses on the AAMC Graduation Questionnaire on questions concerning the library services. The library participated in LibQual surveys offered by the Association of research Libraries in 2002 and in 2005. The library director serves on the curriculum oversight committee. There are several suggestion boxes available for input.

The information technology group is responsive to student and faculty needs. The director of Faculty Instructional Technology Services reports to the chief information officer. Every course/clerkship utilizes the Blackboard system and it is well supported. Wireless connectivity is available throughout the medical school. In the last two years the school converted to computerized testing. Each student is

required to have a laptop computer and smart phone or palm device. Recently, the histology course converted to virtual microscopy and the IT group supports the virtual microscopy server.

The school is now using the MyEvaluation system for student evaluations in the clerkships and other courses.

Self-learning behaviors are cultivated from the first year of medical school. Staff librarians present to students in the beginning of educational segments regarding what search tools would be helpful in the classes.

Faculty are well supported in their desired uses of audiovisual and information technology. Students have access to all electronic educational resources at any off-campus site that has internet connections. The quality and reliability of audiovisual and information technology is sufficient.

The 2009 AAMC Graduation Questionnaire reports 90% of students are satisfied-to-very satisfied with the library services and 91% are satisfied-to-very satisfied with the computer resource center services. 85.5 % feel that the time devoted in medical school to systematic literature review is adequate and 90% feel that they have appropriate knowledge and skills to carry out sophisticated searches of medical information databases.

APPENDICES

Accreditation Survey Visit to University of Connecticut School of Medicine by *ad hoc* Team Representing the Liaison Committee on Medical Education, January 24-27, 2010

Ad hoc survey team representing the LCME:

Jeffrey P. Gold, M.D., Chair Dean, University of Toledo College of Medicine Toledo, OH	Surgery
David Seiden, Ph.D., Secretary Associate Dean, Student Affairs Professor, Neuroscience and Cell Biology UMDNJ-Robert Wood Johnson Medical School Piscataway, NJ	Anatomy
Barbara A. Schindler, M.D., Member Vice Dean, Educational and Academic Affairs Professor of Psychiatry Drexel University College of Medicine Philadelphia, PA	Psychiatry
C. Nanette Clare, M.D., Member Senior Associate Dean and Associate Dean for Academic Affairs University of Texas Medical School at San Antonio San Antonio, TX	Anatomic/Clinical Pathology
Larry Reimer, M.D., Faculty Fellow Assistant Dean for Curriculum and GME University of Utah School of Medicine Salt Lake City, UT	Internal Medicine, Pathology

All meetings are in EG013 unless otherwise noted.

Sunday January 24, 2010: Background, Governance, Administration and Overview

4:30 pm Team caucus at Homewood Suites

6:00 Dean's perspective: Accomplishments, goals, challenges, at Homewood Suites
Cato T. Laurencin, M.D., Ph.D., Dean, School of Medicine and Vice President for Health Affairs, University of Connecticut School of Medicine

Strengths and weaknesses of the school; changes since last LCME survey, if appropriate; major current issues; School's goals and directions; principal findings of institutional self-study; Organizational relationships of college with university and teaching hospital(s); organization of dean's staff; interaction of dean with college's governance organization, councils, committees and academic departments; Financial status and projections; Research programs and funding; Status of facilities for education, research, and patient care; Faculty development: appointment tracks, promotion, tenure.

Monday January 25, 2010: Educational Program

8:00 am Team is collected at hotel/shuttle leaves hotel

8:30 Educational program design, implementation, management, and evaluation
Bruce Koeppen, M.D., Ph.D., Dean for Academic Affairs
Jacqueline Nissen, M.D., Associate Dean for Graduate Medical Education
Dan Henry, M.D., Course Director, MAX
Robert Bona, M.D., Course Director, Inpatient (outgoing)

Educational objectives, outcome measures, and how they are integrated throughout the curriculum; General design of the curriculum; coverage of disciplines and subject areas required by accreditation standards; Appropriateness of instructional methods and student evaluation strategies for the achievement of the school's objectives; Resident preparation for teaching and evaluating students; System for implementation and management of the curriculum; adequacy of resources and authority for the educational program and its management; Methods for evaluating the effectiveness of the educational program and evidence of success in achieving objectives; comparability of educational experiences at all sites.

10:30 Break

10:45 Library and information services
Sandra Armstrong, Chief Information Officer
Evelyn Morgen, Director, Lyman Maynard Stowe Library
Yanko Michea, M.D., Ph.D., Director, Faculty Instructional Technology Services
William P. Hengstenberg, Director, Biomedical and Media Communications

Role of the library and information services in the educational program; adequacy of resources and services for the achievement of institutional goals.

11:15 Group A: Drs. Seiden, Schindler and Reimer
Tour of library (including 24/7 study rooms and computer learning facility), lecture halls, small group classrooms, FITS, labs, and study areas used for pre-clerkship education of medical students.
Tour guides: Anne Roberts (MSIV), Lindsay Brown (MSIV)

Group B: Drs. Gold and Clare
Tour of clinical skills center, simulation center, student lounge, student services offices, and John Dempsey Hospital.
Tour guides: Tour guides: Clarke Nelson (MSII), Glenn Russo (MSII)

12:00 noon Lunch with pre-clerkship students, Onyiuke dining room

Discussion of student life; personal, academic, career, and financial counseling, financial aid; health services; infection control education and counseling; the learning environment and student mistreatment policies; student perspective of the curriculum, teaching, and evaluation/grading; students' role and perceived value of student input in institutional planning, implementation, evaluation.

Naomi Avery (MSII)
Katelyn Dannheim (MSI)
Patty Davis (MSII)

Dylan Graetz (MSI)
Colin Huguenel (MSII)
Naima Joseph (MSII)
Alison Romegialli (MSI)
Greg Rosner (MSI)
Shaun Mclaughin (MSI)
Megan Toal (MSII)
Jeff Thorne (MSII)
Arija Weddle (MSI)

Required Courses and Clerkships

Discussion of notable achievements and ongoing challenges in individual courses and clerkships; contributions of individual courses and clerkships in achieving institutional educational objectives; adequacy of resources for education, including availability of faculty to participate in teaching; preparation of residents and graduate students for their roles in medical student teaching and evaluation.

1:30 Phase I Courses Directors
Thomas Manger, M.D., Human Systems
Lynn Kosowicz, M.D., Clinical Medicine Course
Nancy Adams, M.D., Phase I electives (former chair; current chair unavailable)
Yvonne Grimm-Jorgensen, Ph.D., Correlated Medical Problem Solving
Dan Henry, M.D., co-Director, Correlated Medical Problem Solving II
Mary Casey Jacob, Ph.D., Human Development and Health
Melinda Sanders, M.D. Mechanisms of Disease

2:30 Phase II Clerkship Directors
Robert Bona, M.D., In-patient course (outgoing) and Home Weeks
Thomas Brown, M.D., Beginning to End
Dan Henry, M.D., MAX course, and In-patient medicine clerkship
Melissa Held, M.D., In-patient Pediatrics clerkship
Bruce Brenner, M.D., In-patient Surgery and MAX Surgery clerkships
Catherine Lewis, M.D., In-patient Psychiatry and MAX Psychiatry clerkships, and newly appointed In-patient course director
Paula Algranati, M.D., MAX Pediatrics clerkship
David Henderson, M.D., MAX Family Medicine clerkship
Ellen Nestler, M.D., MAX Medicine clerkship
Craig Rodner, M.D., MAX Orthopaedics clerkship
Jeffrey Spiro, M.D., MAX Otolaryngology clerkship
Walter Trymbulak, M.D., MAX OBGYN clerkship

3:30 Break

3:45 Phase III: Required Courses and Clerkships
David Henderson, M.D., ACE AIE Family Medicine clerkship
Dan Henry, M.D., ACE AIE Medicine clerkship
Melissa Held, M.D., ACE AIE Pediatrics clerkship
James Menzoian, M.D., ACE AIE Surgery
Thomas Regan, M.D., (ACE Emergency Medicine)
Raymond Foley, M.D., ACE Critical Care)
Stacey Brown, Ph.D., Selectives

4:45 Plans for addressing student relaxation and student services space.
Bruce Koeppen, M.D., Ph.D. Dean for Academic Affairs

5:15 shuttle to hotel

7:30 pm Max's Oyster Bar, 964 Farmington Avenue, West Hartford, 860-236-6299

Tuesday January 26, 2010: Students, Educational Resources, Finances, Departments

8:00 am Team is collected at hotel/shuttle leaves hotel

8:30 Group A: Drs. Seiden and Schindler
Bruce Koeppen, M.D., Ph.D. Dean for Academic Affairs
T.V. Rajan, Ph.D., M.D., Chair, Academic Advancement Committee
Yvonne Grimm-Jorgensen, Ph.D., Director, Reinforcement Program

Effectiveness of academic counseling; policies and procedures for student advancement and graduation and for disciplinary actions; review of standards of conduct and policies for addressing student mistreatment.

8:30 Group B: Drs. Gold, Clare, and Reimer
Anthony Ardolino, M.D., Associate Dean for Student Affairs
David Henderson, M.D., Predoctoral Director, Family Medicine, and planner of career counseling programs for Student Affairs office
Nancy Adams, M.D., 4th year Electives

Career guidance strategies; advanced and subspeciality clerkships and electives for rounding out clinical education of medical students.

9:15 Group A: Drs. Seiden, Clare and Reimer
Admissions; financial aid & debt management counseling and services
Richard Zeff, Ph.D., Assistant Dean for Admissions (newly appointed)
Keat Sanford, Ph.D., Assistant Dean for Admissions (outgoing)
Anton Alerte, M.D., Chair, Admissions Committee
Marja M. Hurley, M.D., Associate Dean for Health Career Opportunity Programs
Andrea Devereux, B.S., Director, Financial Aid
Cliff Sargis, M.S., Director of Enrollment Services

Discussion of admissions process, selection criteria, quality of applicant pool and matriculants; policies and goals for diversity; financial aid services and debt counseling.

9:15 Group B: Drs. Gold and Schindler
Personal counseling; health services
Anthony Ardolino, M.D., Associate Dean for Student Affairs
Charles Rowland, Graduate School Bursar/Student Health Plan Administrator
Debra Johnson, MS, APRN, BC, Student Mental Health Services
Oluremi Aliyu, M.D., MPH, Interim Director, Employee Health

Review of student health services; health and disability insurance; personal counseling and mental health services; immunizations and policies regarding exposure to infectious diseases and environmental hazards.

10:00 Break

10:15 **Team A:** Drs. Gold, Schindler, Reimer
Special programs, joint degree programs, research opportunities
Barbara Kream, Ph.D., Director, M.D./Ph.D. program
David Gregorio, Ph.D., Director, M.P.H. program
Ann Kenny, M.D., Director, Masters Program in Translational Research
Bruce Gould, M.D., Associate Dean for Primary Care; Director, Connecticut AHEC Program, Director, Urban Service Track; Advisor for some student volunteer programs such as the Migrant Worker's Program and
Keat Sanford, Ph.D., Assistant Dean for Medical Student Affairs and Admissions; Director, Post-Baccalaureate Program, Combined Program in Medicine, Summer Research Program
Stacey Brown, Ph.D., Director, Community Based Education

Discussion of special educational opportunities; MD/PhD and other joint degrees, research opportunities.

Team B: Drs. Seiden and Clare
Tour of Hartford Hospital and Connecticut Children's Medical Center. (time 10:15 to noon, including travel)
Tour guides: Andrea Gross (MSIV) and Kristin Loening, (MSIV)

11:00 Team A: Finances
Cato T. Laurencin, M.D., Ph.D., Dean, School of Medicine and Vice-President for Health Affairs
John Biancamano, Chief Financial Officer, UCONN Health Center
David Gillon, Associate Dean for Finance and Administration

Adequacy of finances for the achievement of the school's missions; recent financial trends and projections for various revenue sources; financial health of and market conditions for the clinical enterprise.

Noon Lunch with third and fourth year students (six each; to be named); Onyiuke dining room

Discussion of student life; personal, academic, career and financial counseling; financial aid; health services; infection control education and counseling; the learning environment and student mistreatment policies; student perspective of the curriculum, teaching, and evaluation/grading; students' role and perceived value of student input in institutional planning, implementation, evaluation .

Paige Armstrong (MSIII)
Paul Baldwin (MSIV)
Brian Gaudino (MSIII)
Reema Mehta (MSIV)
Sarah Morocco (MSIV)

Bryan Piccirillo (MSIV)
Neena Qasba (MSIII)
Andrew Raissis (MSIII)
Natercia Rodrigues (MSIII)
Nitin Roper (MSIV)
Joe Tremaglio (MSIV)
Shubha Venkatesh (MSIII)

1:30 pm Resources for clinical education

Cato T. Laurencin, M.D., Ph.D., Dean, School of Medicine and Vice President for Health Affairs, University of Connecticut Health Center
Michael Summerer, M.D., Interim Director, John Dempsey Hospital, and Assistant Dean for Education, John Dempsey Hospital
Peter Albertsen, M.D., Associate Dean for Clinical Affairs
Jeff Flaks, COO, Hartford Hospital
Neil Yeston, M.D., Assistant Dean for Education, Hartford Hospital
Martin Gavin, CEO, Connecticut Children's Medical Center
Edwin Zalneraitis, M.D., Assistant Dean for Education, Connecticut Children's Medical Center
Christopher Dadlez, CEO, St. Francis Hospital and Medical Center
Howard Shaw, M.D., Assistant Dean for Education, St. Francis Hospital and Medical Center
Laurence Tanner, CEO, The Hospital of Central Connecticut
Tom Lane, M.D., representing Dr. Steven Hanks, Assistant Dean for Education, The Hospital of Central Connecticut

Meeting with the leadership of major clinical education facilities, focused on (1) the adequacy of resources for medical student education, such as physical facilities, patient numbers and variety, regulatory or compliance constraints, etc.

3:00 Break

3:15 Basic science departments

David Gregorio, Ph.D., representing Dr. Thomas Babor, Ph.D., Chair of Community Medicine and Health Care
Laurinda Jaffe, Ph.D., Cell Biology (interim)
Marc Lalande, Ph.D., Genetics and Developmental Biology
Sandra Weller, Ph.D., Molecular, Microbial and Structural Biology
Richard Mains, Ph.D., Neuroscience
Pramod Srivastava, Ph.D., M.D., Immunology (interim)

Successes and ongoing challenges in administrative functioning of departments; adequacy of resources for all missions (research, scholarship, teaching); departmental support for faculty and graduate programs; balancing of research and other academic demands on faculty.

4:15 Clinical departments

Robert Cushman, M.D., Family Medicine
Paul Dworkin, M.D., Pediatrics

James Egan, M.D., Obstetrics and Gynecology
Leighton Huey, M.D., Psychiatry
Denis Lafreniere, M.D., Surgery (interim)
Joseph Palmisano, M.D. Medicine (interim)
Harold Moskowitz, M.D., representing Dr. Douglas Fellows, Diagnostic Imaging and Therapeutics
Jane Grant-Kels, M.D., Dermatology
Jeffrey Gross, M.D., Anesthesia
A.J. Smalley, M.D. representing Dr. Lenworth Jacobs, M.D., Traumatology and Emergency Medicine
Jay Lieberman, M.D., Orthopaedic Surgery
Melinda Sanders, M.D., Pathology and Laboratory Medicine
Leslie Wolfson, M.D., Neurology

Successes and ongoing challenges in administrative functioning of departments; adequacy of resources for all missions (clinical, research, scholarship, teaching); departmental support for faculty and residents; balancing of clinical and academic demands on faculty.

5:30 shuttle leaves for hotel

Wednesday January 27, 2010: Faculty, Academic Environment, Exit Conferences

7:30 am Team is collected at hotel/shuttle leaves hotel

8:00 Light breakfast with junior faculty; Onyiuke dining room
Srdjan Antic, M.D., M.S., Department of Neuroscience
Kimberly Dodge-Kafka, Ph.D., Department of Cell Biology
Bing Hao, Ph.D., Department of Molecular, Microbial and Structural Biology
Kamal Mohan Khanna, Ph.D., Department of Immunology
Laksmi Nair, Ph.D., Department of Orthopaedics (Institute for Regenerative Engineering)
Kourosh Parham, Ph.D., M.D., Department of Surgery (Otolaryngology)
Jason Ryan, M.D., Department of Medicine (Cardiology)
Wilner Sampson, M.D., Department of Medicine (Nephrology)
David Shapiro, M.D., Department of Surgery, St. Francis Hospital and Medical Center
Susan Tannenbaum, M.D., Department of Medicine (Hematology/Oncology)
Jennifer Tirnauer, M.D., Department of Medicine (Center for Molecular Medicine)
Lori Wilson, M.D., FACS, Department of Surgery (Surgical Oncology)

Discussion of faculty development and mentoring; positioning for promotion and tenure; teaching and evaluation skills; perceptions of curriculum and students; understanding of institutional goals; role in faculty governance; faculty life.

9:00 Institutional faculty issues
Mary Casey Jacob, Ph.D. Senior Associate Dean for Faculty Affairs
Jeri Hepworth, Ph.D., Vice-Chair, Family Medicine, working on Faculty Development Programs through Faculty Affairs Office
Howard Tennen, Ph.D., Chair, Senior Appointments and Promotions Committee
Daniel McNally, M.D., Chair, Oversight Committee
Richard Simon, M.D., Compensation Plans Administrator

Discussion of faculty appointment, promotion, and tenure policies; faculty development opportunities; effectiveness of faculty governance; faculty compensation and incentives; opportunities for collegial interaction among faculty.

10:00 Break

10:15 Graduate program in basic sciences; basic science and clinical research
Bruce Koeppen, M.D., Ph.D., Dean for Academic Affairs
Lawrence Klobutcher, Ph.D., Associate Dean, Graduate School
Marc Lalande, Senior Associate Dean for Research Planning and Coordination
Judith Fifield, Ph.D., Director, Ethel Donaghue Center for Translating Research in Practice and Policy, co-PI, CTSA submission
Victor M. Hesselbrock, Ph.D., Director, Alcohol Research Center; co-PI, CTSA submission
Peter Albertsen, M.D., Associate Dean for Clinical Research Planning and Coordination

Discussion of funding, quality, and review of graduate training programs in basic sciences; levels of scholarly productivity and health of the research enterprise.

11:00 Team Caucus and Lunch (Private Session)

1:00 pm Exit Conference with Dean
Cato T. Laurencin, M.D., Ph.D., Dean, School of Medicine and Vice-President for Health Affairs, University of Connecticut Health Center

1:45 Exit Conference with University Leadership and the Dean
Cato T. Laurencin, M.D., Ph.D., Dean, School of Medicine and Vice-President for Health Affairs, University of Connecticut Health Center
Peter J. Nicholls, Ph.D., Provost and Executive Vice-President for Academic Affairs

Composition of Self-study Steering Committee, Task Force, Subcommittees

LCME TASK FORCE

1. Chair: Cato Laurencin, M.D., Ph.D. Dean, School of Medicine and Vice-President for Health Affairs
2. Nancy Bull, Ph.D., Vice Provost for Academic Administration, UCONN, Storrs
3. Michelle Cloutier, M.D., Professor, Department of Pediatrics
4. Paul Dworkin, M.D., Professor and Chair, Department of Pediatrics
5. Robert Englander, M.D., Professor, Department of Pediatrics
6. Judith Fifield, Ph.D., Professor, Department of Family Medicine, Director, Ethel Donaghue Center for Translating Research into Practice and Policy, Co-Principal Investigator, Clinical Translational Science Award
7. David Gillon, CPA, Associate Dean for Finance and Administration
8. Jon Goldberg, Ph.D., Professor, Department of Reconstructive Sciences, Member of the BOD
9. David Henderson, M.D., Associate Professor, Department of Family Medicine
10. Dan Henry, M.D., Professor, Department of Medicine
11. Jeri Hepworth, Ph.D., Professor and Vice-Chair, Department of Family Medicine
12. Charles Huntington, MPH, PA, Associate Professor, Community Medicine and Health Care, Associate Dean for Community and Continuing Education
13. Marja Hurley, M.D., Professor, Department of Medicine, Associate Dean for Health Career Opportunity Program
14. Mary Casey Jacob, Ph.D., Professor, Departments of Psychiatry and Obstetrics and Gynecology, Senior Associate Dean for Faculty Affairs
15. Yusuf Khan, Ph.D., Assistant Professor, Department of Orthopaedic Surgery
16. Bruce Koeppen, M.D., Ph.D., Professor, Department of Medicine, Dean for Academic Affairs
17. Lynn Kosowicz, M.D., Associate Professor, Department of Medicine
18. Bruce Liang, M.D., Professor, Department of Medicine, Director, Pat and Jim Calhoun Cardiology Center
19. Joseph Palmisano, M.D., Professor and Interim Chair, Department of Medicine
20. Achilles Pappano, Ph.D., Professor, Department of Cell Biology
21. Kara Watts, MSIII
22. Sandra Weller, Ph.D., Professor and Chair, Department of Molecular, Microbial, and Structural Biology
23. Lori Wilson, M.D., Assistant Professor, Department of Surgery
24. Neil Yeston, M.D., Assistant Dean for Medical Education, Hartford Hospital
25. Richard Zeff, Ph.D., Professor, Department of Immunology

LCME subcommittees

*member, Task Force

INSTITUTIONAL SETTING

1. Co-Chair: Lawrence Klobutcher, Ph.D., Professor, Department of Molecular, Microbial, and Structural Biology; Associate Dean of the Graduate School
2. Co-chair: William B. White, M.D., Professor, Department of Medicine, Calhoun Cardiology Center
3. Matt Andersen, MSIV
4. Noel Baker, MSIII
5. *Nancy Bull, Ph.D., Vice Provost for Academic Administration, UCONN Storrs
6. *Judith Fifield Ph.D., (Professor, Department of Family Medicine; Director, Ethel Donaghue Center for Translating Research into Practice and Policy
7. *Jon Goldberg, Ph.D., Professor, Department of Reconstructive Sciences, SODM; Member of the BOD)
8. Bruce Gould, M.D., Professor, Department of Medicine; Associate Dean for Primary Care

9. *Marja Hurley, M.D., Professor, Department of Medicine; Associate Dean, Health Career Opportunity Programs)
10. Jessica Johnson, MSII
11. Shigeyuki Kuwada, Ph.D., Professor, Department of Neuroscience
12. Judy Lewis, M.Phil., Professor Emeritus, Department of Community Medicine and Health Care
13. *Bruce Liang, M.D., Professor, Department of Medicine; Director, Pat and Jim Calhoun Cardiology Center
14. Leslie Loew, Ph.D., Professor, Department of Cell Biology; Director, Center for Cell Analysis and Modeling
15. Gregory Makoul, Ph.D., Vice President for Academic Affairs and Chief Academic Officer, St. Francis Hospital and Medical Center)
16. Glenn Russo, MSI
17. Pramod Srivastava, Ph.D., M.D., Professor and Interim Chair, Department of Immunology

EDUCATIONAL PROGRAM LEADING TO THE MD DEGREE

1. Chair: Gerald Maxwell, Ph.D., Professor, Department of Neuroscience, Associate Dean for Postdoctoral and External Affairs
2. Co-chair: *Charles Huntington MPH, PA, Associate Professor, Community Medicine and Health Care, Associate Dean for Continuing and Community Education
3. Cheyenne Beach, MSIII
4. Robert Bona, M.D., Professor, Department of Medicine
5. Stacey Brown, Ph.D., Assistant Professor, Department of Community Medicine and Health Care
6. Luis Diez-Morales, M.D., Associate Professor, Department of Medicine
7. Todd Falcone, MSIV
8. David Gregorio, Ph.D., Professor, Department of Community Medicine and Health Care
9. *Yusef Khan, Ph.D., Assistant Professor, Department of Orthopaedics
10. *Lynn Kosowicz, M.D., Associate Professor, Department of Medicine
11. Barbara Kream, Ph.D., Professor, Department of Medicine
12. Zita Lazzarini, JD, MPH, Associate Professor, Department of Community Medicine and Health Care
13. Xue-Jun "June" Li, Ph.D., Assistant Professor, Department of Neuroscience
14. Louise McCullough, M.D., Ph.D., Associate Professor, Department of Neurology
15. Lakshmi Nair, Ph.D., Assistant Professor, Department of Orthopaedic Surgery
16. Ellen Nestler, M.D., Associate Professor, Department of Medicine
17. Jacqueline (Kiki) Nissen, M.D., Associate Professor, Department of Medicine, Associate Dean for Graduate Medical Education
18. Eugene Orientale, M.D., Associate Professor, Department of Family Medicine
19. Carol Pfeiffer, Ph.D., Professor, Department of Medicine
20. Ben Ristau, MSIV
21. Melinda Sanders, M.D, Professor and Chair, Department of Pathology and Laboratory Medicine
22. Peter Schnatz, DO, Associate Professor, Department of Obstetrics and Gynecology
23. S. Brett Sloan, M.D., Assistant Professor, Department of Dermatology
24. Bruce White, Ph.D., Professor, Department of Cell Biology
25. Qian Wu, M.D., Assistant Professor, Department of Pathology and Laboratory Medicine

MEDICAL STUDENTS

1. *Chair: David Henderson, M.D., Associate Professor, Department of Family Medicine
2. Umapathy Channamalappa, M.D., Assistant Professor, Department of Psychiatry
3. Andrea Devereux, Financial Aid Director
4. Francis DiMario, M.D., Professor, Department of Pediatrics
5. *Robert Englander, M.D., Professor, Department of Pediatrics
6. Gary Gollan, Director, Educational Support Services

7. Mark Greenstein, M.D., Professor, Department of Pediatrics
8. Yvonne Grimm-Jorgensen, Ph.D., Assistant Professor, Department of Cell Biology
9. Anne Kenny, M.D., Associate Professor, Department of Medicine
10. Christine Niekrash, DMD, Assistant Professor, Department of Surgery
11. Kathleen Olsen, MSII, Member, Admissions Committee
12. *Joseph Palmisano, M.D., Professor and Interim Chair, Department of Medicine
13. Joseph Palter, MSII, Member, Admissions Committee
14. Charles Rowland, Student Health Plan Administrator
15. Melinda Sanders, M.D, Professor and Chair, Department of Pathology and Laboratory Medicine
16. Keat Sanford, Ph.D., Assistant Dean for Student Affairs
17. Roger Thrall, Ph.D., Professor, Department of Immunology
18. *Lori Wilson, M.D., Assistant Professor, Department of Surgery
19. Carol Wu, Ph.D., Assistant Professor, Immunology
20. *Richard Zeff, Ph.D., Professor, Department of Immunology

FACULTY

1. Chair: Nancy Adams, M.D., Professor, Department of Medicine
2. Co-chair: Peter Setlow, Ph.D., Professor, Department of Molecular, Microbial, and Structural Biology
3. Paul Baldwin, MSIII
4. John Carson, Ph.D., Professor, Department of Molecular, Microbial, and Structural Biology
5. Samantha Foy, MSIV
6. *Jeri Hepworth, Ph.D., Professor and Vice-Chair, Department of Family Medicine
7. Shan Shan Jiang, MSII
8. Marc Lalande, Ph.D., Professor and Chair, Department of Genetics and Developmental Biology, and Senior Associate Dean for Research Planning and Coordination
9. Iris Mauriello, Corporate Compliance Integrity and Privacy Officer
10. Bruce Mayer, Ph.D., Associate Professor, Department of Genetics and Developmental Biology
11. Raj Shah, MSI
12. Richard Simon, M.D., Professor, Department of Surgery
13. Howard Tennen, Ph.D., Professor, Department of Community Medicine and Health Care
14. Leslie Wolfson, M.D., Professor and Chair, Department of Neurology
15. Laverne Wright, M.D., Assistant Professor, Department of Medicine
16. *Neil Yeston, M.D., Assistant Dean for Medical Education, Hartford Hospital

EDUCATIONAL RESOURCES

1. Chair: Robert Cushman, M.D., Professor and Chair, Department of Family Medicine
2. Selorm Adzaku, MSI
3. Peter Albertsen, M.D., MBA, Professor, Department of Surgery, Associate Dean for Clinical Affairs, Associate Dean for Clinical Research Planning and Coordination
4. Cliff Berg, MSIII
5. Margaret Briggs-Gowan, Ph.D., Assistant Professor, Department of Psychiatry
6. *Michelle Cloutier, M.D., Professor, Department of Pediatrics
7. Elizabeth Eipper, Ph.D., Professor, Department of Molecular, Microbial, and Structural Biology
8. Heather Forouhar-Graff, MSIII
9. Joshua Giaccotto, MSII
10. *David Gillon, CPA, Associate Dean for Finance and Administration
11. Poornima Hegde, M.D., Assistant Professor, Department of Pathology and Laboratory Medicine
12. George Kuchel, M.D., Professor, Department of Medicine, Director, Center on Aging
13. Yanko Michea, MD. Ph.D., Director, Faculty Instructional Technology Services
14. Evelyn Morgan, MSLS, AHIP, Library Director
15. Hilary Onyiuke, M.D., Associate Professor, Department of Surgery

16. *Achilles Pappano, Ph.D., Professor, Department of Cell Biology
17. Lawrence Raisz, M.D., Professor Emeritus, Department of Medicine
18. Edwin Zalneraitis, M.D., Professor, Department of Pediatrics, Assistant Dean for Medical Education, Connecticut Children's Medical Center

SIZE OF THE MEDICAL SCHOOL CLASS

1. *Chair: Dan Henry, M.D., Professor, Department of Medicine
2. Thomas Agresta, M.D., Associate Professor, Department of Family Medicine
3. Paula Algranati, M.D., Professor, Department of Pediatrics
4. Enrique Ballesteros, M.D., Assistant Professor, Department of Pathology and Laboratory Medicine
5. Philip Batista, MSIII
6. Jennifer Bordonaro, MSII
7. Winston Campbell, M.D., Professor, Department of Obstetrics and Gynecology
8. Petra Clark-Dufner, Associate Director, CT AHEC and Director, Urban Service Track
9. Stephen Crocker, Ph.D., Assistant Professor, Department of Neuroscience
10. *Paul Dworkin, M.D., Professor and Chair, Department of Pediatrics
11. *David Gillon, CPA, Associate Dean for Finance and Administration
12. Gary Gollan, Director, Educational Support Services
13. Bruce Gould, M.D., Associate Dean for Primary Care
14. Karen Harrington, MSW, Assistant Professor, Department of Community Medicine and Health Care
15. *David Henderson, M.D., Associate Professor, Department of Family Medicine
16. Bill Hengstenberg, Director, Biomedical and Media Communications Department and Video Communications Department
17. *Charles Huntington, MPH, PA, Associate Professor, Department of Community Medicine and Health Care, and Associate Dean for Continuing and Community Education
18. Robert Kozol, M.D., Professor and Chair, Department of Surgery
19. Chad Sagnella, MSI
20. Robert Tryon, Project Manager and Space Planner
21. *Sandra Weller, Ph.D., Professor and Chair, Department of Molecular, Microbial, and Structural Biology

STUDENT SURVEY

1. Kara Watts (MS III)
2. Katherine Farmer (MS I)
3. Kathaleen Gravel (MS IV)
4. Kristin Loening (MS III)
5. Nimit Patel (MS I)
6. Natercia Rodrigues (MS II)
7. Jonathan Romak (MS III)
8. Frank Santoro (MS IV)
9. Austin Schirmer (MS II)

Self-study Summary Findings

1. *Summarize the medical education program's strengths; challenges, including potential areas of noncompliance with accreditation standards; and areas in transition that may impact future compliance with standards. Analyze changes that have occurred since the last survey visit. Have new strengths or problems emerged? Are changing conditions likely to cause problems in the near future?*
2. *Note major recommendations for the future. How can the strengths be maintained and the most pressing problems addressed? Be brief, but specific in describing actions that will need to be (or already have been) taken.*

In our 2003 accreditation letter, the following **strengths** were noted. We believe they continue.

1. Innovative curriculum
2. Student Continuity Practice
3. Dedicated faculty, including volunteer faculty, who are appreciated by the students.
4. Clinical Skills Assessment program
5. Diverse student body

To that list we would add:

6. Renovated educational facilities including auditoria, small classrooms, the Clinical Skills Assessment suite, the Simulation Center, library with 24/7 study rooms, and information technology resources and support
7. Provisions for student safety
8. Student relationships with faculty and administration and their satisfaction with participation on education governance committees
9. Maintenance of research funding in spite of a smaller basic science faculty

Areas of weakness and potential noncompliance, and how we are addressing them

1. Diversity of faculty. The diversity of our faculty is not reflective of the population of Connecticut nor of medical school faculty nationally. The VP for Health Affairs/Dean has moved quickly to establish clear expectations that we will address this problem quickly, consistently, and fairly. Most notably, our approach to hiring now requires members of search committees to be trained in the development of a diverse applicant pool, and with few exceptions, competitive searches must be conducted. We are also turning our attention to a range of faculty development efforts that we hope will assist with faculty retention. The Senior Associate Dean for Faculty Affairs has been given new responsibilities in this area. The Vice-Chair for Family Medicine has been assigned to devote 30% time in the Office of Faculty Affairs on faculty development. The development of these programs will benefit from close collaboration with the expertise in the Office of Diversity and Equity.
2. Education regarding the principles of clinical and translational research. We have identified clinical and translational research as an area of deficit for our students. The Dean for Academic Affairs has appointed a committee of faculty to develop coordinated ways of introducing this material into our curriculum. Thee committee has begun by identifying a number of areas where related teaching is occurring (see the ED data base). Next steps are to identify additional needs and plan curriculum.
3. Exposure to specialty fields. The student survey identified exposure to specialty fields as a weakness. We have already taken two specific steps to address the concern. First, we have established a formal shadowing program (discussed in the MS data base) and secondly, we have planned required clerkships in Neurology in the 3rd year and Radiology in the 4th year. These clerkships are being piloted currently and will be fully implemented in the 2010/1011 academic year.
4. Timeliness of completion of clerkship evaluations. The student survey report states concern about the timeliness of receiving evaluations. The implementation of electronic evaluations in the last academic

year seems to have largely resolved this problem with the possible exception of surgery. Educational leaders met this past winter with surgery site directors at all locations and are working actively to rectify this issue.

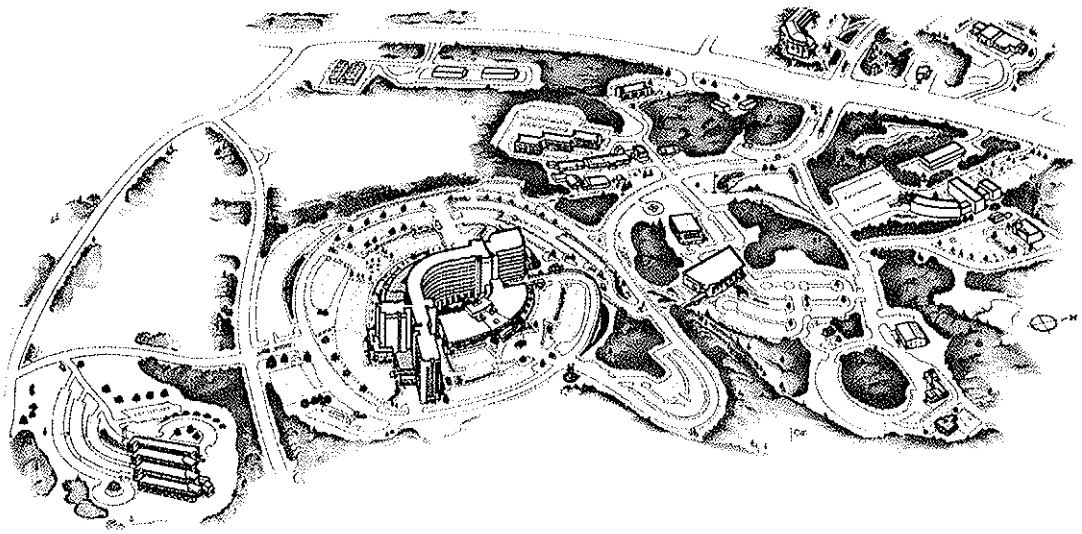
5. Career and residency counseling. The student survey identifies career and residency counseling as an area of weakness, with 2nd year students giving the lowest ratings. The 2009 Graduation Questionnaire also shows that we rank below the national average in all areas of career planning services. In spite of this, 90.2% of our graduates felt very or moderately confident about their specialty choice. We are intent on developing our programs in this area. The MS data base has detailed information about the steps we take to assist students in career choices. In addition, the Office of Medical Student Affairs is working to develop a formal program of career counseling in Phase I (see Appendix 57), and a formal shadowing program called the "Clinical Experiential" has been implemented in this academic year.
6. Student indebtedness. On the student survey, the vast majority of students strongly agreed, agreed, or were neutral about the adequacy of financial aid counseling and services offered. Nonetheless, since we are required by policy of the Board of Governors Of Higher Education to set our tuition and fees between the 70th and 75th percentile for state-funded medical schools, we are concerned about our students' debt. To offset student borrowing, the SOM has increased scholarship and grant support from $981,000 in 1997/98 to $2,399,250 in 2009/10. The actual amount of scholarship and grant aid received increased from 17% to 29% of all aid secured. This increase is attributed to greater institutional commitment related to combined degree program support, scholarship support for URM students, and merit scholarship support. The increased scholarship support, as well as increased debt counseling services for entering, ongoing, and exiting students appears to have curbed excessive indebtedness. The SOM current Cohort Default Rate with the US Department of Education is zero, indicating that our graduates are able to successfully manage their indebtedness.
7. Number of faculty. While we are able to execute our educational program with our present faculty, the concerns we expressed at the time of our 2003 accreditation that our ranks were thinning have only grown. A significant number of faculty with key teaching and educational leadership roles have retired or are approaching retirement age. Several faculty members have expressed a desire to relinquish leadership roles but have been unable to identify replacements. The pressures on the faculty to produce revenue have made it more difficult to have a cohort of young faculty who gradually take on teaching and educational leadership roles. We have similar concerns about the numbers of research faculty and our ability to achieve our aspirations to be a top tier research institution. Fortunately, we have been able to obtain administrative approval for 24 strategic clinical faculty hires in recent months, as well as the basic science faculty mentioned earlier (a total of 8 research strategic plan hires, four biostatics hires with three based at UCHC, and 4-7 hires into the newly created Biomedical Informatics Center).

Areas in transition:

1. The Partnership with Hartford Hospital. The way in which we will address the structural weaknesses in our clinical mission will depend to a large extent on the outcome of this initiative.
2. The Collaborative. This initiative to significantly strengthen our academic collaborations with our affiliated hospitals in education and research is a new attempt at the institutional level. Our history is one of primarily working together at the departmental or discipline level to develop clerkships and manage residencies.
3. Faculty unionization. The faculty vote to unionize or not will be held in November 2009. The outcome of this vote could have an impact on the proposed Partnership with Hartford Hospital.

4. Conflict of interest policy for the Board of Directors. Our BOD has not had a Conflict of Interest policy but one has been developed and will be submitted to the BOD for consideration at its December 2009 meeting.
5. Student evaluations of courses and teachers. For some time we have had in place student evaluations of courses and clerkships, clinical teachers, and teachers in CMC and CMPS. Only in the current academic year have we fully implemented an electronic method for students to evaluate their teachers in the basic medical science courses. We will have some data on how this is progressing at the time of the site visit. The committee that developed these plans was explicit that necessary components of teaching evaluation must include peer evaluation and faculty development. The Office of Faculty Affairs will begin work with the Dean for Academic Affairs to develop these components of the program.
6. Faculty development. With the exception of well established programs to help faculty understand the mechanisms of academic advancement, we have been deficient in opportunities for faculty development in research and education. Our efforts to obtain a CTSA have led to the establishment of CICATS. Between HCRAC and the GCRC, which have been in place for a number of years, and newly developed programs from the TRIPP Center and CICATS, we now have a number of opportunities to help young faculty develop research programs. We have work to do in helping faculty to be aware of the opportunities, and then structure the developing CREATE program so that TE unfunded time is made available to those who wish to develop new skill sets and begin research programs. The assignment of a person to the Office of Faculty Affairs in the area of faculty development will be critical to beginning programs for educational development. The newly created Academy of Distinguished Educators will provide a core group of teachers and role models who will be instrumental in these efforts.

CAMPUS MAP



A Academic Building C-4
ARC American Red Cross B-9
ASB Administrative Services Building C-7
B Building B D-4
B5 Building 5 B-6
B6 Building 6 B-6
B18 Building 18 B-7
B20 Building 20 D-4
C Clinic Building D-5
CCCC Creative Child Care Center D-9
DN Dowling North B-6
DS Dowling South B-6
DU UConn Dialysis Unit A-10
E Academic Research Building D-5
EX The Exchange A-8
FIRE Firehouse D-9
FSC Farmington Surgery Center C-7
GH Green House D-8
GR Grounds C-10
H John Dempsey Hospital C-5
L Lab Building C-5
LCR Lower Campus Research Complex B-6
MARB Medical Arts and Research Building C-7
MEB Medical Examiner's Building C-10
MUN 16 Munson Road E-2
WARE Warehouse D-9

Entry from the 2008-2009 AAMC Directory

University of Connecticut School of Medicine

263 Farmington Avenue
Farmington, Connecticut 06030
860-679-2000; 679-2594 (dean's office); 679-1255 (fax)
Web site: http://medicine.uchc.edu/

The University of Connecticut School of Medicine appointed its first faculty members in 1963 and admitted its first class in 1968. The University of Connecticut Health Center, 35 miles from the main university campus, includes the school of medicine, school of dental medicine, ambulatory services, and John Dempsey Hospital.

Type: public
2008-2009 total enrollment: 337
Clinical facilities: John Dempsey Hospital, Connecticut Children's Medical Center, Veterans Administration Medical Center (Newington), Bristol Hospital, Hartford Hospital, the Institute of Living, Middlesex Memorial Hospital, Mount Sinai Hospital, New Britain General Hospital, Hospital for Special Care, Saint Francis Hospital and Medical Center, the Hebrew Home and Hospital.

University Officials

President . . . Michael J. Hogan
Vice President, Health Affairs . . . Cato T. Laurencin, M.D., Ph.D.
Chief Financial Officer . . . Daniel L. Upton
Chief Information Officer . . . Sandra Armstrong
Associate Vice President, Facilities Management . . . Daniel Penney
Associate Vice President, Research Administration and Finance . . . Jeff Small
Associate Vice President, Human Resources . . . Brian Eaton
Associate Vice President, Communications . . . James Walter
Associate Vice President, Budget . . . Lisa Danville
Director, John Dempsey Hospital . . . James Thornton
Medical Director, U Conn Medical Group . . . Peter Albertsen, M.D.

Medical School Administrative Staff

Dean . . . Cato T. Laurencin, M.D., Ph.D.
Dean for Academic Affairs . . . Bruce M. Koeppen, M.D., Ph.D.
Associate Dean, Administration and Finance . . . David C. Gillon
Associate Dean, Clinical Affairs . . . Peter C. Albertsen, M.D.
Associate Dean, Clinical Research Planning and Coordination . . . Peter C. Albertsen, M.D.
Associate Dean for Continuing Education . . . Charles Huntington, M.P.H.
Associate Dean, Faculty Affairs . . . Mary Casey Jacob, Ph.D.
Associate Dean of the Graduate School . . . Lawrence A. Klobutcher, Ph.D.
Associate Dean, Graduate Medical Education . . . Jacqueline Nissen, M.D.
Associate Dean, Health Career Opportunity Program . . . Marja Hurley, M.D.
Associate Dean for Health Informatics . . . Renee Drabier, Ph.D.
Associate Dean for Postdoctoral and External Affairs . . . Gerald D. Maxwell, Ph.D.
Associate Dean, Primary Care . . . Bruce Gould, M.D.
Associate Dean, Research Planning and Coordination . . . Marc E. Lalande, Ph.D.
Associate Dean, Student Affairs . . . Anthony J. Ardolino, M.D.
Assistant Dean, Clinical Affairs . . . Jane Grant-Kels, M.D.
Assistant Dean, Health Career Opportunity Program . . . Open
Assistant Dean, Student Affairs . . . Keat Sanford, Ph.D.

Department and Division or Section Chairs

Basic Sciences

Cell Biology . . . Laurinda A. Jaffe, Ph.D. (Interim)
Community Medicine and Health Care . . . Thomas Bubor, Ph.D.
Genetics and Developmental Biology . . . Marc Lalande, Ph.D.
  Division of Genetics . . . Robert M. Greenstein, M.D.
Immunology . . . Pramod Srivastava, Ph.D.
Molecular, Microbial, and Structural Biology . . . Sandra K. Weller, Ph.D.
Neuroscience . . . Richard Mains, Ph.D.

Clinical Sciences

Anesthesiology . . . Jeffrey B. Gross, M.D.
Dermatology . . . Jane Grant-Kels, M.D.
Diagnostic Imaging and Therapeutics . . . Douglas Fellows, M.D.
  Radiation Oncology . . . Robert Dowsett, M.D.

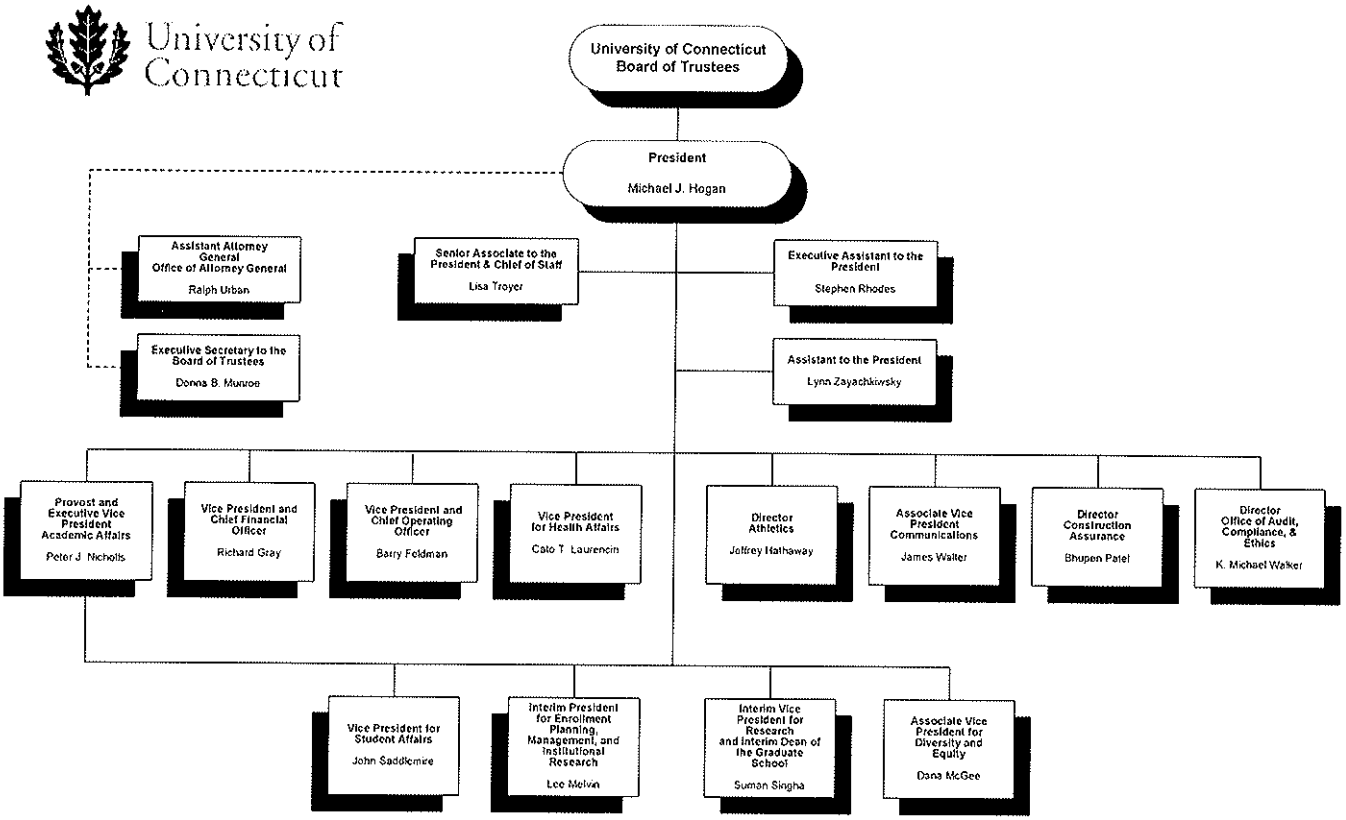
- Radiology . . . Douglas Fellows, M.D.
  - Nuclear Medicine . . . Mozafareddin Karimeddini, M.D.
- Family Medicine . . . Robert A. Cushman, M.D.
- Medicine . . . Joseph Palmisano, M.D. (Interim)
  - Cardiology . . . Bruce T. Liang, M.D.
  - Endocrinology . . . Andrew Arnold, M.D.
  - Gastroenterology . . . John Birk, M.D.
  - General Medicine . . . Adam Silverman, M.D.
  - Geriatrics . . . George Kuchel, M.D.
  - Hematology and Oncology . . . Robert Bona, M.D.
  - Hypertension . . . William B. White, M.D.
  - Infectious Diseases . . . Kevin Dieckhaus, M.D.
  - Nephrology . . . Nancy Adams, M.D.
  - Public Health and Population Sciences . . . Robert Trestman, M.D., Ph.D.
  - Pulmonary and Critical Care Medicine . . . Daniel McNally, M.D. (Interim)
  - Rheumatology . . . Micha Abeles, M.D. (Interim)
- Neurology . . . Leslie Wolfson, M.D.
- Obstetrics and Gynecology . . . James F. X. Egan, M.D.
  - Gynecological Oncology* . . . Molly A. Brewer, M.D.
  - Maternal Fetal Medicine* . . . Winston A. Campbell, M.D.
  - Reproductive Endocrinology and Infertility . . . John C. Nulsen, M.D.
  - Urogynecology . . . Open
  - Generalist . . . Joseph Walsh, M.D.
- Orthopaedic Surgery . . . Jay Lieberman, M.D.
- Pathology and Laboratory Medicine . . . M. Melinda Sanders, M.D.
- Pediatrics . . . Paul Dworkin, M.D.
  - Adolescent Medicine* . . . Aric Schichor, M.D.
  - Ambulatory and Community Affairs . . . Open
  - Behavioral and Development* . . . Neil L. Schechter, M.D.
  - Cardiology* . . . Harry Leopold, M.D.
  - Child and Family Studies* . . . Mary Beth Bruder, Ph.D.
  - Community Pediatrics* . . . Douglas MacGilpin, M.D., and Larry Scherzer, M.D.
  - Critical Care* . . . Aaron Zucker, M.D.
  - Endocrinology* . . . Karen R. Rubin, M.D.
  - Education and Residency Program* . . . Edwin L. Zalneraitis, M.D.
  - Gastroenterology* . . . Jeffrey S. Hyams, M.D.
  - General Pediatrics . . . Richard C. Antonelli, M.D., and Lee M. Pachter, D.O.
  - Hematology and Oncology* . . . Nathan Hagstrom, M.D.
  - Hospitalist Care . . . Robert Englander, M.D.
  - Infectious Diseases* . . . Peter Krause, M.D.
  - Neonatology and Perinatal Medicine . . . Victor C. Herson, M.D. (Interim)
  - Nephrology* . . . Majid Rasoulpour, M.D.
  - Neurology* . . . Francis Di Mario, M.D.
  - Pediatric Allergy and Immunology* . . . Louis Mendelson, M.D.
  - Pediatric Emergency Medicine . . . M. C. Culbertson, M.D.
  - Pediatric Dermatology . . . Mary Chang, M.D.
  - Pediatric Pathology* . . . Vijay Joshi, M.D.
  - Pediatric Psychiatry* . . . Robert Sahl, M.D.
  - Pediatric Radiology* . . . Timothy Brown, M.D.
  - Pediatric Rehabilitative Medicine* . . . Open
  - Pediatric Research* . . . Georgine S. Burke, Ph.D.
  - Pediatric Rheumatology* . . . Lawrence Zemel, M.D.
  - Pulmonary Medicine* . . . Craig Schramm, M.D.
- Psychiatry . . . Leighton Huey, M.D.
- Surgery . . . Robert A. Kozol, M.D.
  - Cardiothoracic Surgery . . . Paul L. Preissler, M.D.
  - General Surgery . . . Robert A. Kozol, M.D.
  - Neurosurgery . . . Hilary Onyiuke, M.D.
  - Ophthalmology and Clinical . . . Jeanine Suchecki, M.D.
  - Otorhinolaryngology . . . Denis Lafreniere, M.D.
  - Plastic Surgery . . . Rajiv Y. Chandawarkar, M.D.
  - Surgery Research . . . Open
  - Urology . . . Peter Albertsen, M.D.
- Traumatology and Emergency Medicine . . . Lenworth Jacobs, M.D.

*Specialty without organizational autonomy.

AAMC *Directory of American Medical Education* update

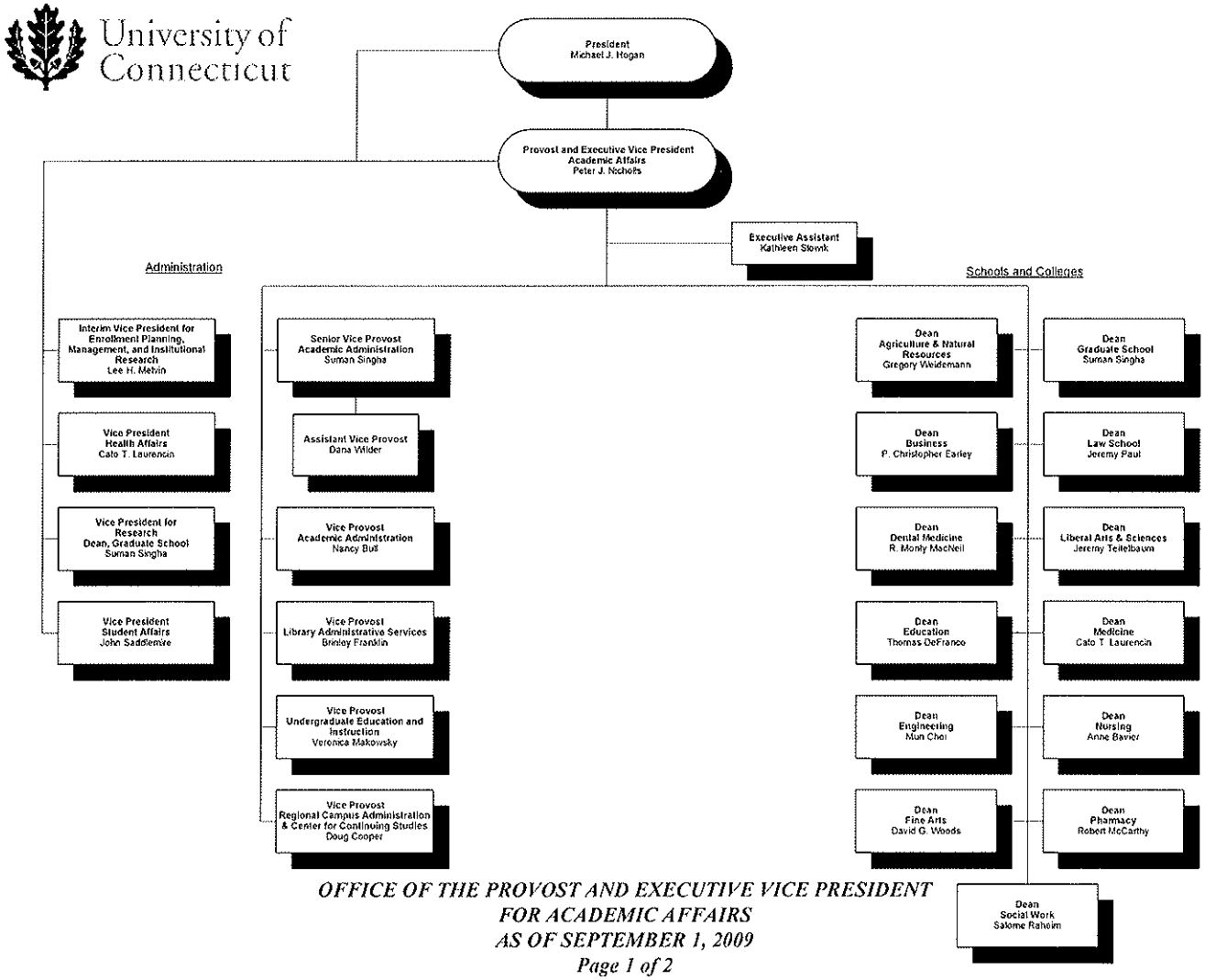
1. Chief Financial Officer – John Biancamano
2. Associate Vice President, Facilities Management – Thomas P. Trutter
3. Associate Vice President, Communications is now Director of Marketing and Communications - Maureen McGuire
4. Interim Director, John Dempsey Hospital - Michael Summerer, M.D.
5. The position of Associate Dean for Clinical Research, Planning, and Coordination has been eliminated.
6. Mary Casey Jacob, Ph.D.'s title is now Senior Associate Dean for Faculty Affairs
7. Associate Dean for Health Informatics – Open
8. Marc Lalande, Ph.D.'s title is now Senior Associate Dean for Research Planning and Coordination
9. Assistant Dean, Health Career Opportunity Program – Granville Wrensford, Ph.D.
10. The interim Division Head of the Division of Genetics in the Department of Genetics and Developmental Biology is now Sally Rosengren, M.D.
11. Dr. Pramod Srivastava is the Interim Chair of Immunology, and a Ph.D., M.D.
12. Dr. Denis Lafreniere is the interim Chair of Surgery.
13. Dr. Dan McNally is the Division Head of Pulmonary and Critical Care in the Department of Medicine (he is no longer interim)
14. Dr. Ann Milanese is the Head of the Behavioral and Development Division in the Department of Pediatrics
15. Dr. Catherine Wiley is the Interim Head of the Division of General Pediatrics in the Department of Pediatrics
16. The Division of Hospital Care in the Department of Pediatrics is now the Division of Hospital Medicine
17. Dr. Juan Salazar is the Head of the Division of Infectious Diseases in the Department of Pediatrics
18. The Division Head position for the Division of Dermatology in the Department of Pediatrics is open
19. A new Division of Pain Medicine has been created in the Department of Pediatrics, and the Division Head is Dr. Neil Schechter
20. Dr. Mansoor Sarfarazi is the Head of the Division of Surgery Research in the Department of Surgery

Organizational Chart
Vice President for Health Affairs & Health Center in relationship to rest of University



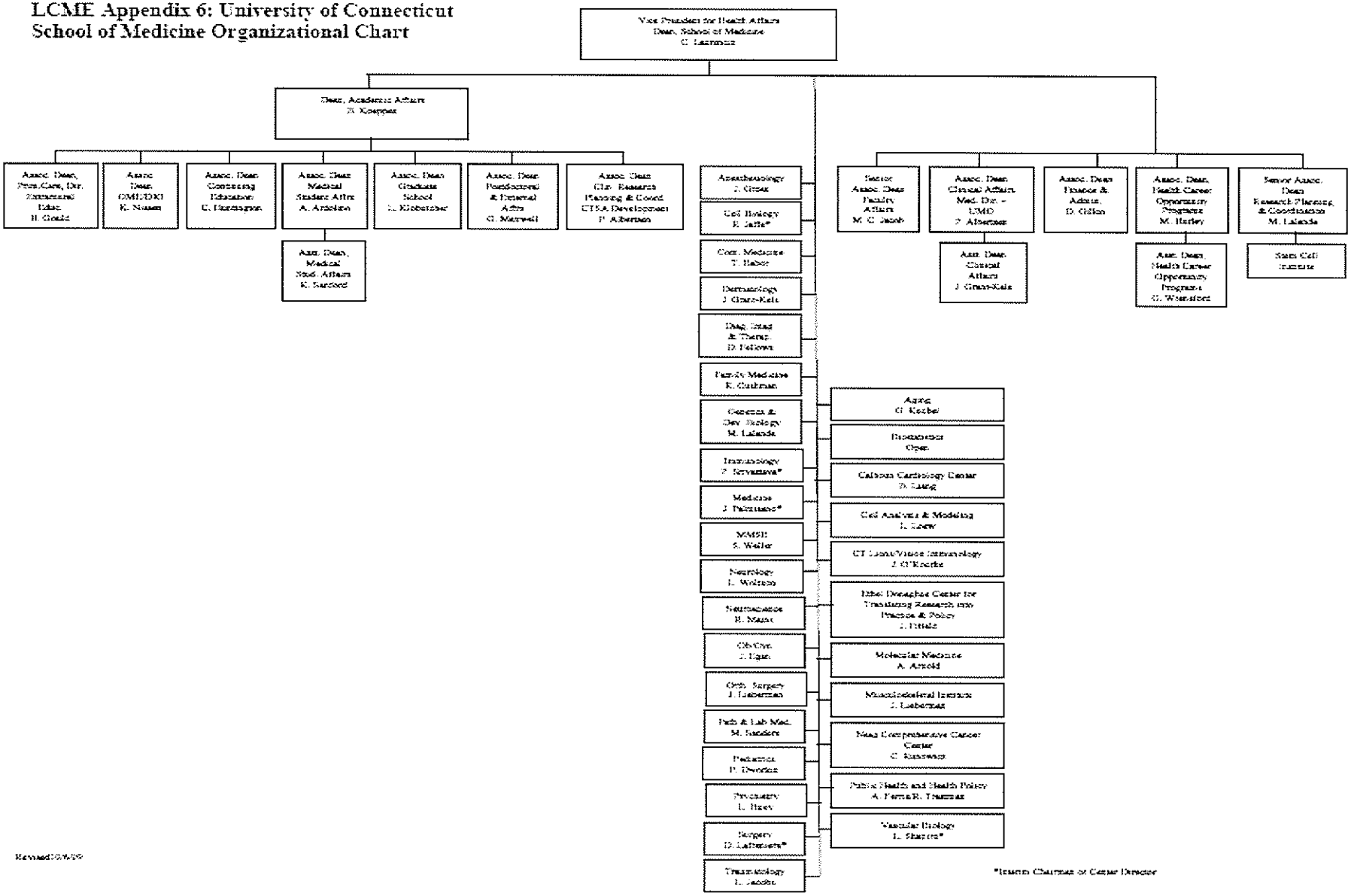
OFFICE OF THE PRESIDENT
AS OF SEPTEMBER 1, 2009

Organizational Chart
Dean, School of Medicine, in relationship to rest of University



OFFICE OF THE PROVOST AND EXECUTIVE VICE PRESIDENT
FOR ACADEMIC AFFAIRS
AS OF SEPTEMBER 1, 2009
Page 1 of 2

LCME Appendix 6: University of Connecticut School of Medicine Organizational Chart



Revised 10/4/09

*Denotes Chairman or Center Director

Cato Thomas Laurencin

Personal Data: 50 Far Hills Drive
Avon, CT 06001
(860) 679-2594

Place of Birth: Philadelphia, PA
Email: Laurencin@uchc.edu

Position (August, 2008)

Vice President for Health Affairs and Dean of the College of Medicine
Van Dusen Distinguished Professor of Orthopaedic Surgery
Professor of Chemical, Materials, and Biomolecular Engineering
The University of Connecticut

Education

1987 M.D. Degree, *Magna Cum Laude*
Harvard Medical School

1987 Ph.D. Degree, Biochemical Engineering/Biotechnology,
Massachusetts Institute of Technology

1980 B.S.E. Degree, Chemical Engineering,
Princeton University

1976 B.A. Central High School, Philadelphia, Pa.

Clinical Training

1993-1994 Fellow, Sports Medicine and Shoulder Surgery
Cornell University Medical Center
The Hospital for Special Surgery

1993 Chief Resident in Orthopaedic Surgery
Harvard Medical School
The Beth Israel Hospital

1988-1993 Resident in Orthopaedic Surgery
Harvard Combined Orthopaedic Surgery Program

1987-1988 Surgical House Officer
The Pennsylvania Hospital, Philadelphia, Pennsylvania

Certifications and Fellowship Designations
Diplomate, National Board of Medical Examiners, U.S. 1988
Board Certification in Orthopaedic Surgery, 1996
Fellow, American Academy of Orthopaedic Surgeons, 1998
Fellow, American College of Surgeons, 1998
Fellow, American Institute for Medical and Biological Engineering, 2000

International Fellow, Biomaterials Science and Engineering, 2000
Re-certification in Orthopaedic Surgery (through 2016), 2004

Other Training**
American Orthopaedic Association (AOA) Leadership Series (Part I) 2003
Kellogg School of Business, Northwestern University
American Orthopaedic Association (AOA) Leadership Series (Part II) July, 2004
Kellogg School of Business, Northwestern University
American Orthopaedic Association (AOA) Leadership Series (Part III) July, 2005
Kellogg School of Business, Northwestern University
Fundamentals of Finance for the Technical Executive March, 2005
Sloan School of Management, Massachusetts Institute of Technology
Dealing with Difficult People and Difficult Situations September, 2005
Harvard Law School, Program on Negotiation
The Program on Negotiation for Senior Executives, September, 2005
Harvard Law School, Program on Negotiation

Employment

2003-2008 University Professor
Lillian T. Pratt Distinguished Professor of Orthopaedic Surgery
Chairman, Department of Orthopaedic Surgery
Professor of Biomedical Engineering
Professor of Chemical Engineering
The University of Virginia

2002-2003 Helen I. Moorehead Distinguished Professor of Chemical Engineering
Drexel University

Vice Chairman, Department of Orthopaedic Surgery
Drexel University, School of Medicine

Clinical Professor of Orthopaedic Surgery
Drexel University, School of Medicine
Philadelphia, PA

Director of Shoulder Surgery
Hahnemann Hospital, Drexel University School of Medicine

Orthopaedic Surgery: 1994-2002

2001-2002 Clinical Professor of Orthopaedic Surgery
MCP-Hahnemann School of Medicine, Philadelphia, PA

1998-2001 Clinical Associate Professor of Orthopaedic Surgery
MCP-Hahnemann School of Medicine, Philadelphia, PA

1994-1998	Associate Professor of Orthopaedic Surgery MCP-Hahnemann School of Medicine, Philadelphia, PA

Engineering and Science: 1994-2002

1998-2002	Helen I. Moorehead Professor of Chemical Engineering Director, Center for Advanced Biomaterials and Tissue Engineering Department of Chemical Engineering Drexel University, Philadelphia, PA
1994-1998	Research Professor of Chemical Engineering Drexel University, Philadelphia, PA
1994-2003	Research Professor of Materials Engineering Drexel University, Philadelphia, PA
	Adjunct Professor of Biomedical Engineering Drexel University, Philadelphia, PA
2000-	Research Professor of Pharmacology and Physiology MCP-Hahnemann School of Medicine, Philadelphia, PA

Engineering and Science 1988-1994

1993-1994	Research Scientist Massachusetts Institute of Technology Division of Health Sciences and Technology
1988-1993	Instructor of Biochemical Engineering Massachusetts Institute of Technology Division of Health Sciences and Technology
1988-1989	Research Fellow Harvard Medical School Children's Hospital Medical Center, Department of Surgery

Academic and Other Teaching Experiences

2007	Instructor/Guest Lecturer Nanotechnology Virginia State Wide Course Bionanotechnology
2007	Guest Lecturer Anthroplology: The Health of Black Folks
2005-	Instructor/Guest Lecturer Biomaterials Course, Biomedical Engineering (University of Virginia)
2003	Instructor Advanced Projects in Biomedical Engineering BIOM 454 (University of Virginia) (student A. Roy)
2002	Instructor, American Academy of Orthopaedic Surgeons Grant Writing Workshop
2001-2003	Instructor and Course Director, Biological Factors in Tissue Engineering, Drexel University
2001-2003	Instructor, Cell-Mediated Tissue Engineering

1999-2003	Instructor and Course Director, Chemical Engineering Energy Processes, Drexel University
1998-2003	Instructor and Course Director, Process Material Balances, Department of Chemical Engineering, Drexel University
1997	Instructor in Shoulder, Allegheny Primary Care Curriculum in Orthopaedic Surgery
1996-1998	Instructor, Orthopaedic Learning Center, Rosemont Il, Courses on Shoulder
1996-2001	Preceptor, Philadelphia Public School District School to Careers Program
1996-2001	Preceptor, Merck-Astra Summer Clinical Program
1995-1998	Preceptor, Allegheny University of the Health Sciences Summer Minority Research Program
1994-1996	Instructor and Course Director, Allegheny University of the Health Sciences Basic Science Course in Orthopaedic Surgery (for Residents)
1995-1998	Instructor, Allegheny University of the Health Sciences Introduction to Clinical Medicine (Sports Medicine)
1995-2003	Instructor, Biomaterials (Core Materials Engineering Graduate Course for Drexel University)
1995-2003	Instructor and Course Co-Director, Tissue Engineering (Materials Engineering Graduate Course for Drexel University)
1993-1996	Preceptor, Harvard Medical School Clinical Elective Program
1990-1993	Preceptor, M.I.T. Minority Summer Science Research Program
1992	Instructor, Primary Care Orthopaedics, Harvard Medical School
1989-1990	Instructor, Biotechnology and Bioengineering (10.02J) Chemical Engineering Department, Massachusetts Institute of Technology (M.I.T.)
1989-1990	Instructor, Patient/Doctor Course (Introduction to Clinical Medicine), Harvard Medical School
1986-1987	Instructor, Physiology, M.I.T. Introduction to Health Sciences Program
1985-1987	Instructor, Biochemistry, M.I.T. M.I.T.E.S. Program (Excellence in Teaching Award, 1985)
1983	Teaching Fellow, Genetics, Harvard University
1981	Instructor, Microbiology, Harvard Medical School Pre-Matriculation Program
1981	Teaching Fellow, Cellular Biology, Harvard University

Scholarly, Academic or Teaching Awards and Honors

2009	Pierre Galletti Award, American Institute for Medical and Biological Engineering
2008	Named to "America's Leading Physicians", Black Enterprise Magazine
2008	Mallory-Coleman Visiting Professor, Ohio State University Department of Orthopaedic surgery
2008	Invited Speaker, Columbus Orthopaedic Society, Columbus, Ohio
2008	Discovery Lecturer, Vanderbilt University School of Medicine
2008	Keynote Speaker, Holland Scholars Program, University of Virginia
2008	Visiting Professor, Grand Rounds Speaker, Vanderbilt University, Department of Orthopaedic Surgery
2008	Named to Scientific American 50 Award List
2008	Keynote Speaker, Earnest Just Memorial Symposium, Medical University of South Carolina
2008	Invited Speaker, The Houston Society for Engineering in Medicine and Biology
2007	SciAm 50" by the Scientific American Magazine
2007	Who's Who in Engineering Higher Education (Academic Keys)
2007	America's Top Doctors
2007	America's Top Surgeons
2007	State of Virginia Department of Health Workforce Recognition Award
2007	Dean's Lecture, School of Medicine, University of Virginia
2007	Plenary Lecturer: U.S. Committee on Biomechanics Summit Meeting, Keystone Colorado

2007	Invited Speaker: National Institutes of Health: NIBIB Diversity Symposium, Keystone Colorado
2007	Co-Chair, American Academy of Orthopaedic Surgery – N.I.H. Workshop on Fracture Repair, Miami Florida
2007	Chair of the Shoulder Advisory Board, Anesiva Corporation
2007	International Program Committee: 7th International Symposium on Ligaments and Tendons
2007	Team Semi-finalist: Oak Ridge National Laboratories Nanonexus Competition
2007	Invited Speaker, American Association for the Advancement Science (Novel Materials and Processes for Medical Prostheses Symposium)
2007	Alvin F. Poussaint, M.D. Lecturer, Harvard Medical School
2007	Grand Rounds Speaker, Harvard Combined Orthopaedic Surgery, Brigham and Women's Hospital
2007	Grand Rounds Speaker, Brown University, Department of Orthopaedic Surgery
2007	**Elected Chair of the College of Fellows, American Institute for Medical and Biological Engineering
2007	Invited Speaker, Helen I. Moorehead-Laurencin, M.D. Research Day, Drexel University
2006	Charles H. Epps Lecturer, Howard University School of Medicine
2006	Fellow, American Academy of Nanomedicine
2006	Invited Speaker, National Academy of Sciences, Institute of Medicine Meeting (Stem Cells and Tissue Engineering) Washington, DC 2006
2006	Nicolas Andry Award (by Association of Bone and Joint Surgeons for Significant Achievements in Orthopaedic Surgery)
2006	Invited Speaker: BME-IDEA Conference, Biomedical Engineering Society Meeting, Chicago, IL
2006	Named to America's Top Surgeons http://consumersresearchcncl.org/Healthcare/top-surgeons/top_surg.htm
2006	Clemson Award (by Society for Biomaterials for Contributions to the Orthopaedic Literature)
2006	**Named to National Science Foundation Advisory Committee for the Directorate of Engineering
2006	Invited Speaker: Roundtable on Evidence Based Medicine Workshop on The Learning Healthcare System
2006	**Named to Institute of Medicine Roundtable on Evidence Based Medicine
2006	Visiting Professor Marquette University, Department of Biomedical Engineering
2006	**Named Co-Chair, National Academy of Sciences, Institute of Medicine Annual Meeting (Theme: Regeneration)
2006	Science Direct top 25 Downloaded paper for Oct.-Dec. 2004: Ligament Tissue Engineering, Cooper, J. et al., Biomaterials, 2005
2005	Keynote Speaker, Society for Biomaterials Annual Scientific Meeting
2005	**Chairman of the Steering and Oversight Committee (SOC), The NMA W. Montague Cobb Health Institute
2005	Invited Speaker, Regenerate 2005 Meeting, Atlanta Georgia
2005	Invited Guest Speaker, O, The Oprah Magazine's Dream Team of Health Experts
2005	America's Top Doctors 2005
2005	Invited Speaker National Academies President's Circle Meeting, Woods Hole, MA
2005	Ribbon Award Winner Paper Symposium AA, Materials Research Society Fall Meeting
2005	Plenary Speaker, Whitaker Foundation Summit
2004	**Named to African Scientific Committee of the African Institute of Science and Technology
2004	**Elected to National Academy of Sciences, Institute of Medicine
2004	Who's Who in America

2004	Invited Participant: Conference on Research at the Interface of the Life and Physical Sciences: Bridging the Sciences (National Science Foundation)
2004	Grand Rounds Speaker, Department of Orthopaedic Surgery, Virginia Commonwealth University, Richmond Virginia
2004	Co-Organizer, National Academy of Sciences Keck Future Initiative in Nanotechnology
2004	America's Top Doctor Award – 2004
2004	Who's Who in Medicine and Health Care
2004	Lead Symposium Organizer: Materials Research Society Fall-04 Nanotechnology and Micron Scale Materials Systems
2004	Visiting Professor, Research Day Invited Speaker, The University of Toronto
2004	Invited Speaker, Spinal Skeletal Solutions: A Global Perspective Conference, Maui, HI
2004	Invited Speaker, Running Medicine Symposium, University of Virginia
2004	Invited Speaker, The OR of the Future workshop, Endicott, MD
2003	Guest Editor, IEEE Medicine and Biology Magazine, September/October 2003
2003	Opening Speaker, Nanotechnology and Health Care International Workshop, Thanjavur, India
2003	Award of Appreciation, Student National Medical Association, Region 6
2003	Invited Speaker, The Gordon Research Conference - Biomaterials: Biocompatibility & Tissue Engineering, Plymouth, New Hampshire
2003	Member, Cancer Center, The University of Virginia
2003	Member, Biotechnology Training Faculty, The University of Virginia
2002	William Grimes Award, American Institute of Chemical Engineers
2002	Provost's Distinguished Lecturer, University of Texas at Austin
2002-2003	Member, Committee on Sciences & the Arts, The Franklin Institute, Philadelphia, PA
2002	Named to National COX-2 Advisory Board, Pfizer Corporation
2002	Profiled by Philadelphia Tribune/ Medical Section September, 2002
2002	Distinguished Professor Designation Bestowed, Drexel University
2002	Named to National Orthopaedic Sports Medicine Advisory Board: Pfizer Corporation
2002	Physician, United States Olympic Training Center, Lake Placid, New York
2002	Named Top 40 African American Physicians in Region, by Black Network Magazine
2002	Named to National Institutes of Health Council on Musculoskeletal and Skin Diseases
2002	**Named Professor of the Year, College of Engineering, Drexel University (as voted by students of the College of Engineering)
2002	Drexel University College of Engineering Outstanding Research Award
2002	Graduation Orator, Sastra University, Madras, India
2001	Awarded the 10(6) Award by Drexel University for 2001
2001	Awarded Special Recognition Award by National Medical Fellowships Inc.
2001	Awarded 2001 Leadership in Technology Award by the New Millennium Foundation
2001	Named to Osteoarthritis Advisory Board, Pfizer, Inc.
2001	**Named Top 101 Doctors in America by Black Enterprise Magazine
2001	Vice-Speaker, House of Delegates, National Medical Association
2001	Awarded 2.3MM N.I.H. RO-1 Grant for New Polymeric Materials for Tissue Engineering
2001	Keynote Speaker Northeastern Bioengineering Conference (Univ. of Conn., Storrs, Conn.)
2001	Invited Speaker, Pittsburgh Tissue Engineering Legislative Roundtable Discussion Group
2001	Organizer, Helen I. Moorehead, M.D. Women's Health Research Day, MCP-Hahnemann School of Medicine
2001	Named to Mid-Atlantic Orthopaedic Surgery Advisory Board, Merck and Co.
2001	Visiting Professor, Department of Chemical Engineering, University of Iowa
2001	Visiting Professor, Department of Chemical Engineering, University of Pittsburgh
2000	Philadelphia School Districted Retired Employees Award for Teaching and Community Service

2000 Lead Invited Speaker, AO Workshop on Bone Graft Substitutes, Davos, Switzerland
2000 Lead Chair and Organizer, American Society for Testing Materials, American Academy of Orthopaedic Surgeons Workshop on Bone Graft Substitutes
2000 Inducted Into Philadelphia Health Care Hall of Fame
2000 Visiting Professor, Howard University, Division of Orthopaedic Surgery
2000 Men's High Achiever Award, Faith Episcopal Church, Philadelphia
2000 Research Profiled by Orthopaedics Today Magazine (July, 2000)
2000 Profiled by Drexel-Link Magazine as National Innovator in Tissue Engineering April, 2000
2000 Profiled by Philadelphia Tribune/ Medical Section April, 2000
2000 American Academy of Orthopaedic Surgeons: Research Committee: Biomaterials Sub-Committee
2000 **Awarded the 10(6) Award by Drexel University for 2000
2000 Keynote Speaker, Central High School Football Awards Dinner
2000 National Medical Fellowships Hall of Fame
1999 Admissions Interviewer (clinical faculty) AUHS, Orthopaedic Surgery Program
1999 Profiled by Voice of America Radio Network
1999 **Named Fellow of the American Institute for Medical and Biological Engineering (AIMBE)
1999 Named to Genzyme Pharmaceutical Co. Scientific Advisory Board
1999 **Named International Fellow in Biomaterials Science and Engineering, by International Union of Biomaterials Societies
1999 Profiled by IEEE in "Scientists of the Millennium" Series
1999 Center for Advanced Biomaterials and Tissue Engineering Named Pennsylvania "Center of Research Excellence" by Ben Franklin Technology Program
1999 **Awarded the American Orthopaedic Association's American, British and Canadian (ABC) Traveling Fellowship
1998 Named Fellow, American College of Surgeons
1998 Elected Member, American Orthopaedic Society for Sports Medicine
1998 Visiting Professor, Department of Orthopaedic Surgery, University of Texas at San Antonio
1998 Distinguished Alumni Award, Princeton University
Association of Black Princeton Alumni
1998 Inaugural Address, Musculoskeletal Biomedical Engineering Center, University of Texas at San Antonio
1998 Invited Speaker, American Association for the Advancement of Science
1998 Invited Instructor in Shoulder Surgery, American Academy of Orthopaedic Surgery, Orthopaedic Learning Center (Rosemont, IL)
1998 Student National Medical Association, Region VII Award for Mentoring
1998 Appointed to ASTM (Amer. Soc. for Testing Mater.) F04.4 Committee (Tissue Engineering)
1998 Appointed Regular Panel Member, Food and Drug
Administration, Orthopaedic Devices Panel
1997 Keynote Speaker and Recipient, Community Service Award,
LaSalle University, Philadelphia PA
1997 Selected as Participant: National Academy of Sciences
Frontiers of Science Meeting
1997 Named Fellow, American Academy of Orthopaedic Surgeons
1997 Elected to the Council of the Society for Biomaterials
1997 Elected as an Officer of the Society for Biomaterials
1997 Named to Board of Managers, Central High School
1997 Visiting Professor, Department of Orthopaedic Surgery,
Martin Luther King Medical Center, Los Angeles, California
1997 Visiting Professor, Department of Orthopaedic Surgery,

	Baylor College of Medicine, Houston, Texas
1996	Invited Instructor in Shoulder Surgery, American Academy of Orthopaedic Surgery, Orthopaedic Learning Center (Rosemont, IL)
1996	Board Certification in Orthopaedic Surgery
1996	Named to Osteonics Corporation Scientific Advisory Board
1996	Lead Article, Journal of Biomedical Materials Research, March, 1996
1996	Founding Member, The International Cord Blood Society
1996	Visiting Professor, Medical University of South Africa, Republic of South Africa
1996	Member, U.S. Delegation to South Africa in Biomedical Engineering, Eisenhower Foundation Citizen Ambassador Program
1996	The Matilda E. Evans, M.D. Award (Outstanding Professional Achievement) Allegheny University
1995	**Presidential Faculty Fellow Award, The National Science Foundation
1995-1998	Admissions Interviewer (regular faculty) AUHS Orthopaedic Surgery Program
1993	Distinguished Service Award, Postgraduate Section, National Medical Association
1993	International Men of Achievement
1992	Who's Who in Engineering and Science
1991	Lowell Institute Lecturer for Suffolk University
1991	American Orthopaedic Association Award for Resident Research
1988	Awarded Ford Foundation Fellowship for Biomedical Engineering Research
1987	Awarded Kaiser Foundation Grant for Leadership, Scholarship in Medical School
1987	Awarded Robinson Memorial Prize for Surgery (Best Minority Medical Student in Surgery in America)
1984-1987	Awarded Hugh Hampton Young Memorial Prize (M.I.T.'s only Institute-Wide Competitive Award open to all Graduate Students)
1984	Awarded Commonwealth Fund Fellowship
1982-1987	Medical Scientist Training Program (M.S.T.P.) Grant Award, Harvard Medical School, M.D.-Ph.D. Program
1982	American Society of Anesthesiologists Fellowship
1980	Awarded Certificate of Proficiency in Afro-American Studies at Princeton University
1977-1980	Gulf Oil Honors Scholarship at Princeton University
1976	National Achievement Scholarship Award

Public and Community Service

2008	Member, National Science Advisory Board Subcommittee on Office of Regulatory Affairs, U.S. Food and Drug Association
2008	University of Virginia Search Committee: Chair of Ob-Gyn Department
2007	Appointed to Medical Advisory Board, the LPGA
2007	Elected Chair of the Board, the W. Montague Cobb/NMA Health Institute
2007	Inducted in the Third World Academy of Sciences
2007	Appointed to University of Virginia President's Leadership Group
2007	Institute of Medicine: Engineering Health Care Symposium Steering Committee
2007	University of Virginia Search Committee: Head, Division of Cardiology, Department of Medicine
2007	**Member, National Science Foundation Engineering Advisory Committee (ADCOM)
2007	Committee on Programmatic Initiatives: The Commission on the Future of the University of

	Virginia
2007	University of Virginia Search Committee: Cardiology Division Head
2006	Clinical Advisory Board, Kuros Company
2006	Clinical Advisory Board, Osteotech Company
2006	**Member, Working Group on the Evaluation of the FDA
2006	**Member, Institute of Medicine Evidence Application Working Group
2006	University of Virginia Search Committee: Rheumatology Division Head
2006	University of Virginia Search Committee: Emergency Medicine Department Chair
2006	University of Virginia Search Committee: Regenerative Medicine Division Head
2005	O, (Oprah Magazine) Dream Team Guest Expert (Chicago, New York, Atlanta, We Matter Presentations)
2005	**Drexel University Law School Faculty Advisory Board
2005	Reverend Dr. Martin Luther King Day Speaker, The University of Virginia Health System
2005	National Academies Committee on Prospering in the Global Economy of the 21st Century: Focus Group Member- Research
2005	Ad Hoc Reviewer United States - Israel Binational Science Foundation
2005	NSF Panel Member: Nanoscale Engineering Research Program
2005	Coulter Foundation Early Career Translational Research Panel Member
2005	Neurosciences Institute Steering Committee Member
2004	Scientific Advisory Board, Kuros AG
2004	Advisory Committee for the Alvin F. Poussaint, M.D. Visiting Lecture Fund
2004	National Academies KECK Futures Initiative Planning Committee
2004	Search Committee, University of Virginia Associate Dean for Clinical Research
2004	Member, Hugh Hampton Young Fellowship Committee, M.I.T.
2004	Neurosciences Project Steering Committee, University of Virginia
2003-2005	**Speaker of the House, National Medical Association
2003-	**National Advisory Board, Soldier Nanotechnology Initiative, M.I.T.
2003-2005	Executive Committee Member, Board of Trustees, National Medical Association
2003-2005	**Chairman, Governance Committee, Board of Trustees, National Medical Association
2003-	Orthopaedic Research and Education Foundation Career Development Award Review Committee
2003-	**National Science Board. U.S. Food and Drug Administration
2003	Dean for Clinical Research Search Committee, The University of Virginia School of Medicine
2003-2005	**Space Management Committee, The University of Virginia, School of Medicine
2003-	Executive Committee, Department of Orthopaedic Surgery The University of Virginia
2003-	Search Committee, Department of Orthopaedic Surgery The University of Virginia
2003-	Research Committee, Department of Orthopaedic Surgery The University of Virginia
2003-	Executive Director, University of Virginia Athletic Health Services
2003-	Clinical Staff Executive Committee, The University of Virginia Health System
2003	Operating Room Strategic Planning Committee, The University of Virginia Health System
2002	**University Merger Transition Committee, Drexel University
2002	National Institutes of Health, National Advisory Council for Arthritis, Musculoskeletal and Skin Diseases

2002	Scientific Advisory Board, ETG (Engineered Tissue Growth) Symposium
2002	External Advisory Board, Pittsburgh Tissue Engineering NIH Training Grant Program (T32)
2002	Member, Research Committee, Drexel University School of Medicine
2002	**Drexel University School of Medicine Research Taskforce/ Infrastructure Work Group
2002	**Member, Financial Oversight Committee, National Medical Association
2002	Executive Committee Member, Region II, National Medical Association (Annual Meeting)
2002-	Scientific Advisory Board Member, Gentis Company
2001	Lecturer in Pharmacology, Central High School
2001	Panel Member, Biotechnology and Life Sciences City of Philadelphia Technical Education Workforce Development Summit 2001
2001	Site Visit Team: National Science Foundation Engineering Research Center Program (Georgia Tech)
2001	Invited Participant: National Science Foundation/National Institutes of Health Workshop on Research Training Programs
2001	Advisory Board, Vanderbilt Engineering Research Center Consortium (VaNTH)
2001-2003	**Tenure and Promotion Committee, Drexel University College of Engineering
2001-2003	Vice-Speaker of the House, National Medical Association
2001-2003	**Member, Finance Committee, National Medical Association
2001- 2003	**Vice-Chair Research Development Committee, National Medical Association
2000-2003	Mediation and Grievance Panel Member, MCP-Hahnemann School of Medicine
2000-2003	Advisory Council on Councils, MCP-Hahnemann School of Medicine
2000	South Africa Site Inspection Committee, National Medical Association
2000-2003	Biomedical Technology Evaluating Committee, Ben Franklin Technology Partnerships (Eastern Pennsylvania)
2000-	Gladden Orthopaedic Surgery Society, Chairman, Research Committee
1999	Study Section Member, National Science Foundation SBIR Award Panel in Tissue Engineering, Biomaterials and Drug Delivery
1999- 2001	Reviewer Drexel Synergy Grant Program
1999- 2002	Study Section Member (ad hoc), National Institutes of Health, Orthopaedics
1999-2001	Secretary, House of Delegates, National Medical Association
1999-2001	Medical Society of Eastern Pennsylvania, Director, Educational Programs
1999-2002	Medical Society of Eastern Pennsylvania, Board of Directors
1999-	Member Board of Trustees, National Medical Association
1999-2001	Member Committee on International Affairs, Board of Trustees, National Medical Association
1999-2001	Member, Grants and Proposals Committee, Board of Trustees, National Medical Association
1999-2001	Member, Educational Affairs Committee, Board of Trustees, National Medical Association
1998	American Academy of Orthopaedic Surgery, Capitol Hill Visiting Group Member
1998-2003	Graduate Committee, Department of Chemical Engineering, Drexel University
1999	Nominations Committee Member, Society for Biomaterials
1997-1998	Contributing Editor, Biomaterials Forum Journal
1998	Advisory Committee Member, Vanderbilt University Biomedical Engineering Research Center
1998-2003	Member, Biological Implants Committee, American Academy of Orthopaedic Surgeons

1998-	Member F-04 Committee, American Society for Testing of Materials.
1998-	Ringside Physician, New Jersey State Boxing Commission
1998-2002	Guest teacher/lecturer in Chemistry, Central High School
1997-1998	Contributing Editor, Biomaterials Forum Journal
1997-1999	Chair, Medical Economics Committee, National Medical Association
1997-2000	**Member, Orthopaedic Device Panel, Food and Drug Administration
1997	Member, Committee on Biomedical Engineering and Biomedical Implants, American Academy of Orthopaedic Surgery
1997	Ad hoc committee member, Finance Committee, Society for Biomaterials
1997-1998	**Council Member, Society for Biomaterials
1997	**Chairman, Committee on Special Interests Groups, Society for Biomaterials
1997	Chairman, Society for Biomaterials, Drug Delivery Special Interest Group
1996	Vice-Chairman, Society for Biomaterials, Drug Delivery Special Interest Group
1996	U.S. Delegation to South Africa in Biomedical Engineering Member, Eisenhower Foundation
1997	Chairman, Committee on Medical Economics, National Medical Association
1997	Member, Committee on Talent Recruitment and Retention, National Medical Association
1997-1998	Member, Program Committee, Society for Biomaterials
1997	Member, Task Force on Tissue Engineering, Allegheny University of the Health Sciences
1996	Study Section Member, National Science Foundation Career Grant Award Panel in Bioengineering
1996	National Evaluation Panel Member (Study Section), Ford Foundation Pre-doctoral and Dissertation Fellowships, (Physical Science, Mathematics, and Engineering)
1996	Member, Admissions Committee, M.D.-Ph.D. Program, Allegheny University of the Health Sciences,
1996	Member, Trauma Committee, Allegheny University-MCP Allegheny University of the Health Sciences
1996	Member, Task Force on Medical Admissions, Allegheny University of the Health Sciences
1996	Member, Task Force on Graduate Education Allegheny University of the Health Sciences
1995-1998	Volunteer, Beeber Middle School Career Guidance
1995-1998	Physician Volunteer, Philadelphia Special Olympics
1994-1996	Member, Limbach Foundation Grants Committee, Allegheny University of the Health Sciences
1994-1997	Team Physician, Community College of Philadelphia
1994-1997	Physician, USA Boxing
1994-	Boxing Physician, Pennsylvania State Athletic Commission
1994-1996	Study Section Member, N.I.H. S.B.I.R. Multidisciplinary
1994-1997	Member, Main Admissions Committee (Interviewer), Allegheny University of the Health Sciences
1994-1998	Member, Institute on Aging Allegheny University of Health Sciences Special Emphasis Group
1993	Medical Staff, New York Mets Baseball Team
1993	Medical Staff, St. John's University Football Team
1993	Medical Staff, St. John's University Basketball Team
1993-1997	National Evaluation Panel Member (Study Section) National

	Science Foundation, Bioengineering
1993-2004	Member, Advisory Board, Bristol-Myers Squibb, Commonwealth Fund Fellowship Program
1992	National Evaluation Panel Member (Study Section), National Science Foundation, Bioengineering, (SBIR Program)
1993-1997	Chairman, Committee on Medical Education, National Medical Association
1991-1993	Trustee, National Medical Association
1991- 1993	Member, Grants and Proposals Committee, National Medical Association
1991-1993	Member, Centennial Committee, National Medical Association
1991-1993	Member, Membership Services Committee, National Medical Association
1991-1993	Member, Student and Auxiliary Liaison Committee, National Medical Association
1991-1992	Planning Committee Member, Ford Foundation Fellowship Program
1991-1995	Fellow, Francis Weld Peabody Society, Harvard Medical School
1991	"Scientist in Residence" Black Achievers in Science Series, Boston Museum of Science, Boston, MA
1991- 1992	Medical Staff, Boston Marathon
1990	Chairman, Planning Committee (Resident), National Medical Association
1990-	Senior Affiliate, Eliot House Senior Common Room, Harvard College
1989-1995	Chairman, Lectureship Committee, Member Coleus Alumni Association, Harvard Medical School
1999	Medical Staff, Manufacturers Hanover Road Race
1988- 1992	Mentor, Minority Summer Science Program
1988-1992	Member, Admissions Committee Minority Summer Science Program
1982-1988	Member, Board of Pre-Medical Advisors, Harvard College
1985-1987	Member, Admissions Committee, Minority Introduction to Engineering and Science (M.I.T.E.S.) Program
1982-1987	Member, Black Graduate Students Association
1984- 1993	Steering Committee Member, Co-founder, Member Hinton-Wright Biomedical Science Society
1982- 1993	Member, Senior Common Room, Eliot House, Harvard College
1982-1987	Chairman of the Pre-Medical Advisory Committee Eliot House, Harvard College
1985-1987	Consulting Pre-medical Advisor Harvard University Extension School
1982-1987	Chairman, Committee on Financial Aid The Third World Caucus, Harvard Medical School
1981-1985	Member, Harvard Medical School Admissions Committee
1981-1985	Assistant Director, Coordinator of Advising, Advisor The Harvard Summer Health Professions Program Harvard University
1981-1982	Freshman Advisor and University Proctor, Harvard College (Harvard Yard)
1981	Proctor, Dunster House, Harvard Summer School
1980	Editor-in-Chief, Nassau Herald (Yearbook), Princeton University
1979-1980	Editor-in-Chief, Princeton Student Course Guide
1978-1980	Executive Committee Member, University Council
1978-1980	Student Director, Princeton University Libraries
1978-1980	Resident Advisor, Princeton Inn College
1977-1979	Chairman, Academics Committee, National Society of Black Engineers

Scholarly Society Memberships and Offices Held

Memberships Held (Past and Present)

American Association for the Advancement of Science
American Academy of Orthopaedic Surgeons
American College of Surgeons
American Chemical Society (Polymer Chemistry Division and Polymer Science and Materials Engineering Division)
American Institute for Medical and Biological Engineering
American Institute of Chemical Engineers
The American Orthopaedic Association
The American Orthopaedic Society for Sports Medicine
The American Society of Bone and Mineral Research
The American Society of Engineering Educators
The American Society for Testing Materials
Association of Bone and Joint Surgeons
The Biophysical Society
The Controlled Release Society
The International Cord Blood Society
The Materials Research Society
Medical Society of Eastern Pennsylvania
The National Medical Association
The Old Dominion Medical Society
The Philadelphia Orthopaedic Society
The Philadelphia College of Physicians
The Philadelphia Orthopaedic Sports Medicine Society
The Orthopaedic Research Society
The Society for Biomaterials
The Union League of Philadelphia
USA Boxing
USA Wrestling

Editorial Review Board Activities

Applied Biomaterials (Board of Editors)
Asian Chitin Journal (Board of Editors)
Biologics: Targets & Therapy (Board of Editors)
Biomaterials (Board of Editors)
Clinical Orthopaedics and Related Research (Advisory Board Editor)
Emedicine Orthopaedics Journal (Board of Editors (shoulder))
Expert Review of Medical Devices (Board of Editors)
International Journal of Nanomedicine (Board of Editors)
Journal of ASTM International (Board of Editors)
Journal of Biomedical Materials Research (Board of Editors)
Journal of Biomedical Nanotechnology (Board of Editors)
Journal of Biopharmaceutics and Biotechnology (Board of Editors)
Materials Science and Engineering C: Materials for Biological Applications (Board of Editors)
Recent Patents in Biomedical Engineering (Board of Editors)

Regenerative Medicine (Board of Editors)
Tissue Engineering (Board of Editors)

Acta Biomaterialia (Reviewer)
Advanced Materials (Reviewer)
Advanced Functional Materials (Reviewer)
American Journal of Physiology -Cell Physiology (Reviewer)
American Journal of Sports Medicine (Reviewer)
Annals of Biomedical Engineering (Reviewer)
Annals of Internal Medicine (Reviewer)
Annals of Pharmacotherapy (Reviewer)
Applied Biomaterials (Reviewer)
Bioelectromagnetics (Reviewer)
Bioinorganic Chemistry (Reviewer)
Bioinspiration and Biomimetics (Reviewer)
Biomacromolecules (Reviewer)
Biomedical Materials (Reviewer)
Biotechnology and Bioengineering (Reviewer)
Biotechnology Progress (Reviewer)
Bone (Reviewer)
Cell Proliferation (Reviewer)
Chemistry of Materials (Reviewer)
Colloids and Surfaces A (Reviewer)
European Journal of Histochemistry (Reviewer)
European Physical Journal, Applied Physics (Reviewer)
European Polymer Journal (Reviewer)
European Journal of Polymer Science (Reviewer)
F.E.B.S. Letters (Reviewer)
Gene Therapy (Reviewer)
IEEE Engineering in Medicine and Biology Magazine (Reviewer)
International Journal of Therapeutics (Reviewer)
In Vitro (Reviewer)
Indian Journal of Medical Sciences (Reviewer)
Journal of the American Ceramic Society (Reviewer)
Journal of Biomaterials Applications (Reviewer)
Journal of Biomechanical Engineering (Reviewer)
Journal of Biomedicine and Biotechnology (Reviewer)
Journal of Biomaterials Science: Polymer Edition (Reviewer)
Journal of Bone and Joint Surgery (Reviewer)
Journal of Bone and Mineral Research (Reviewer)
Journal of Dental Research (Reviewer)
Journal of the National Medical Association (Reviewer)
Journal of Microscopy (Reviewer)
Journal of Orthopaedic Research (Reviewer)
Journal of Pharmacy and Pharmacology (Reviewer)
Journal of Trauma (Reviewer)
Langmuir (Reviewer)
Materials Research Bulletin (Reviewer)
Macromolecular Rapid Communications (Reviewer)
Macromolecules (Reviewer)
Nanomedicine (Reviewer)

Pharmaceutical Research (Reviewer)
Pharmaceutical Science and Technology (Reviewer)
Polymer International (Reviewer)
Proceedings of the National Academy of Sciences (U.S.A.) (Reviewer)
Process Biochemistry (Reviewer)
Stem Cells (Reviewer)
Trends in Biotechnology (Reviewer)

Research Grants Support: Principal Investigator

Polymeric Materials for Controlled Drug Delivery	
National Institutes of Health, B.R.S.G. Grant S07RR070470513	1987-1990
Controlled Release of Bone Morphogenetic Substances	
The Ford Foundation	1989-1990
Controlled Release of Macromolecules (Co- Principal Investigator)	
National Institutes of Health GM26698	1989-1992
Effects of Gamma Radiation on Biomedical Polymers	
National Institutes of Health DE09441	1990-1992
Development of Bioerodible Polymer Matrices for Osteoblast Growth and Maturation	
National Science Foundation BCS9011170	1990-1994
Novel Degradable Polymers (Co-Principal Investigator)	
National Institutes of Health AR41972	1992-1996
Bioerodible Polymer Matrices for Osteoblast Growth	
National Science Foundation BCS9311375/BES9496336	1993-1997
In Vivo Biocompatibility of Polymers (Equipment Grant)	
Synthes Incorporated	1995-1996
Tissue Engineered Constructs for Cartilage and Bone	
National Science Foundation BES9553162/BES 9817872	1995-2001
Novel Bioerodible Polymers for Orthopaedic Use	
Osteonics Corporation	1997-1998
A Novel Treatment for Rheumatoid Arthritis Using Taxol	1997-1999
The Arthritis Foundation	
Radiosensitizer Therapy Treatment for Ewing's Sarcoma (Co-Principal Investigator)	1997-1999
Allegheny-Singer Research Institute	
Age-Related Effects on Osteoblast Function	1997-1998
National Institutes of Health AG00532 (under Core Grant)	
Age-Related Changes Non-Union Healing Using Polymers	1997
Nathan Shock Center of Excellence	
Bioerodible Matrices for Tissue Regeneration	1997-2002
National Science Foundation BES9896282	
Research and Curriculum in Tissue Engineering	
National Science Foundation EEC-9980298	1999-2002
Tissue Engineered Systems for Anterior Cruciate Ligament Regeneration	
National Institutes of HealthAR46117	1998-2000
Center for Advanced Biomaterials and Tissue Engineering	
Ben Franklin Technology Center	1999-2002
Arthritis Outstanding Research Scholarship	2000-2001

Arthritis Foundation (Eastern Pennsylvania Chapter)
Gamma and Electron Beam Radiation Effects on Degradable Polymers 2000-2002
Drexel University/MCP-Hahnemann University Synergy Award
Acquisition of a complete whole arm manipulator (WAM) Robot System (co-P.I. with J. Desai)
National Science Foundation EIA0079830 2000-2002
Taxol Based Delivery Systems for the Treatment of Prostate Cancer (Co-P.I. with M. Attawia) 2000-2002
Drexel University/MCP-Hahnemann University Synergy Award
Novel Degradable Polymers for Tissue Engineering 2001-2006
National Institutes of Health RO-1 AR46560
Biocompatibility of Nanoparticles for Biomedical Applications 2001-2002
Drexel University/MCP-Hahnemann University Synergy Award
Gene Therapy for Bone Regeneration: The Delivery of BMP-2 Producing Cells Using a 3-Dimensional, Biodegradable Matrix
Department of Defense 2001-2003
A Proposal for Minority Student Support (co-P.I. with M. Choi)
GEM Foundation 2001-2006
Nanobased fibers for Wound Healing
Department of Defense
National Medical Test Bed 2000-106500 2001-2003

Polymer Chitosan Matrices for Tissue Engineering 2001-2004
National Science Foundation INT0115595

Taxol Based Delivery Systems for Cancer Treatment
U.S.-Egypt USDA Grant Program BIO5-003-004 2001-2004
Bioreactor Based Bone Tissue Regeneration 2001-2005
National Science Foundation BES0115404
Acquisition of an Environmental Scanning Electron Microscope (co-P.I. with T. Lowman)
National Science Foundation BES 0216343 2002-2004
Training in Nanoengineering and Nanoscale Science (IGERT) (co P.I. with Y. Gogotsi)
National Science Foundation 2002-2007
Bioerodible Polymers for Bone Tissue Engineering
National Science Foundation BES0201923 2002-2006
Adipose Based Tissue Engineering
National Institutes of Health R21 AR050704 2003-2006
Bioerodible Matrices for Bone Tissue Engineering
National Science Foundation BES0336736 2003-2006
Bioreactor Based Tissue Engineering Using Polyphosphazenes
NASA NRA-01-OBPR-08-B 2003-2007
Nanobased fibers for Wound Healing 2004-2006
Department of Defense (US Army)
Musculoskeletal Tissue Repair and Regeneration
National Institutes of Health T32- AR050960 2005-2010
Optimization of Bioreactor Based Tissue Engineering of Bone
National Science Foundation BES0503207 2005-2008
Vascularized Bone Grafts for Tissue Engineering

(P.I. Mentor to Botchwey)
National Institute of Health K01AR052352 2006-2010
Novel Biodegradable Polymers for Bone Tissue Engineering
National Institutes of Health RO-1 EB004051 2005-2010
Polymer-Ceramic Composites for Tissue Engineering 2005-2010
National Institutes of Health RO-1 AR052536
Development of a Novel Injectable Controlled Analgesic 2007-2010
Delivery System for Effective Pain Management
Department of Defense (U.S. Army) PR064604
Universal Smart Coatings for Prosthetics 2007-2009
National Academy-Keck Futures Initiative NAKFI SP14
Development of a Novel Tissue Engineering Strategy Toward 2007-2008
Limb Regeneration
Department of Defense (U.S. Army) PR06104002
Novel Structured Nanofibrous Scaffolds for Bone Healing
(Co-P.I.) with X. Yu
Coulter Foundation Grant 2007-2009
Biological, Chemical and Mechanical Surface Cues for Cell Migration,
Proliferation and Differentiation: An Integrated Approach to Regeneration of
Tissues
National Science Foundation EFRI -0710321 2007-2011

Mentored Research Grants

N.I.H. Research Training Award			2003
	Recipient:	Joseph Freeman	
N.I.H. Research Training Award			2002
	Recipient:	Duron Lee	
Bristol Myers Squibb Research Award	Recipient:	Addisu Mesfin	2003
Bristol Myers Squibb Research Award	Recipient:	Saddiq El-Amin	2002
Bristol Myers Squibb Research Award	Recipient:	Paul Gittens	2001
NSF Research Fellow (College)			
	Recipient:	Alice Gitau	2001
NSF Research Fellow (College)			
	Recipient:	Sharron King	2001
NSF Research Fellow (High School)			
	Recipient:	Justin Mitchell	2001
NSF Research Fellow (High School)			
	Recipient:	Jasmine Benwar	2001
Bristol Myers Squibb Research Award	Recipient:	Duron Lee	2001
Bristol Myers Squibb Research Award	Recipient:	Brian Monroe	2000
Bristol Myers Squibb			

Research Award	Recipient:	Natalee Campbell	2000
National Institutes of Health Research Service Award	Recipient:	Saadiq El-Amin	1999
National Institutes of Health Research Service Award	Recipient:	James Cooper	1999
Bristol Myers Squibb Research Award	Recipient:	Christopher Taylor	1999
National Institutes of Health Research Service Award	Recipient:	Christopher Taylor	1998
Association for Minority Physicians	Recipient:	Brian Monroe	1998
University of Rochester, School of Medicine, Summer Research Grant	Recipient:	Fenton Hubert	1998
Allegheny Minority Summer Research Program	Recipient:	Ashley Barber	1998
Medical Society of Eastern Pennsylvania/ Astra Merck Award	Recipient:	Nykia Walker	1998
Allegheny Minority Summer Research Program	Recipient:	Emily Nichols	1997
Glenn/ AFAR Award for Research in the Biology of Aging:	Recipient:	Mark Borden	1997
Alpha Omega Alpha Medical Student Research Award	Recipient:	Kelly Herbert	1997
Alpha Omega Alpha Medical Student Research Award	Recipient:	James Nicholson	1997
Medical Society of Eastern Pennsylvania Astra Merck Award	Recipient:	Aaron Henderson	1997
Medical Society of Eastern Pennsylvania Astra Merck Award	Recipient:	Reginald Trammel	1997
Allegheny Minority Summer Research Program	Recipient:	Cheryl Coates	1997
National Institutes of Health Individual Research Service Award	Recipient:	James Cooper	1997
Bristol Myers Squibb Research Award	Recipient:	Jay Gorum	1996
Pfeiffer Foundation Award	Recipient:	Patrick Sennatus	1992
M.I.T. Minority Summer Scientist Research Award	Recipient:	Edward Botchwey	1992
Bristol Myers Squibb Research Award	Recipient	Ruby Skinner	1992
Pfeiffer Foundation Award	Recipient	Raymon Keaton	1991
Pfeiffer Foundation Award	Recipient	Henri Pierre-Jacques	1990

Ph.D. Theses Mentored: 13

Master's Students Mentored: 7

Undergraduate M.I.T Theses Mentored: 3

Residents Trained as Chairman, The University of Virginia: 25

ARTICLES IN PEER-REVIEWED JOURNALS: 255

ABSTRACTS: 205

OTHER PRESENTATIONS: 159

PATENTS: 42

Enrolled master's and doctoral students in graduate programs in the biomedical sciences

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Master's	0	0	0	0	2	166	167
Doctoral	143	145	159	157	176	180	170

Residents and clinical fellows on duty in ACGME-approved programs that are the responsibility of the medical school faculty

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Residents	512	502	495	484	492	490	492
Fellows	89	83	88	83	79	81	80

2008/2009 number of residents who are the responsibility of UConn faculty, by training program

Specialty of Training Program	PGY-1 residents	Total Residents	Clinical Fellows (ACGME-approved programs)	Clinical Fellows (Non-ACGME approved programs)
Anesthesiology	0	25	0	0
Dermatology	0	4	0	0
Emergency Medicine	13	35	5	0
Family Medicine	7	19	2	0
Internal Medicine	64	183	59	4
Neurology	0	13	0	0
Obstetrics & Gynecology	9	37	0	6
Occupational & Environmental Med	0	1	0	0
Orthopaedics	4	20	3	0
Otolaryngology	2	10	0	0
Pediatrics	17	56	8	0
Psychiatry	6	24	0	1
Child & Adolescent Psychiatry	0	2	0	0
Radiology	0	8	0	0
Surgery	15	46	3	0
Urology	0	9	0	0
Total	137	492	80	11

Educational Program Objectives

Goal

The University of Connecticut School of Medicine requires its medical students to develop competency in the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The expected level of competency attained must be sufficient to allow these new physicians to be successful in graduate medical education programs, and must also to provide them with the attitudes, skills and values requisite to continually update these competencies over the lifetime of their careers. Students will be broadly trained and prepared to undertake advanced training for careers in patient care, academic medicine, public health, and/or research. Faculty members, as teachers, mentors, and role models, are committed to support the development of these student competencies.

Patient Care Competency

Graduates must be able to collaborate effectively to provide patient care that is compassionate, appropriate and effective both for the treatment of health problems and the promotion of health. Our graduates will:

1. gather essential information from all available sources, including other healthcare professionals, to obtain an accurate and relevant medical history that is developmentally, culturally, and age appropriate, and that identifies the patient's view of the problems and needs.
2. perform a relevant and accurate physical examination, distinguishing normal and abnormal findings.
3. apply their knowledge of pathophysiology to the interpretation of history, physical examination and laboratory data.
4. create and prioritize a comprehensive problem list.
5. assess each problem appropriately, formulating and prioritizing a differential diagnosis when indicated.
6. use decision analysis, relative costs, and discussion with other healthcare professionals to order and accurately interpret common diagnostic procedures (including but not limited to blood tests, CXR, EKG, urinalysis).
7. learn and perform common medical procedures (including but not limited to obtaining a venous and arterial blood sample, insertion of a peripheral IV line, Foley catheter, and nasogastric tube, performing basic suturing and a lumbar puncture).
8. document accurately, legibly and succinctly: historical and physical examination data; interpretation of test results; problem lists and management plans that include supportive clinical reasoning; discussions with patients/families/consultants; procedure notes; informed consent; and discharge or follow-up plans, including prescriptions.
9. develop diagnostic and therapeutic strategies for common medical conditions, acute care, emergencies, chronic care, end of life care, and wellness.
10. demonstrate the ability to work with the health care team to identify, assess and manage pain and suffering of patients, and provide support and comfort when cure may not be possible.
11. identify and address risk factors to prevent disease and promote health, including the use of screening tools to identify patients/families experiencing problems with literacy, environmental conditions, violence, substance use, physical, psychological and/or sexual abuse.
12. be able to identify appropriate resources and educational materials for patients, including community-based organizations, other healthcare professionals, support groups, Internet sources, and handouts.
13. provide appropriate, accurate and timely information when transferring a patient's care to another provider.
14. recognize when additional help is needed and understand the role of a consultant as a member

of the healthcare team.

Medical Knowledge Competency

Our graduates will know the:

1. normal structure and function of the body and each of its major organ systems.
2. molecular, biochemical, genetic and cellular mechanisms important to maintaining the body's homeostasis.
3. pathogenesis of disease, including but not limited to altered structure and function and the pathophysiology of pain.
4. developmental changes and milestones, psychological development, and the differences between normal variation and disease across the human life span.
5. etiology, epidemiology, clinical manifestations, prognosis, and natural history of common illnesses.
6. principles of contemporary therapeutics, including but not limited to molecular, biological, pharmacological, surgical, and complementary and alternative medicine.
7. common sources of medical error and basic concepts of risk management in medical practice.
8. power and limitations of the scientific method and evidence-based medicine in establishing the causation of disease and the efficacy of traditional and non-traditional therapies, as well as the central role of research in medicine, including an appreciation of the contributions of basic science, translational research, public health, and clinical studies to the development of medical care.
9. principles of nutrition as they relate to health maintenance and the care of acutely and chronically ill patients.
10. principles of clinical epidemiology and biostatistics.
11. legal and ethical framework and principles that govern sound clinical decision making, including adherence to standards of care.
12. the role of communities in influencing health and illness, and providing resources for prevention and patient care.

Practice-based Learning and Improvement Competency

Graduates should have the knowledge, skills and attitudes necessary to evaluate their method of practice and implement strategies for improvement of patient care. Our graduates will:

1. understand and utilize performance improvement processes (including but not limited to identifying areas for improvement, designing and implementing strategies for improvement, and assessing outcomes).
2. demonstrate the ability to practice evidence-based medicine by formulating clear clinical questions, knowing where and how to find best sources of evidence, evaluating and appraising the evidence for validity and usefulness with respect to particular patients or populations, and determining when and how to integrate new findings into practice.
3. appropriately utilize information technology and employ electronic communications to facilitate acquisition, storage, retrieval and analysis of patient and practice data.
4. understand the role and limitations of practice guidelines and clinical pathways to improve the quality of care for populations of patients.

Interpersonal and Communication Skills Competency

Graduates must demonstrate the skills and attitudes that allow effective interaction with patients, families and all members of the healthcare team. Our graduates will be able to:

1. demonstrate empathy and respect for others, including sensitivity to cultural, gender and sexual orientation differences, personal preferences and level of understanding.
2. demonstrate an appreciation of the impact of an illness and its treatment on patient, family, and significant others.

3. demonstrate effective interviewing skills, including attentive listening, eliciting patient's concerns, establishing rapport, skilled use of open and closed questions, appropriate use of verbal and nonverbal facilitation techniques, clarifying and summarizing information, and exploration of patient's context/ perspective/ beliefs/ emotions.
4. demonstrate the ability to provide information with sensitivity and clarity and in a language understood by the patient/family, while checking for understanding and encouraging questions (including but not limited to such skills as giving bad news, discussing risks and benefits of treatments, discussing medical errors and utilizing interpreters).
5. share decision-making and negotiate management plans with patients, families and other healthcare professionals, incorporating information about patients' perspectives, experiences and available supports and resources (including end-of-life decisions, behavioral counseling, informed consent and discussion of alternative treatment options).
6. demonstrate effective oral presentation skills (e.g., accurate content and efficient process).
7. critique in oral and/or written format scientific publications (e.g., basic science, educational or clinical research articles, case reports, consensus guidelines).
8. demonstrate the ability to constructively give feedback to, and receive feedback from, preceptors, peers, and team members.
9. appropriately engage faculty, peers, or other healthcare providers to elicit and/or clarify information.
10. use appropriate techniques for collaborating with and teaching other students (e.g., effective participation in small learning groups).

Professionalism Competency

Graduates must demonstrate the knowledge, skills, attitudes and behaviors necessary to promote the best interests of patients, society and the medical profession. Our graduates will demonstrate:

1. honesty and integrity with patients/families, peers, the healthcare team, community members, faculty and others.
2. reliability and responsibility by completing duties in a timely fashion and not engaging in patient care responsibilities if emotionally or physically impaired.
3. the ability to maintain appropriate confidentiality.
4. respect for others, including appropriate grooming, punctuality, courtesy, non-derogatory backroom discussions, inclusiveness, and use of socially acceptable language and humor.
5. compassion and empathy in words and deeds when dealing with patients/families, peers, the healthcare team, community members, faculty and others.
6. awareness of appropriate professional boundaries and the inappropriateness of the exploitation of patients for any sexual advantage, personal financial gain, or other private purpose.
7. a commitment to self-improvement, including being open and responsive to feedback, reflection and self-evaluation, and actively setting and pursuing learning goals and applying knowledge gained.
8. the ability to accept responsibility for errors and evaluate failures in education and patient care.
9. recognition and acceptance of personal limitations in knowledge, skill and behavior, seeking guidance and supervision when appropriate.
10. the ability to recognize the role of personal wellness, values and priorities in their practice of medicine.
11. the ability to identify and appropriately respond to unprofessional behavior in others.
12. the willingness and capability to work collaboratively and resolve conflicts in a variety of settings to achieve common patient care and educational goals of all involved.
13. altruism and advocacy demonstrated by a commitment to promoting health care needs of patients and society, and to improve quality and access to care and a just distribution of finite resources.
14. recognition of and sensitivity to culture, race, disabilities, age and other differences in order to

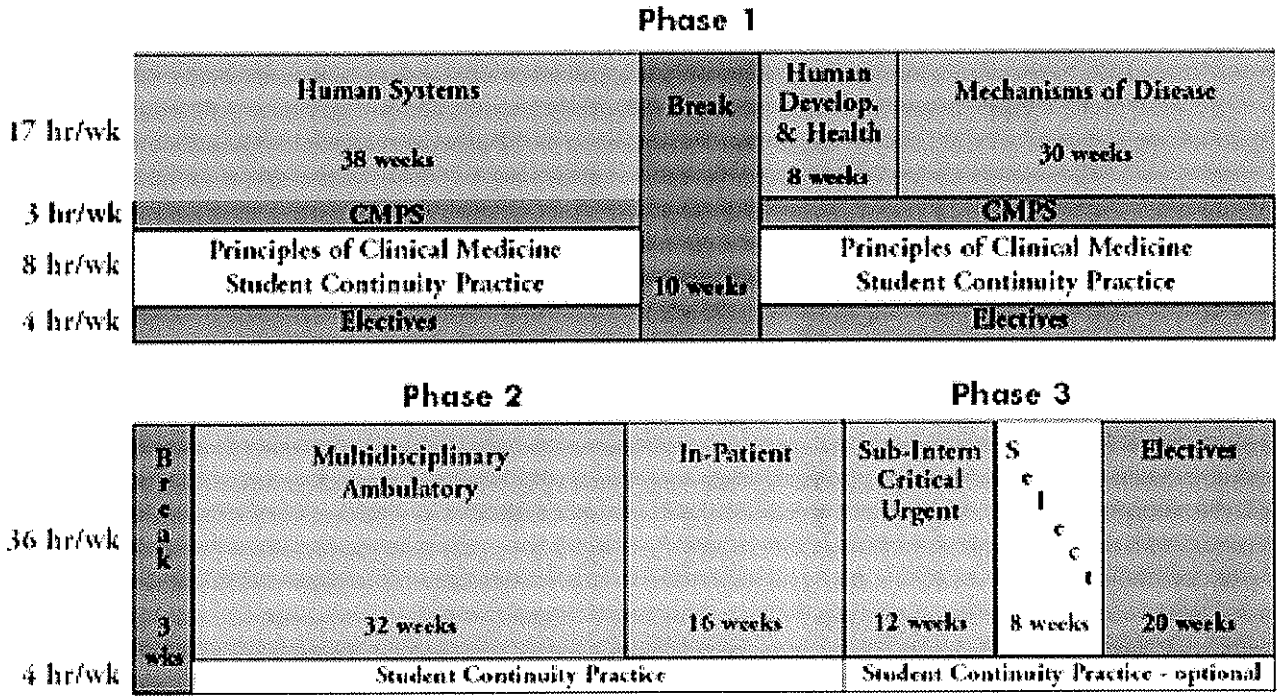
prevent health care discrimination.
15. the ability to identify potential conflicts of interest arising from the influence of marketing and advertising, as well as financial and organizational arrangements.
16. the ability to apply legal and ethical principles to patient care, clinical research, and the practice of medicine.
17. participation in defining, organizing and evaluating the educational process for current and future students.

Systems-based Practice Competency

Graduates must demonstrate the knowledge, skills and attitudes necessary to provide high quality care for their patients within the context of the larger healthcare system. Our graduates will:

1. demonstrate knowledge of various approaches to the organization, financing and delivery of healthcare.
2. demonstrate an understanding of biological, social, psychological and environmental risk factors for inadequate healthcare or inadequate access to healthcare.
3. advocate for patients and/or communities by implementing strategies to access healthcare services and assistance.
4. demonstrate collaborative practice by identifying key personnel, understanding the role of each healthcare team member, and participating in a coordinated effort to optimize patient care.
5. consider cost-effectiveness and resource allocation in developing diagnostic and treatment strategies that promote quality of care.
6. understand the nature of systems errors and strategies to minimize them, such as failure modes/effects analysis, root cause analysis, electronic medical records and order entry.

Schematic showing the placement of courses and clerkships within each academic period



Teaching Time Devoted to Subjects Required for Accreditation

Content Area	Subject Included in		Number of Hours in Required	
	Required Course	Elective Course	Preclinical Course(s)	Clinical Clerkship(s)
Biostatistics	✓		20	3
Communication skills	✓		120+	9
Community health	✓, Sel 3	*	11+	10
Complementary/alternative health care	✓, Sel 1	*,#,4	3.5+	4
Cultural diversity	✓	*,#	6	4
End-of-life care	✓		7.5+	5
Epidemiology	✓, Sel 1	4	29	1
Evidence-based medicine	✓	*,4	2+	8
Domestic violence/abuse	✓	✓	6+	3
Global health issues	Sel 1	*,#		
Health care financing	✓	*,#	2	
Health care systems	✓	#	9	1
Health care quality improvement		4,#		1
Health disparities	✓	4,#	5+	3
Human development/life cycle	✓	#	44+	3
Human sexual/gender development	✓		7	
Human sexuality/sexual functioning	✓		5+	1
Medical ethics	✓	*,#,4	23+	3
Medical genetics	✓	4	43	4
Medical humanities		*,#		4
Medical informatics				5
Medical jurisprudence	✓		18	
Medical socioeconomics	✓	#	.5+	
Nutrition	✓, Sel 3	*,4	11.5+	5.5
Occupational health/medicine	✓	4	10.5+	1
Pain management	✓		17+	5
Palliative care	✓	*,#,4	4	2
Patient safety			1.5	
Population-based medicine	✓	#	4	
Prevention/health maintenance	✓	4	14+	10
Rehabilitation/care of the disabled		#,4	1+	
Research methods**	✓, Sel 40	*		11***
Substance abuse	✓, Sel 1	4	14.5+	4.5

* = Phase 1 elective, 10-30 hours for varying credit

** = most of our required teaching about research methods is done in the Clinical Epidemiology section of HDH and those hours are in this table under "Epidemiology"

Sel = Selectives, a required 4th year experience in which students (1) establish an in-depth experiential and knowledge base as a researcher, educator, or advocate for community health, and (2) identify a problem, review the literature, design a project, engage in research/evaluation, analysis, and develop a professional presentation (both written and oral).

= 6 students do independent projects/presentations in this area as part of a required course (HDH)

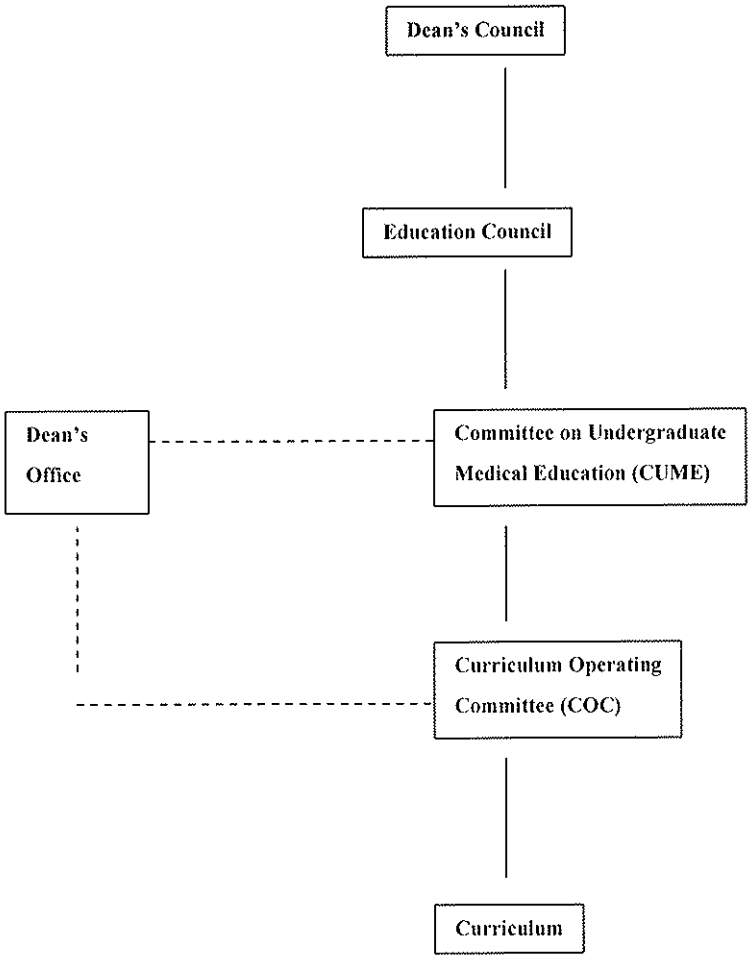
4 = 4th year elective, usually about 180 hour experience, with this topic area the primary focus or one of several.

+ = SCP is a longitudinal experience over 3 years and hours on a particular topic are difficult to quantify and will vary considerably between students. + indicates that the topic is in the SCP objectives and covered as a "significant topic" by all students.

*** this includes required completion of the CITI course on research with human subjects, a

requirement for all students in HDH.

Organizational chart for management of the curriculum



USMLE results for first-time takers

STEP 1:

Year or Academic Year	Number Examined	Percent Passing	Mean Total Score	National Mean Total Score
2006	81	96	219 (22)	218 (23)
2007	84	96	219 (18)	222 (22)
2008	74	95	226 (24)	221 (23)

STEP 2 CK:

Year or Academic Year	Number Examined	Percent Passing	Mean Total Score	National Mean Total Score
06/07	70	90	222 (23)	225 (24)
07/08	80	96	228 (23)	226 (23)
08/09	79	99	232 (18)	229 (23)

STEP 2 CS:

Year or Academic Year	Number Examined	Percent Passing
06/07	89	100
07/08	75	100
08/09	66	98

STEP 3:

Med School Graduation Year	Number Examined 1st attempt	UCONN 1st time pass rate	National 1st time pass rate	Number examined repeat performance	UCONN repeat pass rate	National repeat pass rate
2003	76	96%	96%	2	0%	96%
2004	61	100%	97%	0	--	94%
2005	54	98%	97%	1	0%	93%
2006	61	98%	96%	1	0%	88%

Students enrollment in each academic year of the medical curriculum in 2008/2009

First Year	Second Year	Third Year	Fourth Year	Total
88	87	78	78	331

. **Mean MCAT scores for *new* (not repeating) first-year students**

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Verbal Reasoning	9.50	9.60	9.70	9.90	9.90	9.80	10.00
Physical Sciences	10.30	9.90	10.20	10.30	9.90	10.10	10.40
Biological Sciences	10.40	10.20	10.60	10.60	11.00	10.60	10.90
Writing Sample (Mode)	R	Q	Q	Q	Q	Q	Q

Mean premedical GPA for *new* (not repeating) first-year students

2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
3.58	3.60	3.66	3.66	3.65	3.66	3.68

Gender, racial, and ethnic distribution of medical students

Category	**First Year Students** (08/09)	**First Year Students** (09/10)	**All Students** (08/09)	**All Students** (09/10)
Male	40	39	136	153
Female	45	46	195	193
Caucasian	61	50	223	222
Black/African American	8	12	37	41
Hispanic/Latino	5	4	4	17
Native American	0	2	3	5
*Asian/Pacific Islander	11	17	51	53
Total under-represented min.	13	18	44	63

*Students in this group are not considered underrepresented at the Health Center because they are not underrepresented in the applicant pool relative to the population.

Note: All Student Enrollment Unknown Race Totals:

- 08/09 = 13
- 09/10 = 8

Percentage of first-year students and percentage of all students who withdrew or were dismissed from the medical school

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
First-year class	--	2.5	--	2.5	2.5	1.0	1.0
All students	0.9	0.6	--	1.0	0.9	1.0	.3

Number of students who left school, exhibited academic difficulty, or took leave of absence (2008-2009)

Number of Students Who:	Class Year				Total
	First	Second	Third	Fourth	
Withdrew	1	1	0	0	2
Dismissed	0	0	0	0	0
Transferred to another medical school	0	0	0	0	0
Repeated the entire academic year*	4	3	0	0	7
Repeated one or more required courses*	0	0	1	0	1
Moved to a decelerated curriculum	0	0	0	0	0
Took a leave of absence due to academic problems	0	0	0	0	0
Took a leave of absence for academic enrichment (including research or joint degree programs)	0	1	18**	1	20
Took a leave of absence for personal reasons	2	2	1	0	5

*Four students in year 1 and three students in year 2 needed to repeat a core basic science course (Human Systems and Mechanisms of Disease, respectively), but did not need to repeat the CMPS course or Human Development and Health)

** 18 students include: 16 students in all years of their PhD training, 1 pursuing MPH, 1 pursuing MBA

Medical Student Performance Evaluation - LCME Sample 1

November 1, 2008
Identifying Information:
..... is a fourth-year student at the University of Connecticut School of Medicine.
Unique Characteristics
A. Premedical
.....to a health technologist and teacher, was born in..... She moved with her family to the United States when she was a high school sophomore. A graduate of .....High School in..... .... selected for ... undergraduate preparation. A review of her transcript reveals an outstanding academic performance, with a major in Biology and a minor in Chemistry. Her upper division coursework included Human and Medical Genetics, Biochemistry, Genetics, Cell Biology, and Comparative Vertebrate Anatomy. Her humanities selections gave her exposure to literature, psychology, theater, philosophy, and Spanish. To complement her course program, ... worked as a lab assistant in the Department of Biology. She was instrumental in establishing the college's chapter of the Golden Key Society. She also worked as a laboratory assistant at Unilever and Cadbury-Schwepps prior to beginning her medical studies. A Magna Cum Laude graduate, she impressed all of her professors, interviewers, and Committee reviewers. Her college referees wrote, "Evaluators were convinced of ..... sincere commitment toward becoming a physician.
They stress her initiative and motivation exemplified by her work in bringing a chapter of the Golden Key International Honor Society to our campus. She worked as a resident advisor and as a nurse's aide. One of her sisters is a physician. Her motivation derives from personal and family health history, her love of the sciences, and the desire for human service. Clearly .... has the knowledge of the profession and a well thought out plan." One senior faculty interviewer wrote, "Interviewing . .... brightened an otherwise dull morning. She is a natural communicator with intuitive understanding, wit, and focus. She has a positive, independent attitude and asked perceptive questions about our educational program and community." We were thrilled to invite her to join our first year class.

B. Extracurricular Activities in Medical School
...has been a class leader in the medical school community. Her major professional investment was serving on the Admissions Committee in her second year, which involved a two hour meeting every other week and several hours of chart review per week. ..... has been a member of the Student National Medical Association since her first year. She has helped organize several activities and worked to reinstitute the program that teaches science to inner city middle school children. ..... is currently a mentee of the American Academy of Dermatology Association Diversity Mentorship Program. She is a member of the National Medical Association and AMSA. ..... and one of her Dermatology attendings developed a teaching module entitled 'Summer Sun Safety Education' for middle school children. This teaching module is now being used by first year medical students to teach other groups of middle school children. .... has served as manager and volunteer at the South Park Inn, a student-run clinic in a homeless shelter. She has volunteered at the Migrant Farm Workers Clinic. In her first year she taught in the Hartford Health Education Program, presenting weekly health related topics to middle school children in Hartford. In her free time ... enjoys running (she ran in a 5K heart disease fundraiser), baking, spending time with friends, decorating, and arts and crafts.

Academic History for Dual Degree Students:
Date of expected graduation from medical school: -----May, 2009
***Date of initial Matriculation*:** ----- August, 2005
Date of initial Matriculation in other degree program (MPH): August, 2005
Date of expected graduation from other degree program: May, 2009
... will receive a dual MD/MPD degree in only four years, a rare accomplishment at UConn.
Extensions, leaves, gaps or breaks: None Repeated or remediated coursework: None
Adverse actions: None

ACADEMIC PROGRESS:

Preclinical/basic science curriculum:

We are a pass/fail school with no grade point average or class rank. Evidence of .....'s mastery of the Basic Science material is a USMLE Step 1 score of 230. Narrative comments from the first two years include those from the Principles of Clinical Medicine Course: ".....'s skill development has exceeded expectations. Her history and physical exam write-ups are particularly well-organized and thorough. She approaches patients with an appropriate degree of confidence and professionalism. She is able to establish an easy rapport while simultaneously progressing through the history and physical in an efficient manner. ..... is very bright, competent, conscientious, well-organized, eager to learn and committed. She shows honesty and integrity in her interactions. She expresses her opinions clearly and directly." .....'s Health Law and Ethics seminar preceptor wrote, ".....'s excellent understanding and sensitivity were demonstrated on a number of occasions. She did a very good job presenting the sexual harassment case; sensitivity to the subtleties of the case was very evident." .....'s Clinical Epidemiology seminar leader wrote, "..... had active participation in a strong group. She was a regular contributor and was always prepared. She had a strong grasp of material and her comments reflected an understanding of concepts. Very strong work overall."

MPH Degree Coursework

..... has completed coursework in Environmental Health, Community Research Methods, Law and Public Health, Investigations of Disease Outbreaks, Health Administration, Approaches to Data Management and a summer practicum. Her summer practicum was titled "Access to Healthcare among Sickle Cell Patients in Nigeria". The purpose of this study was to assess the patterns of utilization of healthcare resources by sickle cell patients, and the factors that are associated with that utilization in Nigeria. She is currently working on developing her thesis project, titled: "Misperceptions and barriers to seeking dermatologic care in minority populations". Her remaining courses include Tropical Medicine, in Costa Rica, and Border Health at the US-Mexico border.

Core Clinical Clerkships and Elective Rotations:

Please note that our Core Clerkships—with the exception of Family Medicine and Ob/Gyn—consist of both an inpatient and an outpatient phase often separated by several months; therefore, it is not possible to present them in strict chronological order.

Family Medicine

..... was assigned to a private practice for family medicine. She received excellent ratings in the following domains: interviewing skills, interactions with patients, medical knowledge, management plans, physical diagnostic skills, interactions with staff members, reliability, participation and initiative. ..... was given outstanding ratings for her self-directed learning. Her preceptor wrote, "..... demonstrated an ability to elicit comprehensive histories. She was able to put patients at ease with her interviewing style. She is very bright and has an excellent fund of knowledge. She wrote well-organized notes that were easy to follow. Her management plans are consistently appropriate and sensitive to the individual patient's circumstances.....demonstrated good diagnostic skills throughout her rotation, with good differential diagnoses. ..... is very quick to read on conditions seen in our patients. She is consistent in her solicitation of feedback, and clearly wants to learn. She is very professional, self-motivated and mature. .....was frequently looking for opportunities to educate our patients and help family members in whatever way possible. ..... is a bright and self-motivated learner. She has an excellent way with patients and is able to set them at ease and communicate effectively."

Internal Medicine

..... was assigned to John Dempsey Hospital for inpatient medicine, and worked under the direction of the course director. He awarded her ratings of 7-9/9 in all categories, with particular praise for her clinical reasoning and professionalism (interactions with staff members, reliability, participation and initiative). ..... demonstrated outstanding logical thought process in developing comprehensive differential diagnoses. She was a superb patient advocate who effectively considered the VNA, social services and family members to improve patient care. .....demonstrated outstanding interviewing skills, with a style effectively adjusted to the patient's perspectives and clinical situation. Her preceptor concluded, "This is one of the best third year students I have encountered. She will be successful in any field. She is motivated, hard working, very smart and can produce a list of pertinent differential diagnosis given a set of patient data. She did outstanding work."

..... was assigned to the VA Hospital Clinic for ambulatory internal medicine. She was awarded ratings of excellent or outstanding in all categories for another honors-level clinical performance. Her preceptor wrote, ".....'s interviewing skills are excellent. She is able to make patients feel relaxed during the interview. She dealt well with our elderly VA patients. Her presentations were well-organized, concise and appropriate. She was able to adjust to the various case presentation formats within the various clinics. She had excellent rapport with patients and families. Her notes were well-organized and her problems well-defined. Her differential diagnoses were good and she was able to think through alternative problems. Management plans were also very good. She was very active in asking for feedback for improvement. She had an excellent use of resource management. ..... was very conscientious, on time for clinics and took initiative in seeing patients, even in the very busy rheumatology clinic. She worked well with all the clinic staff. In summary, was a pleasure to work with. She was enthusiastic, competent and worked well in the clinic. She was attentive to detail. She performed procedures very well. She interacted with the residents well."

Obstetrics and Gynecology -HONORS

..... had a superior clinical performance during her Ob/Gyn rotation at Hartford Hospital. She received excellent and outstanding ratings in all domains. ..... demonstrated exemplary interpersonal skills, chart documentation and effort throughout the rotation. ..... was extremely sensitive to the work and needs of others on the team and always constructive in the team approach to care. She was outstanding at soliciting and receiving constructive criticism with interest and grace. She was self-motivated to expand her knowledge and skills. She made an extra effort to learn about patient problems and showed extraordinary progress throughout the rotation. ..... was an independent thinker who used logic above the expected level in developing thorough differential diagnoses. Her preceptor concluded, "..... was enthusiastic, self-motivated and eager to be involved in patient care. Her interaction with patients was excellent. She was a strong team player. Her presentation on caesarian delivery was very good. Exam score was in the 79th percentile on the national shelf examination."

Pediatrics

..... has a strong performance overall during her inpatient pediatric rotation at the Connecticut Children's Medical Center. Her preceptor wrote, "..... has a good approach to interviewing. Her verbal presentations were concise and effective in allowing the team to understand her patients' issues and to care for her patients in her absence. ..... had a pleasant interactive style with patients, parents and members of the health care team. ..... came well-prepared for tutorials and clearly did outside reading to expand that base. ..... demonstrated excellent clinical reasoning skills, both in her verbal presentations and in her written documentation. She also reasoned well through the cases

presented in tutorials. ..... performed well on her observed history and physical examination. .....'s management plans followed well from her clinical reasoning. Her written H&P's were overall excellent in their thoroughness and assessments. Her daily progress notes were equally complete. ..... was quite conscientious in completing all of the required tasks. She presents herself with poise and a professional demeanor. .....'s interpersonal skills are excellent. She rapidly assimilated to the team and became a valued member. ..... quickly learned and
utilized a myriad of resources available to her to improve her patient's care. In summary, ... did a very good job. She utilized the varied learning opportunities well, sought feedback and responded to it positively. She is a delightful individual and had positive feedback from all on her interpersonal skills. Overall, a job very well done."
..... was assigned to UConn Health Partners for ambulatory pediatrics. She received excellent or outstanding ratings in every category. Her preceptor wrote, "..... consistently displayed excellent interviewing skills and was sensitive to the patient's perspectives, emotion and visit type. Several complemented her on her questioning style. She gave very organized presentations with excellent detail. ..... used her humor and pleasant attitude to relate well to our patients. She showed that she cared for them by taking on a lot of patient education by herself. She had an excellent knowledge base by the end of the rotation. ..... rarely missed problem-focused information. Her findings were consistent with mine almost always. She demonstrated one of the best chart-keeping skills I have seen thus far. They were clear with depth and updated problem lists. ..... was able to bring in excellent differentials. She was able to integrate patient's social support systems, like grandparents, into her management plans. She consistently attended to family's needs with detailed and relevant history taking. She had relevant hand-outs for safety, etc. She actively sought suggestions and made rapid changes showing a terrific increment in her confidence level and clinical skills. ..... displayed regular use of technology for patient care and education. The team loved her warmth, humor and efficiency. She was very conscientious and dependable. Under my direction she took initiative to make several calls to the hospital billing department on behalf of a recent immigrant with language issues. She consistently demonstrated outside reading and displayed enthusiasm in seeing extra patients and learning from these experiences. In summary, ... worked very hard to improve her skills."

Psychiatry
..... was assigned to John Dempsey Hospital for inpatient psychiatry. She was commended for her superior interpersonal skills and advanced interviewing. She obtained comprehensive and accurate information from patients and was adept at adjusting her style to the patient's affect. She demonstrated outstanding skills at forming a helping relationship with patients. She managed boundaries skillfully, put patients at ease and immediately developed a trusting relationship with psychiatric patients. ..... was commended for her high level of participation and initiative. Her preceptor concluded, "..... was able to relate in a very helpful way with several very difficult patients, her empathy having a clear, positive impact in the patient's recovery." ..... rotated at the University Practice for ambulatory psychiatry. She received ratings of 7-9/9 in all categories, with particular praise for her reliability, self-directed learning, interpersonal skills, participation and initiative. ..... presented all clinical information accurately, with evidence of sophisticated analysis of the primary problem. Her preceptor wrote, ".....'s presentations are well-organized and consistent. She presents a thorough mental status examination. Her notes are well-organized, complete yet concise. Her initial evaluation dictations are well-organized and thorough. She asked for and provides feedback regarding the rotation. She actively asked questions and researches literature. ..... is a team player and often helps the resident coordinate the patient visit. She is conscientious, well-organized and enthusiastic."

Surgery
..... was assigned to Waterbury Hospital for inpatient surgery and was evaluated by several attendings. The chief surgical educator concluded, "..... did an excellent job, especially for her first clinical rotation. She was delightful to have on the service, fitting in well and with an excellent attitude. I am confident she will do very well." A second attending awarded her outstanding ratings in every domain and wrote, "..... always answered all the basic and resident level questions I have asked her. She has a solid knowledge base. She showed a high level of interest in all rounds, always helping the residents seeing patients and writing perfect H&P notes. She was always seeking feedback on her performance. It was nice having ..... working with us. She was very pleasant and very interactive, very knowledgeable and all residents felt at ease working with her. She was always requesting to participate in the operating room in a respectful way. She always wanted to perform skills essential in a surgical rotation (central lines, chest tubes, etc.). I feel that she came here to get the best out of this rotation and I am glad that she did." A third attending wrote, "..... performed well in this rotation. She was enthusiastic and
asked great questions." ..... worked with a private surgical group at Hartford Hospital for ambulatory surgery. She received very good and excellent ratings in all categories. She received commendation for her clinical diagnostic skills, self-directed learning and professionalism (interactions with staff members, reliability, participation and initiative). Her preceptor wrote, "..... is a wonderful student and a joy to work with. She will make a fine doctor in her chosen specialty."

Student Continuity Practice
The Student Continuity Practice is a required course at the University of Connecticut. Students are assigned to a primary care office for one half-day per week over the first three years of medical school, where they actively practice clinical skills with patients. ..... was assigned to a private pediatric office for SCP. At the completion of her third year, she was awarded excellent or outstanding ratings in every domain. Her preceptor wrote, "....."s strengths include her willingness to listen and to learn. She has excellent physical examination skills. ..... is an earnest, hard working student. She gets along well with staff and with patients and is continuing to grow as a medical student. I am pleased with her progress. ....."s personality is congenial and she gets along well with my office staff. ..... is a fine student that should do well in her future career."

AMBULATORY PROJECT PRESENTATION:
At the completion of her ambulatory rotations, ... presented a formal seminar to a group of her peers and two faculty members. The title of the talk was Skin Diseases: Incidence and Management in Minority Populations. ..... was awarded outstanding ratings for her presentation skills and content. Her preceptors wrote, "..... 's presentation was excellent. She conveyed a confidence and commitment in her review of the use of dermatologists by minority patient populations. She chose three dermatological conditions as example of diseases that benefit from dermatology assessment and treatment, with data that show minority patients do not routinely access this specialty when these diseases occur. She presented a good selection of recommendations to address education for minority populations and for dermatologists in practice. Very nice presentation overall."

Fourth Year Block 1: June 30-July 27, 2008: Dermatology Elective, John Dempsey Hospital
..... exceeded course expectations in all domains. These include: knowledge of facts, understanding concepts, use of resources, problem solving, verbal communication, written communication, technical skills, relating to others, accepting responsibility, seeking feedback, motivation, initiative and judgment. Her preceptor, Dr. Marti Rothe, wrote, "..... is a highly intelligent and motivated student with an excellent fund of knowledge. She has outstanding rapport with patients and staff. She has a terrific work ethic and integrity. ..... gave excellent presentations on vitiligo, dermoscopy and off-label indications of biologics."

Fourth Year Block 2: 7/28 – 8/24, 2008, Dermatology Elective, University of Massachusetts Memorial Medical Center
..... was again rated as exceeding course expectation in every domain. These include: knowledge of facts, understanding concepts, use of resources, problem solving, verbal communication, written communication, technical skills, relating to others, accepting responsibility, seeking feedback, motivation, initiative and judgment. Her preceptor, Dr. Leah Belazarian, wrote, ".....was an absolute pleasure to have in Dermatology Clinic. Her participation in our clinic truly made them more enjoyable. Her fund of knowledge was far above the expected level of a medical student and she truly functioned as a dermatology resident while here. She is a very motivated individual with exceptional work ethic. She will make a stand-out dermatology resident."

Fourth Year Block 3: 8/25-9/21, 2008 Dermatopathololgy Elective – UConn Health Center
..... met course expectations in all domains. Her preceptor wrote, "..... did an excellent job on this rotation. She has a great attitude, and is very motivated and intelligent. By the end of the rotation ..... was able to diagnose many skin biopsies accurately. She is an enthusiastic learner."

Fourth Year Block 4: 9/22-10/19, 2008 Internal Medicine Subinternship– John DempseyHospital
Evaluation not available for review by 10/29/08.

SUMMARY:
The best way to begin summarizing .....'s performance at the University of Connecticut School of Medicine is to highlight her contributions to our academic community. She has fully embraced all available learning opportunities, both curricular and extracurricular. She participated in international research in Nigeria in the summer after her first year. She has completed her MD/MPH dual degree program in four years, a remarkable accomplishment. She has been heavily involved in the Admissions Committee and the Student National Medical Association. I watched her contribute extensively to the Admissions Committee process. Her comments were well-reasoned, her preparation was impeccable and her judgment was always right on the mark. It is noteworthy that during her second year, ... devoted several evenings per week to the clinician who brings empathy and keen intellect to her care of patients. .....'s dual MPH degree has added significantly to her candidacy for residency. She initially entered the MPH program with a desire to do more than just help one patient at a time. She has a commitment to study health disparities and to understand the reasons behind the disparities. ..... recognizes that her MPH training gives her a broader perspective as she enters her medical career; she is able to take a systems approach to community health. She assumes this added responsibility both seriously and willingly.
..... has had a long standing interest in the field of dermatology. Recognizing the risk of sounding trite, she genuinely finds the study of skin disorders fascinating. Dermatology fits

Admissions Committee and to her MPH electives, and still scored significantly above the national mean on the USMLE Step 1 exam..... does all of her activities with enthusiasm, high energy and an ever present smile. ..... is one of the rare individuals who works at a high speed yet appears to do everything effortlessly. As a clinician, ... has been repeatedly commented for her ability to engage in effective patient education. She excels at doing real-time research for patients and providing them with information from on-line sources. She is energized in her role of a student-physician, both in acquiring knowledge and providing it directly to patients. She is a natural her visual learning style and her need to directly apply her learning to patient care. ..... combines her interest in skin disorders with a deep seated compassion for the patient behind the disease. She recognizes that many skin disorders can lead to embarrassment and ostracism. In caring for patients with psoriasis for example, ... looks forward to a career of educating the public as well as the patients themselves about the true nature of the disease. ..... will bring energy, superior interpersonal skills and superior clinical reasoning to her residency program. We are delighted to recommend ..... to you as an **Excellent-Outstanding** candidate for postgraduate training.

Signature_____

Anthony J. Ardolino, MD,
Professor of Medicine
Associate Dean for Medical Student Affairs
ardolino@nso1.uchc.edu
860-679-2113
Soc Sec: 000-00-0000

Medical Student Performance Evaluation- LCME Sample 2
November 1, 2008
Identifying Information:
.... is a fourth-year student at the University of Connecticut School of Medicine in Farmington,Connecticut.

Unique Characteristics
A. Premedical
.... was born and raised in Norwalk, Connecticut. An academically gifted student at ..... High School, ... won admission to Trinity College. .... route to medicine has the steady, determined story of a young man influenced by his physician father, trained in a rigorous academic liberal arts and science curriculum, and advantaged with research, clinical, and community service enrichments. A review of his transcript reveals a sterling overall record at Trinity, where .... majored in Neuroscience. He did outstanding work in numerous upper division sciences such as Biochemistry, Neurochemistry, and the Biology of Infectious Diseases. He received numerous academic awards and recognitions. His candidacy was further distinguished by exceptional research enrichments. At Trinity he worked with Dr. William Church on the etiology of Parkinson's Disease. At Norwalk Hospital, he worked at the Sleep Disorder Center studying the sleep patterns of adolescents. To gain clinical experience, he worked on the Trinity Emergency Response Team and in Trinity's Health Fellows Programs with Dr. Dennis Mello at the Connecticut Children's Medical Center. Outside of his academic prowess, ... played and served in leadership roles on the Trinity College Rugby Team. His pre-med letter read, "Mr. .... is an outstanding student who was selected to participate in Trinity's Interdisciplinary Science Program, a program for a select few who are judged to have exceptional scientific and mathematical aptitude. Achieving Dean's List and Faculty Honors, ... graduated in the top five percent of his class with Honors in Neuroscience and General Scholarship." We were pleased to
welcome .... as a good fit to our academic community.

B. Extracurricular Activities in Medical School
.... has been an active member of the Surgical Scholar's Group. In his first year he taught in the Hartford Health Education Program, presenting weekly health related topics to middle school children in Hartford. He has volunteered at the South Park Inn, a student-run clinic in a homeless shelter. .... has been active in the Men's Squash League at Trinity College throughout medical school. He has participated in poetry competitions. He is an avid stamp collector and enjoys snowboarding and mountain biking.

Academic History:
Date of expected graduation from medical school: -----May 2009
***Date of initial Matriculation*: -----** August 2005
Extensions, leaves, gaps or breaks: None Repeated or remediated coursework: None
Adverse actions: None

ACADEMIC PROGRESS:
Preclinical/basic science curriculum:
We are a pass/fail school with no grade point average or class rank. Evidence of .... mastery of the Basic Science material was a USMLE score of 245. Narrative comments from the first two years include those from the Principles of Clinical medicine course, ".... was an excellent asset to our class through his ability to articulate patient's perspectives, especially those of elders. He demonstrated excellent creative writing skills as evidenced by his professional journals. He showed a strong and consistent command of clinical skills." .... Health Law and Ethics preceptor wrote, "He was an active participant in a strong group. He was prepared and ready to respond. He had a very good grasp of material. His questions reflected an understanding of concepts. He was

attentive and involved and showed strong work overall." .... participated in a History of Medicine elective, and an Arts and Medicine elective. He took an elective entitled 'Surgical Pearls', under the direction of Dr. Robert Kozol, Chair of the Department of Surgery. Dr. Kozol wrote, ".... was always particularly prepared and demonstrated excellent acquired knowledge on the assigned material."

Core Clinical Clerkships and Elective Rotations:
Please note that our Core Clerkships—with the exception of Family Medicine and Ob/Gyn—consist of both an inpatient and an outpatient phase often separated by several months; therefore, it is not possible to present them in strict chronological order.

Family Medicine
.... was assigned to a private practice for Family Medicine. He gave outstanding verbal presentations that were concise, appropriate, organized and easy to follow. He developed, negotiated and implemented superior cost effective management plans. .... demonstrated outstanding logical thought process in developing comprehensive differential diagnoses. He was exceptionally conscientious and dependable, and often made an extra effort to take care of patients in a coordinated fashion. His preceptor concluded, ".... was exceptionally bright and prepared with extraordinary grasp of science and with a broad knowledge base. He dependably worked hard, adapted to our office setting and sought out interesting cases."

Internal Medicine
.... had a strong rotation during inpatient internal medicine at Hartford Hospital. His preceptor wrote, ".... starts out being impressive with his knowledge of medicine with a strong background in physiology. He has the initiative to participate with enthusiasm in all activities of patient care and learning. He is curious to learn and asks a lot of questions he would like to clarify. He has the ability to obtain a comprehensive medical history, and document the same in a chronologic and logical/ prioritized manner. His ability to present the same at the bedside or at formal teaching rounds is very good. He presented more than twice at formal teaching rounds. He does so without prompting. He was able to come up with a well thought-out assessment and a fairly mature management plan for his cases. He relates reasonably well with his team and patients. Overall .... did very well this block and his performance was rated as very good." .... rotated at the Burgdorf Clinic for ambulatory internal medicine. He was given excellent ratings for his clinical diagnostic skills and outstanding ratings for professional behaviors (interaction with staff members, reliability, participation and initiative). His preceptor wrote, "....was able to address his presentation based on the case, omitting unnecessary data and focusing on the appropriate information concisely and in an organized fashion. .... approached patient education in a professional manner. He worked hard to avoid jargon. He provided practical, accurate information and clearly developed rapport with the patients, who trusted him. He had an excellent fund of knowledge and was often able to support his assessment and plan with
evidence. .... used probabilities and epidemiology to guide the diagnostic process. He is able to synthesize clinical and laboratory data into coherent differential diagnoses. He is motivated to learn about all the cases he saw to add to his experience and to educate his colleagues. He is thorough and persistent with patient follow-ups. He took a genuine interest in patient outcomes; .... demonstrated an active sense of responsibility. He is an enthusiastic learner who often brought in evidence to support his assessment and plans. .... is a mature professional with excellent skills in knowledge and clinical reasoning. What sets him apart, however, is his active sense of responsibility. .... has a calm demeanor, which serves him well and he remained organized and focused."

Obstetrics and Gynecology - HONORS
.... rotated at Hartford Hospital for Ob/Gyn. He was given outstanding ratings in 14/14 domains for a truly superior performance. .... was commended for his outstanding medical knowledge, well-developed clinical diagnostic skills and impeccable professionalism. .... was extremely sensitive to the work and needs of others on the team and always constructive in the team approach to patient care. He was exceptionally conscientious and dependable. He made an extra effort to take care of patients in a coordinated fashion. He assumed a much higher level of responsibility than expected. He reported back to the team using evidence-based medicine on patients he had seen. His preceptor concluded, ".... was proactive, energetic and had a strong knowledge base. He was a hard worker and a team player. He gave a good presentation on sterilization. He always presented himself in a professional manner."

Pediatrics - HONORS
.... had a strong performance during his inpatient pediatric rotation at the Connecticut Children's Medical Center. He received outstanding ratings in all domains. His preceptor, the pediatric residency director, wrote, ".... has very well-developed interviewing skills that he adapted to the pediatric setting nicely. .... takes the time to research information and applies it to the clinical reasoning process. He was directly observed to be able to obtain a thorough history. His management plans were very logical, concise and based on strong reasoning skills. He quickly made himself trusted and welcomed as part of the team; all spoke highly of him. .... was always well-prepared, seeking information to prepare for tutorials and in the care of patients. .... strengths are his thorough diagnostic approach, his well-developed professional behavior and outstanding work ethic." .... was assigned to the Burgdorf Clinic for ambulatory pediatrics and had one of the strongest performances of any student over the year. He was awarded excellent and outstanding ratings in all categories. His preceptor concluded, "....'s performance in the pediatric rotation was excellent, marked by exponential growth in many areas. He was able to obtain both comprehensive and focused histories from all age groups and demonstrated strong physical examination skills. His oral presentations were excellent, fluently offering a comprehensive yet concise summary of the encounter, inclusive of his well-reasoned differential diagnoses, assessments and management plan. .... typically took the management plan beyond the initial level and often included the proposed use of support and ancillary services. He was particularly interested in being able to provide good patient education and utilized different resources to support his verbal instruction. The entire faculty commented on ....'s ability to bring forward any knowledge obtained from one patient encounter and apply it to the next. This allowed him to gain both breadth and depth of knowledge and experience. He was an avid seeker and receiver of feedback and demonstrated great initiative in all aspects of patient care. .... interacted well with his colleagues, our residents and our clinic staff."

Psychiatry - HONORS
.... rotated at the Institute of Living for inpatient psychiatry. His preceptor awarded him excellent and outstanding ratings in all clinical domains. She wrote, "....'s verbal presentations were very well-organized. He was very empathetic and respectful in his interactions with patients. He had a very good medical knowledge. He demonstrated outstanding logical thought processes and grasp differential diagnoses. He had an unusually advanced synthesis of biopsychosocial aspects of patient histories. He actively sought feedback for improvement. He was exceptionally conscientious and dependable. He consistently reads up on the literature and made an extra effort to see patients. In summary, ... is one of the best medical students I have taught. He is very bright,

highly motivated, inquisitive and empathetic. He is unusually advanced in his ability to integrate complex data into differential diagnoses. He presented one of his cases in a weekly case conference in a comprehensive manner which led to a fruitful discussion. He showed remarkable initiative by organizing additional call and adding observation of ECT sessions." .... was awarded ratings of 7-9/9 in all clinical categories for an outstanding performance during ambulatory psychiatry. His preceptor wrote, ".... consistently gave excellent presentations. He interacts well with patients and families. He is empathetic and facilitating. He was always respectful to the patients. He had a superior fund of knowledge for an MSIII in general psychiatric and neurologic fund of knowledge. Started out high and finished higher. Clearly was reading articles and text and was able to incorporate those into the work on the service. .... took learning very seriously during this rotation. He is highly self-motivated in learning and handles feedback very well. He is a gifted learner, very reliable, with excellent interpersonal skills. He clearly demonstrated superior rating in areas of participation and initiative. .... exceeded the requirement for the rotation routinely. .... joined forces with a colleague and they both collaborated on an extra project developing a guided psychiatric assessment for bariatric surgery referrals, on which they did an excellent job. .... will clearly make an outstanding physician; clearly a superior performance all around by .... has natural psychiatric skills and will be able to apply them appropriately in other fields of medicine to the benefit of his patients."

'Surgery - HONORS

.... rotated at Saint Francis Hospital for inpatient surgery. His fourth year resident awarded him ratings of 8-9/9 in all domains, with exceptional ratings for his professional behavior. He concluded, ".... did a very good job. He is very interested in surgery, is knowledgeable, liked to be in the OR, and likes to read. ....'s chief resident awarded him equally superior ratings in all domains and wrote, "A very enthusiastic, bright student. He has the right attitude to do well in surgery. I believe he is interested in a surgical residency. He is reliable and dependable. His main strength is, however, his attitude. He is a very hard working individual and will do well." One attending physician awarded .... excellent or outstanding ratings across the board and concluded, "An excellent student, committed to learning, performs strongly during his rotation at Saint Francis Hospital." A second attending noted that his medical knowledge was outstanding for his level of training. He understood surgical principles at a much greater level than expected. .... was awarded exemplary ratings for his professional behavior. The attending concluded, ".... was wellprepared, great initiative, wanted to learn and wants to be involved. He is comfortable in the operating room, great potential." A third surgeon concluded, "I enjoyed working with ..... He was interested in the thoracic surgery cases and came into the OR quite often. He followed these patients on the floor and wrote thorough notes. His knowledge of thoracic surgery grew during the rotation due to his interest and commitment to the care of patients."

BTE (Integrated Inpatient Experience)

BTE is a unique two-week inpatient experience at the University of Connecticut where students are assigned to patients from the ED through discharge. The intent of the experience is to have students work intensively with a preceptor on clinical skills and to understand inpatient medicine from a patient's perspective. Students meet daily with the preceptor to present cases and work on physical diagnostic skills. .... was assigned to New Britain General Hospital for BTE. His attending awarded him ratings of 8-9/9 in all categories and wrote, "Exceptional write-ups. ....was an extremely motivated, very professional student who worked independently and was very adept at finding interesting patients and exploring their medical history and hospital course. Excellent student."

Student Continuity Practice
The Student Continuity Practice is a required course at the University of Connecticut. Students are assigned to a primary care office for one half-day per week over the first three years of medical school, where they actively practice clinical skills with patients. .... was assigned to a private practice for SCP. He received excellent or outstanding ratings in all categories. His preceptor concluded, ".... .... is very enthusiastic about seeing patients in my office. He even comes in on school holidays. He has a superior intellect and easily applies his in-depth knowledge of basic medical science to clinical care. I am impressed by his concern for the patients' emotional well being as well as their medical disease management. ....'s knowledge base is more advanced than I would expect at his stage of training. He surprises me with accurate application of his knowledge to specific patient problems. I find this enhances patient care, suggesting better care than I may not have given without him. He has an engaging personality and all the patients relate well to him; I get regular comments from patients praising his skills as a doctor. .... believes that being a doctor is interesting and exciting. He has respect for his patients and loves using his medical knowledge to help them. His enthusiasm is contagious both to me and my patients. I would predict that .... would prove to be a strong asset for any organization he is associated with."

Fourth Year Block 1: 6/30-7/27, 2008 Surgical Subinternship, New Britain General Hospital
HONORS – .... had a truly superior performance during his surgical Subinternship, receiving perfect 5/5 ratings in every ACGME competency. His preceptor wrote, "Very thoughtful and clear in his presentations. Doesn't mince words; tells you exactly what you need to know. Took time to listen and explain issues with patients in the clinic. Very professional in his interactions. Well read, excellent fund of knowledge; always prepared for cases in terms of reading about them so that he could participate to the fullest. Exceptional in his ability to gather information, process it and derive a well thought out differential and diagnostic and treatment plan. Pays attention to detail. Listens carefully and doesn't make assumptions. ....'s professionalism is one of his greatest strengths. He really gives priority to his patients and works for their needs. .... comes into a case or into a patient's room with an attitude that this is the most important thing he's doing all day; very refreshing to work with someone like that. Works well with everyone involved in a team approach to the patient. Outstanding sub-I. Deserves honors. Has such a deep commitment to taking care of patients, working for his team and learning as much as he can. Technical skills in the operating room also excellent for his level. .... understands the seriousness of each interaction and brings a level of professionalism which is refreshing to see in a student. Will make an outstanding surgical resident."

Fourth Year Block 2: 7/28- 8/24, 2008 Plastic and Reconstructive Surgery - Hartford Hospital
.... was rated as exceeding course expectations in the following domains: use of resources, technical skills, motivation and initiative. His preceptor, Dr. Alan Babigian, wrote, "Very good! Please see attached letter of recommendation."

Fourth Year Block 4: 9/22-10/19, 2008 Plastic and Reconstructive Surgery, Cornell University
Evaluation not available for review by 10/29/08

SUMMARY:
As evidenced by four Honors in the six core disciplines in year three and Honors in his fourth year surgery subinternship, ... has performed at an exceptional level at the University of Connecticut. .... is clearly one of the our finest medical students. He was consistently commended for a wonderful combination of strong clinical skills and outstanding medical knowledge. As others have said, what separates .... from his peers is his admirable commitment to his own education. As he has demonstrated repeatedly, ... has the ability to simultaneously attend to patient care and to his own education. He is self-critical and always trying to improve. .... exhibited tenacity and commitment on every clinical rotation. He has exemplary interpersonal skills, is receptive and friendly in group settings, and is quickly able to smoothly integrate into teams. .... is by nature a soft spoken man who brings a great sense of importance to the matter at hand and responds to tasks diligently. Perhaps the word that describes him best is 'earnest'. .... has had a long standing interest in surgery, which dates back to a clinical experience in college. He is intrigued by the precision and meticulous aspects of surgery, by the camaraderie inherent to the field, and need to adopt specific roles in the operating room to be successful. .... is facile thinking on his feet; he finds this particularly useful in surgical settings. He appreciates surgery's ability to correct a disease process and improve patient's situations quickly. He also brings to his interest of surgery a broad recognition of and capability in all aspects of medicine;
he is aware of the importance of careful pre and post-op management as part of surgical care.
....will undoubtedly rise to a position of leadership in the most competitive of residency programs.

We are delighted to recommend .... to you as an **Exceptionally Outstanding** candidate for postgraduate training.

Signature_____

Anthony J. Ardolino, MD,
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Associate Dean for Medical Student Affairs
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LCME Appendix 60

AAMC

Tomorrow's Doctors, Tomorrow's Cures

LCME I-B Student Financial Aid Questionnaire

University of Connecticut School of Medicine

Return to Survey

Welcome to the 2008-2009 Liaison Committee on Medical Education (LCME) Part I-B Student Financial Aid Questionnaire.

The data requested by this annual survey are classified as unrestricted and are used by the LCME as part of the medical school accreditation process. These data are also entered into the AAMC's Medical School Profile System to provide schools with benchmarking reports. Additionally, some data from this survey are used in the financial aid section of the AAMC publication, Medical School Admission Requirements (MSAR), the most comprehensive guide to all 131 U.S. medical schools.

Please return your completed questionnaire by Friday, October 2, 2009.

If you have any questions involving technical aspects of the survey, contact Susan Gallierd at sgallier@aamc.org. If you have questions that relate to how to report your data, contact Shelley Yeeman by email at syeeman@aamc.org.

SECTION 1 - Financial Assistance Obtained by Students for Academic Year 2008-2009

Instructions:

Column A) Student counts are extracted from your school's 2008-2009 LCME Part II Annual Medical School Questionnaire and pre-populated in the cells below. Since the student counts from the Part II questionnaire are collected in the middle of the academic year, there is a chance that these data may need to be adjusted to reflect the most recent student data available. Please make any modifications necessary.

Column B) Indicate the number of students who received financial assistance in the 2008-2009 academic year.

Column C) Indicate the total dollar amount of aid that students reported in Column B received during the 2008-2009 academic year. Please note that if the total dollar amount of aid reported below does not agree with the sum of the awards reported in Grants/Scholarships (Section 2), Loans (Section 3), and Work-Study (Section 4), an explanation must be given for the discrepancy in Section 5 of the questionnaire.

	A) Number of Students	B) Number of Students Receiving Aid	C) Total Dollar Amount of Aid
First Year Students	88	79	3202100
(All first year students enrolled in the MD program, including those repeating the first year.)			
Second Year Students	85	81	3165475
(All second year students enrolled in the MD program, including those repeating the second year.)			
Third Year Students	79	74	2803053
(All third year students enrolled in the MD program, including those repeating the third year.)			
Fourth Year Students	4	3	68234
(All students enrolled in the fourth year MD program or students who did not graduate during the 2008-2009 academic year.)			

MD/PhD Graduates	75	67	2675304
(All graduating students who graduated during the 2008-2009 academic year.)			
Total	331	301	11908135

If you have any difficulty with the survey, please contact Susan Gallierd at sgallier@aamc.org.

SECTION 2 - Grants/Scholarships

Instructions:

Please report the number of students who received grants/scholarships, the number of grants/scholarships awarded, and the dollar amount of grants/scholarships awarded to all students in the 2008-2009 academic year in each category below.

1. Grants/scholarships without a service commitment

	Total number of students receiving grants/scholarships	Total number of grants/scholarships	Total dollar amount of grants/scholarships
A. Institutional grants for needy and/or disadvantaged students (NOT)	0	0	0
B. Other grants and scholarships (exclude tuition)			
1) Need Based	167	171	2251332
2) Non-need Based			
MD/PhD support	0	0	0
Tuition Remission for employees and/or spouses	0	0	0
Other	43	126	142990
C. Other grants and scholarships, including amounts received from NHSC			
1) Need Based	39	42	150525
2) Non-need Based			
MD/PhD funding	0	0	0
Other	0	0	0
TOTAL Dollar Amount of Grants/Scholarships in Section 2, 1			2544847

2. Grants/scholarships with a service commitment

In reporting grants/scholarships with a service commitment, please include the dollar amount of tuition and other reimbursable expenses (e.g., books, health insurance, and supplies). It is recognized that exact amounts for reimbursable expenses may not be known; in such cases, provide estimates. Do not include living expense stipends.

National Health Service Corps	2	2	56727

Armed Forces Health Professions	5	5	170012
State Funded	0	0	0
Other	0	0	0
TOTAL Dollar Amount of Grants/Scholarships in Section 2, II			226749
TOTAL Dollar Amount of Grants/Scholarships in Sections 2, I and 2, II			2771666

1. Please include the number of students who received each grant/scholarship in the 2008-2009 academic year. Only count each student once per category, even if the student has received multiple grants/scholarships.
2. Please include the number of grants/scholarships awarded per category in the 2008-2009 academic year. One student could have received multiple scholarships per category.
3. Please include the total dollar amount of each grant/scholarship category in the 2008-2009 academic year.
4. Please include the grants and scholarships (need-based, M.D.-PhD. support, tuition remission, and other) funded with institutional resources.
5. Please include the grants and scholarships (need-based, M.D.-PhD. funding, and other) funded by federal state, foundations, or other external sources.

If you have any difficulty with the survey, please contact Susan Gallierd at sgallierd@aamc.org.

SECTION 3 - Loans

Instructions:

Please report the number of loans and the dollar amount of loans awarded to all students in the 2008-2009 academic year in each category below.

	Total number of loans[1]	Total dollar amount of loans[2]
Federal Unsubsidized Stafford Loans (private lenders)	0	0
Federal Unsubsidized Stafford Loans (other lenders)	233	8651433
Federal Subsidized Stafford Loans (private lenders)	0	0
Federal Subsidized Stafford Loans (other lenders)	268	2257821
Federal Direct Subsidized Student Loans	0	0
Federal Direct Unsubsidized Student Loans	0	0
Grad PLUS Loan (FFELP)	0	0
Grad PLUS Loan (FDLP)	32	359842
Federal Perkins Loans	0	0
Primary Care Loan (PCL)[3]	0	0
State Funded Loans	0	0
Private/Alternative Loan Programs[4]	9	254030
Loan for Disadvantaged Students (LDS)	0	0
Total other State-sponsored funding[5]	0	0
Total other Institutional funding[6]	115	593643
TOTAL Dollar Amount of Loans in Section 3		9136470

1. Please include the number of loans awarded to all students in each category in the 2008-2009 academic year. One student could have received multiple loans in each category.
2. Please include the total dollar amount of each loan awarded to all students in the 2008-2009 academic year.
3. Subject PCL loan data should not be included with PCL data; include Subject PCL loan data in Question 1 in the Supplemental Data Section of this questionnaire.
4. Please include only those private and alternative loans that the financial aid office has certified.
5. Please include state aid loans that universities, agencies, foundations, or other external sources funded.
6. Please include institutional scholarships funded.

If you have any difficulty with the survey, please contact Susan Gallierd at sgallierd@aamc.org.

SECTION 4 - Work-Study

Instructions:

Please report all college work-study payments in the "federally-funded" category (include both federal and school contributions). Enter "NA" if the program is not offered.

	Total number of students receiving payments	Total dollar amount of work-study payments
Federally funded	0	0
Non-federally (e.g., school-only) funded	0	0
Total Dollar Amount of Work-Study Payments		0

If you have any difficulty with the survey, please contact Susan Gallierd at sgallierd@aamc.org.

SECTION 5 - Grand Total dollar amount of grants, scholarships, loans and work-study

Instructions:

Sections 1 through 4 must be completed before Section 5 can be completed. The Grand Total of Sections 2, 3, and 4 is a sum of the grand total dollar amounts as reported in Grants/Scholarships (Section 2), Loans (Section 3), and Work-Study (Section 4). The Total from Section 1, Column C is the total dollar amount of aid as reported in Financial Assistance (Section 1). If the Grand Total of Sections 2, 3, and 4 does not equal the Total from Section 1, Column C, an explanation must be provided in the text box below.

	Total dollar amount of awards
Grand Total of Sections 2, 3, and 4	11908136
Total from Section 1, Column C	11908136
Difference	0

The Grand Total of Sections 2, 3, and 4 MUST agree with total dollar amount of assistance reported in Total from Section 1, Column C.
If they do not agree, please provide an explanation below.

If you have any difficulty with the survey, please contact Susan Gallant at sgallant@aamc.org.

SECTION 6 - Educational Indebtedness

1. To the best of your knowledge, please report the total *pre-medical* indebtedness of all members of the 2008-2009 first year class prior to their medical school matriculation. National Student Loan Data Systems (NSLDS) data are acceptable. If you are unable to report the number of students with pre-medical debt or the amount of pre-medical debt, please enter "NI" in the appropriate box and provide an explanation in the text box below.

Number of indebted students	34
Total amount of indebtedness	636955

If you entered "NI" in the boxes above, please provide an explanation below.

II. Please report the total cumulative *medical* school indebtedness (excluding debt associated with enrollment in joint, dual, or combined degree programs) per class of indebted students as of the end of the 2008-2009 academic year. If you are unable to report the number of students with medical school debt or the amount of medical school debt, please enter "NI" in the appropriate box and provide an explanation in the text box below. Please note that the values in the "Percentage of Graduates with Medical School Debt" and the "Average Graduate Debt" boxes will be automatically calculated and displayed for your convenience. You will not need to make these calculations.

	Number of students with medical school debt	Total medical school debt amount for all students
First year	72	3478864
Second year	86	5180459
Third year	79	5196468
Fourth year	79	7883864
Other Graduates	69	7896604
Total	384	29736049
	Percent of Graduates with Medical School Debt	Average Graduate Debt
	92	114429

If you entered "NI" in the boxes above, please provide an explanation below.

III. Please report the number of graduating students with total *educational* debt, including educational debt incurred prior to medical school matriculation, in each of the ranges below. The total number of graduates will be automatically calculated and must equal the number reported in Section 1 of the survey.

	Number of Graduates with Educational Debt
No Educational Debt	9
$ 1 - $ 10,000	0
$ 20,000 - $ 29,999	3
$ 30,000 - $ 39,999	3
$ 40,000 - $ 49,999	3
$ 50,000 - $ 59,999	2
$ 60,000 - $ 69,999	1
$ 70,000 - $ 79,999	1
$ 80,000 - $ 89,999	5
$ 90,000 - $ 99,999	6
$100,000 - $109,999	5
$110,000 - $119,999	2
$120,000 - $129,999	0
$130,000 - $139,999	3
$140,000 - $149,999	3
$150,000 - $159,999	7
$160,000 - $169,999	8

$[illegible] - $149,999	4
$[illegible] - $199,999	3
$[illegible] - $199,999	2
$[illegible] - $249,999	2
$[illegible] - $299,999	0
$[illegible] - $299,999	2
$[illegible] - $299,999	0
$[illegible] - $349,999	0
$350,000 or greater	0
Total Graduates with Educational Debt	66
Total Graduates	75

1. The fourth year row is to be used for students who are in their fourth, fifth or sixth year of medical school and who will graduate after the 2009 graduating class.
2. The 2009 Graduates row is to be used for all students who graduated during the 2008-2009 academic year.

If you have any difficulty with the survey, please contact Susan Gallard at sgallard@aamc.org.

Supplemental Data Section

Instructions:

The Supplemental Section of the LCME Part I-B Student Financial Aid Questionnaire is optional. The following data are not required by the LCME, but are requested for use in research and development efforts associated with current issues and trends in medical school financial aid and educational debt.

While the majority of the data derived from this supplemental section of the survey are unrestricted and may be published with school identification, data from a few items may be considered 'Restricted' and may only be released in limited situations in which the data will not be published with institutional identification. These items will be labeled with the letter 'R' to indicate their 'Restricted' classification.

I. Report the number of students and the total dollar amount awarded of "Super PCL" to 3rd and 4th year students for the purpose of paying off the balances of higher cost educational loans.

	Number		Super PCL Amount
3rd year students:	0	Total dollar amount of Super PCL:	0
4th year students:	0	Total dollar amount of Super PCL:	0

II. Do you provide an in person exit interview?

(•) Yes ( ) No

III. Excluding entrance and exit interviews, do you hold any debt management sessions for students during the academic year? (For example, for 2nd and 3rd year students)

(•) Yes ( ) No

IV. Has your school already IMPLEMENTED any initiatives or programs designed to help reduce students' educational debt?

(•) Yes ( ) No

If yes, please select and describe all that apply:

[ ] Guaranteed tuition and fees for the length of the MD curriculum

[ ] Non-traditional tuition structure

[ ] Expand campus-based income or scholarship funds

[ ] Partnership with outside organizations to reduce student debt

[ ] Change in grant or scholarship requirements

[X] Other

We sponsor numerous financial literacy programs through out the students's

V. Has your school already CONSIDERED the implementation of any of the following initiatives or programs to address students' educational debt?

(•) Yes ( ) No

If yes, please select and describe all that apply:

[ ] Guaranteed tuition and fees for the length of the MD curriculum

[ ] New institutional loan programs

[x] Capital campaign to increase scholarship funds

[ ] Partnership with outside organizations to reduce student debt

[ ] Changes in grants or scholarship requirements

[ ] Other

VI. a. To the best of your knowledge, how many of your 2009 medical school graduates were enrolled in a combined/dual/joint degree or certificate program (e.g., M.D./Ph.D. and M.D./M.P.H. programs) since their matriculation at your institution or another institution?

Number: 7

b. Was the educational debt they incurred while enrolled in the degree or certificate program(s) included in the medical school total indebtedness amount reported in Section D, Part II of the LCME I-D Questionnaire?

(•) Yes ( ) No

c. If yes, can you differentiate combined/dual/joint degree or certificate program debt from medical school debt reported in the LCME I-D?

( ) Yes (•) No

d. If yes, what is the total amount of non-medical debt incurred as a result of these students enrollment in the combined/dual/joint degree or certificate program(s)?

Amount:

VII. (R) a. Do you have the ability to identify the federal cohort default rate for your medical school?

(•) Yes ( ) No

(R) b. If yes, what is the most recent federal cohort default rate for your medical school?

0

If you have any difficulty with the survey, please contact Susan Gallardo at sgallardo@aamc.org.

Survey Contact Information

Please enter the contact information of the individual who completed the survey

*First Name:	Andrea
Middle Name:	Blanchette
*Last Name:	Devereux
Suffix:	
*Title 1:	Director of Financial Aid
Title 2:	
Title 3:	
*Phone: (XXX-XXX-XXXX)	860-679-3574
Phone Ext.:	
*Email:	devereux@uchc.edu

Return to Survey

2009-027

Executive Summary

Below is an Executive Summary of the principal findings from current medical students' feedback.

Areas of Strength

- ***Overall Academics and Curriculum*** – Students are very satisfied with the systems-based approach of UConn's curriculum, as well as structural integration of small group learning with lectures. Students are also very satisfied with the current class size and the pass/fail system that serves as the basis for grades during the first two years of medical school. They report that they feel the curriculum and program at UConn fully enables them to develop into exceptional physicians. Finally, students rated highly the overall responsiveness of faculty to their needs.
- ***Overall Academics and Curriculum: First and Second Years*** – Students again report being very satisfied with the overall first- and second-year curriculum, as well as with the pass/fail system. Praise is also given to the utility of laboratory time, as well as that of small group time. Furthermore, the Organ Systems (OS 1, 2, 3) courses are highly rated.
- ***Overall Academics and Curriculum: Third and Fourth Years*** – Students report that they receive an excellent exposure to primary care fields during these two years, and that that third and fourth year clerkships highly re-enforce the curriculum taught during the first two years. Furthermore, they report that the curriculum strongly prepares them for the Step 2 CK and CS examinations.
- ***Facilities*** – Students are very satisfied with the lecture halls, MDL classrooms, and anatomy labs. They are also very satisfied with the library facilities, the educational resources available in the library, and the safety at affiliated clinical sites.
- ***Extracurricular Activities*** – Students are overall very satisfied with the availability of extracurricular activities offered through the school.
- ***Student-Faculty-Administration Relationships*** – This section is also rated very highly in regards to the availability of faculty to students, the emphasis faculty place on student education, the responsiveness of the faculty and administration, and the sense of welcome that students feel on student-faculty committees.
- ***Student Life*** – Students praise the class size and the ease with which they feel they can make friends at UConn.
- ***First Year Curriculum*** – All of the components of the first-year curriculum, with the exception of histology and the Principles of Clinical Medicine I course, received very positive overall ratings.
- ***Second Year Curriculum*** – All of the components of the second-year curriculum, with the exception of the behavioral sciences component of the Human Development and Health course and the pharmacology component, were ranked very highly.
- ***Third Year Curriculum*** – All third year clerkships, with the exception of the Beginning to End and the Outpatient Psychiatry clerkships, received overall favorable ratings.
- ***Fourth Year Curriculum*** – The sub-internships in medicine, surgery, and pediatrics received overall favorable ratings. In addition, the critical care clerkships in medicine, pediatrics, and surgery also received overall favorable ratings. Finally, the Emergency Medicine clerkship, as well as the electives, were favorably rated.

Areas of Mild Criticism

- ***Overall Academics and Curriculum*** – Of moderate concern is the students' responses to their perceived ability to find faculty mentors during medical school or to receive guidance from advanced students. In addition, there is moderate concern related to the student's level of satisfaction with the continuity between educators, courses, and disciplines throughout the four years.
- ***Overall Academics and Curriculum: First and Second Years*** – The Human Biology (HB 1, 2, 3) and the Human Development and Health (HDH) courses are ranked lower than the Organ Systems courses, indicating courses receiving moderate criticism. There is also some concern over the lack of sufficient rotation of students among the small group settings. Finally, there is a lack of satisfaction with the guidance provided for summer opportunities between the first and second years.
- ***Overall Academics and Curriculum: Third and Fourth Years*** – There is moderate concern about the lack of opportunity to take electives in the students' future field of practice. In addition, students raise some concern about the inconsistency between educational experiences at the different clerkship sites. Finally, there is moderate concern about the objectivity and fairness of evaluations used by attendings to rate the students' performance.
- ***Facilities*** – There is some concern about the library hours and the areas available for personal study at the health center. Furthermore, there is some concern about the cleanliness of the health center.
- ***Student-Faculty-Administration Relationships*** – There is moderate criticism about the amount of financial aid counseling offered to students.
- ***Student Life*** – There is moderate concern regarding the use of MDSG (school government) funding for post-exam parties, as well as the quality of school-sponsored events. There is also some concern regarding the amount of student diversity.
- ***Student Health*** – There is some concern regarding the students' perception of how proactive the administration is in promoting student health.
- ***First Year Curriculum*** – The Histology and Principles of Clinical Medicine I courses were ranked slightly lower in comparison to the other components of the first-year curriculum.
- ***Second Year Curriculum*** – The pharmacology component of this curriculum and the behavioral sciences component of the Human Development and Health course were ranked less favorably than the other components of this curriculum.
- ***Third Year Curriculum*** – The Outpatient Psychiatry rotation was ranked lower in comparison to all other clerkships, with the exception of the Beginning to End clerkship, as mentioned below.

Areas of Moderate Criticism

- ***Overall Academics and Curriculum*** – Students report an overall dissatisfaction with the availability of counseling about career options and residency programs through UConn.
- ***Overall Academics and Curriculum: Third and Fourth Years*** – There is considerable concern about a lack of exposure to specialty fields during the clinical clerkships. Furthermore, there is considerable concern about the timeliness with which clerkship evaluations are completed by attendings.

- ***Facilities*** – Areas of considerable criticism include the new library café, the lack of exercise facilities at the health center, the student lounge, and the availability of student parking.
- ***Third Year Curriculum*** – The Beginning to End (BTE) clerkship received a less than favorable overall response rating, representing a dissatisfaction with this clerkship.
- ***Fourth Year Curriculum*** – The selective project, a requirement of the fourth year curriculum, received poor overall ratings and much criticism. Many students felt that the selective project guidelines were too narrow and limited their potential project ideas. Contrary to students' thoughts, the selective project guidelines allow for almost any project. These guidelines should be better explained to students, informing them that they can design almost any project to fit the selective objectives. Unfortunately, selective-specific questions were not incorporated into this survey. It would have been interesting to obtain objective data on the following questions: 1) Did students conduct a research project prior to the selective?; 2) Does the timeframe of the selective deter students from conducting meaningful research?; 3) Were faculty members responsive to their concerns?; and 4) Do they feel that they can find adequate research opportunities at the University of Connecticut Health Center institution? This committee suggests that selective project be re-evaluated for its importance in the curriculum and whether or not it meets its objectives.

General Questions

Academics and Curriculum

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Attending lectures and conferences were worthwhile experiences.	79	125	19	6	2	1	232
The School of Medicine should have an AOA chapter (medical honors society).	27	45	75	49	36	0	232
It is important for the school to have an honor board and to enforce the honor code.	128	81	20	3	0	0	232
Educators were aware of the goals/objectives of the courses.	48	148	29	4	2	1	232
The continuity of course goals and objectives between educators, courses, and disciplines was excellent.	28	120	67	14	3	0	232
It is better to limit the number of educators teaching a course for improving continuity of learning.	71	107	37	17	0	0	232
The faculty is responsive to student feedback about courses and teaching.	54	111	42	22	2	1	232
The examinations were relevant to courses' objectives.	41	152	31	7	1	0	232
Preceptor feedback was constructive and important to my self-improvement.	42	131	47	6	2	4	232
The evaluation method for critiquing student performance is ideal.	16	103	79	27	4	3	232
The remediation and tutorial services are excellent.	16	46	49	4	5	112	232
The overall class size is ideal given the resources and facilities at UConn.	92	115	19	5	1	0	232
The counseling about careers options and residency programs is excellent.	14	47	67	41	19	44	232
The opportunity to find faculty mentors during medical school is excellent.	33	101	54	27	8	9	232
The opportunity to receive guidance from advanced students is excellent.	52	104	50	18	4	4	232

The clinical skills assessment program is excellent.	67	107	33	18	7	0	232
The opportunity to be engaged in self-directed independent learning is excellent.	41	128	46	9	1	7	232
The UConn curriculum enables me to develop into an exceptional clinician.	84	122	18	6	0	2	232
Overall, the curriculum is successful in its educational goals.	81	133	15	1	2	0	232

Academics and curriculum for the first and second years:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The systems-based curriculum approach is excellent.	131	88	7	2	0	4	232
The quality and organization of the human biology courses (HB-1, HB-2 and HB-3) are excellent.	32	123	47	26.00	1	3	232
The quality and organization of the organ systems courses (OS-1, OS-2, and OS-3) are excellent.	66	132	19	10	0	5	232
The quality and organization of the human development and health course (HDH) is excellent.	35	65	39	12	9	72	232
The mechanisms of disease courses (MOD 1, MOD 2, MOD 3, MOD 4) are excellent.	49	81	25	5	1	71	232
The pass/fail curriculum of the first two years is ideal.	150	59	16	4	0	3	232
The time spent in labs helped to expand upon knowledge learned in lecture.	84	121	17	6	1	3	232
Small group classes are excellent learning environments.	104	100	20	4	1	3	232
There is sufficient rotation of students among small groups.	44	94	31	47	13	3	232
There is an excellent dynamic between the medical and dental school classes.	35	81	64	42	6	4	232
The curriculum in the first two years adequately prepared me for USMLE Step 1.	28	56	28	10	4	106	232
The variety and quality of first and second year electives are excellent.	41	98	58	21	4	10	232
The guidance for summer opportunities between first and second years is excellent.	23	62	69	55	14	9	232

Academics and curriculum for the third and fourth years:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The clinical clerkships reinforced the basic sciences and mechanisms of diseases curriculum that were taught during the first two years of medical school.	30	9	11	2	0	115	232
The exposure to primary care disciplines (internal medicine, pediatrics, OBGYN, and family medicine) was excellent.	50	5	7	0	2	115	232
The exposure to specialties during the clinical clerkships was excellent.	10	10	12	37	25	116	232
The opportunity to take electives in my future field of practice was excellent.	22	12	14	19	9	133	232
The rotations at UConn-affiliated clinical sites provide similar educational experiences.	17	15	17	15	4	117	232
Clerkship evaluations were completed in a timely manner.	7	24	26	31	11	116	232
The evaluations (myevaluations.com) fairly and objectively reflected clerkship performance.	14	25	27	16	5	115	232
The curriculum adequately prepared me for USMLE Step 2 CK (Clinical Knowledge).	23	8	11	2	0	168	232
The curriculum adequately prepared me for USMLE Step CS (Clinical Skills).	41	5	8	1	0	168	232

Facilities

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The lecture halls are excellent.	87	59	16	11	0	2	227
The MDL classrooms are excellent.	61	70	38	5	2	1	227
The anatomy laboratory rooms are excellent.	70	63	29	7	1	2	227
The quality of the library facilities is excellent.	57	66	33	19	7	3	227
The library hours are appropriate for a medical school.	34	62	25	47	8	3	227
The educational resources/textbooks/journals/online journal subscriptions available in the library are excellent.	75	71	18	7	2	3	227
The reference librarians are excellent.	63	62	33	4	0	21	227
The areas available for personal study at the health center are excellent.	38	57	37	41	17	2	227
The student lounge space is excellent.	13	31	51	69	53	7	227
The parking available for students is excellent.	8	34	46	71	78	3	227
The merchandise available at the bookstore is excellent.	32	65	57	9	2	5	227
The health center's cafeteria is excellent.	19	59	69	36	23	2	227
The new cafe outside of the library is excellent.	6	31	44	57	76	24	227
It is acceptable that there are no exercise facilities on the health center campus.	6	23	24	48	139	2	227
Students were made aware of showers/locker rooms for personal use.	4	20	24	65	111	6	227
The cleanliness of the health center is sufficient.	36	62	38	25	10	1	227

The health center's commitment to "green" technologies is excellent.	11	52	93	51	21	16	227
Campus security at the health center is adequate	39	76	51	5	2	5	227
I feel safe at our affiliated hospitals & clinical sites.	46	74	25	8	1	20	227

Student-Faculty Administration Relationships

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Basic science faculty are available and easily accessible to students outside of class.	78	70	18	4	0	2	227
Student education is a priority for basic science faculty.	74	70	31	13	1	3	227
Clinical faculty are available and easily accessible to students outside of class.	68	68	30	1	0	8	227
Student education is a priority for clinical faculty.	73	65	24	5	0	8	227
Administration is available and easily accessible to students.	96	61	18	4	1	1	227
Administration is aware of student issues.	72	66	28	8	2	2	227
Administration is responsive in a timely and adequate manner to student concerns.	62	71	31	14	3	4	227
Students are welcomed and valued on medical school committees.	82	56	24	2	2	12	227
Financial aid administration is available and accessible to students.	61	70	20	8	8	16	227
Financial aid counseling is adequate.	49	57	38	19	11	19	227

Student Health

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The administration is proactive in promoting student health.	32	86	65	18	7	1	227
Students would benefit from having access to an on-campus student health clinic.	56	84	54	21	2	1	227
The health insurance coverage that the school provides for students is adequate.	43	79	39	15	4	4	227
I feel comfortable seeking help for a psychological health issue through the school's student counseling services.	41	71	36	16	8	24	227
I would feel comfortable referring myself or another impaired student to CHIPS (Confidential Help for Impaired Students) for counseling.	23	84	57	11	8	14	227

Student Life

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
I am satisfied with the amount of time I spend with my family and friends.	34	62	25	41	7	1	227
Since I have started medical school I have found new ways to be social and to enjoy myself.	30	77	52	32	8	1	227
I have missed significant events in my personal life due to medical school obligations.	19	62	44	81	17	1	227
I am able to manage my time in order to do things that I enjoy.	31	83	41	13	3	1	227
I find that it is easy to make friends at UConn and that I belong in this community.	61	74	27	9	6	1	227

I believe that I am able to maintain a healthy level of physical fitness while in medical school.	32	69	40	58	9	1	227
I believe that I can maintain a healthy diet while in medical school.	32	80	40	38	6	1	227
I think the class sizes are just right for appropriate connections.	59	84	24	3	2	1	227
School-sponsored events are fun.	48	86	34	16	7	5	227
Post-exam events are a good use of MDSG funding.	56	69	46	21	19	3	227
There are sufficient events and activities within the school to promote student connections.	41	84	36	23	5	1	227
There is adequate representation of student diversity at this medical school.	49	75	39	17	10	2	227

Extracurricular Options

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
There is an adequate selection of extracurricular activities offered by the school.	34	79	44	23	4	1	227
The student scholar groups are valuable and easily accessible.	68	71	20	5	0	5	227
The student-run clinics are important for the community and for my education.	89	57	15	9	1	5	227
There are adequate venues to participate in non-academic extracurricular activities such as athletics, music and art.	25	74	69	36	6	2	227
There are readily available opportunities to be involved in academic medicine and research.	35	76	50	13	2	6	227
The school provides many ways to volunteer and support the community (e.g. teaching, tutoring, health fairs, etc.)	98	68	12	2	0	2	227

First Year Basic Science Courses

Anatomy

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	55	153	8	3	0	2	221
Faculty were enthusiastic and effective in accomplishing course objectives.	80	121	13	6	0	1	221
The academic demands and workload were challenging.	77	136	4	2	1	1	221
Overall, the course was successful and valuable.	77	132	6	5	0	1	221

Neuroscience

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	43	125	27	18	5	3	221
Faculty were enthusiastic and effective in accomplishing course objectives.	56	115	24	20	3	3	221
The academic demands and workload were challenging.	104	102	9	2	1	3	221
Overall, the course was successful and valuable.	57	117	26	14	4	3	221

Physiology

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses

The objectives were made clear and were accomplished.	59	136	10	4	0	12	221
Faculty were enthusiastic and effective in accomplishing course objectives.	71	125	9	4	0	12	221
The academic demands and workload were challenging.	66	129	11	3	0	12	221
Overall, the course was successful and valuable.	73	123	10	2	0	13	221

Biochemistry

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	52	136	26	6	0	1	221
Faculty were enthusiastic and effective in accomplishing course objectives.	74	123	17	6	0	1	221
The academic demands and workload were challenging.	78	130	9	3	0	1	221
Overall, the course was successful and valuable.	58	132	23	7	0	1	221

Histology

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	52	117	27	22	2	1	221
Faculty were enthusiastic and effective in accomplishing course objectives.	66	101	32	19	2	1	221
The academic demands and workload were challenging.	46	126	30	17	1	1	221
Overall, the course was successful and valuable.	50	117	28	22	2	2	221

Problem-Based Learning (Year 1)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	64	123	18	10	4	2	221
Faculty were enthusiastic and effective in accomplishing course objectives.	72	114	25	3	5	2	221
Faculty and group dynamics greatly enhanced my medical education.	64	104	32	15	4	2	221
The academic demands and workload were challenging.	45	124	39	8	3	2	221
Overall, the course was successful and valuable.	58	125	23	7	5	3	221

Principles of Clinical Medicine I

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	34	121	38	20	7	1	221
Faculty were enthusiastic and effective in accomplishing course objectives.	53	128	20	14	5	1	221
Clinical Skills has been a valuable tool to practice the skills learned in PCM and SCP.	64	108	26	15	7	1	221
The academic demands and workload were challenging.	22	97	66	28	7	1	221
Overall, the course was successful and valuable.	42	110	39	15	13	2	221

Second Year Basic Science Courses

Behavioral Sciences:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	36	95	14	3	1	71	220
Faculty were enthusiastic and effective in accomplishing course objectives.	48	87	13	1	0	71	220
The academic demands and workload were challenging.	20	68	34	23	4	71	220
Overall, the course was successful and valuable.	34	78	26	9	2	71	220

Epidemiology

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	32	99	16	3	0	70	220
Faculty were enthusiastic and effective in accomplishing course objectives.	36	91	23	0	0	70	220
The academic demands and workload were challenging.	18	87	27	17	1	70	220
Overall, the course was successful and valuable.	29	97	20	4	1	69	220

Microbiology:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	28	82	27	12	2	69	220
Faculty were enthusiastic and effective in accomplishing course objectives.	35	79	27	8	2	69	220
The academic demands and workload were challenging.	67	75	7	2	0	69	220
Overall, the course was successful and valuable.	36	81	27	5	2	69	220

Pathology:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	40	100	8	2	0	70	220
Faculty were enthusiastic and effective in accomplishing course objectives.	48	90	9	3	0	70	220
The academic demands and workload were challenging.	47	91	8	4	0	70	220
Overall, the course was successful and valuable.	43	97	9	1	0	70	220

Pathophysiology:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	43	96	9	2	0	70	220
Faculty were enthusiastic and effective in accomplishing course objectives.	52	90	7	1	0	70	220

The academic demands and workload were challenging.	56	89	5	0	0	70	220
Overall, the course was successful and valuable.	51	92	6	1	0	70	220

Pharmacology

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	17	67	43	20	3	70	220
Faculty were enthusiastic and effective in accomplishing course objectives.	23	76	32	15	4	70	220
The academic demands and workload were challenging.	43	85	15	5	2	70	220
Overall, the course was successful and valuable.	16	73	41	15	5	70	220

Student Continuity Practice (SCP), year 2:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	50	87	14	0	1	68	220
Preceptors were enthusiastic and effective in accomplishing course objectives.	75	67	5	5	0	68	220
The experience at SCP will make me a better clinician.	91	50	11	0	0	68	220
The academic demands and workload were challenging.	39	76	27	10	0	68	220
Overall, the course was successful and valuable.	78	66	6	2	0	68	220

Problem-Based Learning (PBL), year 2:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	43	94	9	4	1	69	220
Faculty were enthusiastic and effective in accomplishing course objectives.	55	78	13	4	1	69	220
Faculty and group dynamics greatly enhanced my medical education.	51	76	15	6	3	69	220
The academic demands and workload were challenging.	38	93	16	4	0	69	220
Overall, the course was successful and valuable.	50	83	9	6	3	69	220

Principles of Clinical Medicine (PCM), year 2:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
The objectives were made clear and were accomplished.	47	83	15	5	1	69	220
Faculty were enthusiastic and effective in accomplishing course objectives.	67	71	9	4	0	69	220
The Clinical Skills Assessment Program has been a valuable tool to practice the skills learned in PCM and SCP.	51	71	19	7	3	69	220
The academic demands and workload were challenging.	35	79	27	9	1	69	220
Overall, the course was successful and valuable	52	78	16	4	1	69	220

Third Year Clerkships

Beginning to End

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	7	28	12	19	4	34	104
Residents were enthusiastic and effective teachers throughout the rotation.	8	15	21	13	6	41	104
Faculty were enthusiastic and effective teachers throughout the rotation.	23	37	20	5	5	14	104
My patient care responsibilities were appropriate for my level of training	9	47	13	14	4	17	104
I saw a wide variety or patients and chief complaints.	13	37	21	17	3	13	104
The overall quality of the rotation was excellent.	8	27	22	22	13	12	104

Family Medicine

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	19	47	12	7	1	18	104
Residents were enthusiastic and effective teachers throughout the rotation.	19	22	4	1	0	58	104
Faculty were enthusiastic and effective teachers throughout the rotation.	45	35	3	2	1	18	104
My patient care responsibilities were appropriate for my level of training	40	41	1	3	1	18	104
I saw a wide variety or patients and chief complaints.	43	37	4	2	0	18	104
The overall quality of the rotation was excellent.	37	37	10	1	1	18	104

Internal Medicine (Inpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	44	45	1	0	0	14	104
Residents were enthusiastic and effective teachers throughout the rotation.	43	37	9	0	2	13	104
Faculty were enthusiastic and effective teachers throughout the rotation.	36	49	4	1	1	13	104
My patient care responsibilities were appropriate for my level of training	37	49	4	1	0	13	104
I saw a wide variety or patients and chief complaints.	42	43	4	1	0	14	104
The overall quality of the rotation was excellent.	39	43	7	0	1	14	104

Internal Medicine (Outpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	30	52	3	0	0	19	104
Residents were enthusiastic and effective teachers throughout the rotation.	25	32	7	3	0	37	104
Faculty were enthusiastic and effective teachers throughout the rotation.	39	39	4	2	2	18	104
My patient care responsibilities were appropriate for my level of training	37	46	2	0	1	18	104

I saw a wide variety or patients and chief complaints.	36	43	3	2	2	18	104
The overall quality of the rotation was excellent.	33	47	2	2	2	18	104

Obstetrics/Gynecology

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	36	44	6	1	0	17	104
Residents were enthusiastic and effective teachers throughout the rotation.	32	35	9	8	3	17	104
Faculty were enthusiastic and effective teachers throughout the rotation.	37	36	11	3	0	17	104
My patient care responsibilities were appropriate for my level of training	31	48	7	1	0	17	104
I saw a wide variety or patients and chief complaints.	33	42	8	3	1	17	104
The overall quality of the rotation was excellent.	30	43	12	1	1	17	104

Orthopedics

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	23	52	3	4	2	20	104
Residents were enthusiastic and effective teachers throughout the rotation.	23	33	2	3	0	43	104
Faculty were enthusiastic and effective teachers throughout the rotation.	30	45	4	6	0	19	104
My patient care responsibilities were appropriate for my level of training	20	37	16	11	1	19	104
I saw a wide variety or patients and chief complaints.	20	45	12	8	0	19	104
The overall quality of the rotation was excellent.	19	44	19	3	0	19	104

Otolaryngology (ENT)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	15	63	5	3	0	18	104
Residents were enthusiastic and effective teachers throughout the rotation.	15	32	5	0	0	52	104
Faculty were enthusiastic and effective teachers throughout the rotation.	26	56	5	1	0	16	104
My patient care responsibilities were appropriate for my level of training.	14	42	16	14	2	16	104
I saw a wide variety of patients and chief complaints.	15	49	14	10	0	16	104
The overall quality of the rotation was excellent.	16	52	16	4	0	16	104

Pediatrics (Inpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	52	33	4	1	0	14	104
Residents were enthusiastic and effective teachers throughout the rotation.	54	33	2	2	0	13	104

Faculty were enthusiastic and effective teachers throughout the rotation.	60	27	1	2	1	13	104
My patient care responsibilities were appropriate for my level of training.	47	36	7	0	1	13	104
I saw a wide variety or patients and chief complaints.	44	42	2	2	1	13	104
The overall quality of the rotation was excellent.	52	31	5	2	1	13	104

Pediatrics (Outpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	43	40	3	0	0	18	104
Residents were enthusiastic and effective teachers throughout the rotation.	30	24	3	2	0	45	104
Faculty were enthusiastic and effective teachers throughout the rotation.	49	31	2	4	1	17	104
My patient care responsibilities were appropriate for my level of training.	43	40	2	1	1	17	104
I saw a wide variety or patients and chief complaints.	40	39	5	2	1	17	104
The overall quality of the rotation was excellent.	43	35	5	3	1	17	104

Psychiatry (Inpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	34	38	9	8	0	15	104
Residents were enthusiastic and effective teachers throughout the rotation.	38	36	3	5	2	20	104
Faculty were enthusiastic and effective teachers throughout the rotation.	43	35	7	3	1	15	104
My patient care responsibilities were appropriate for my level of training.	43	35	7	4	0	15	104
I saw a wide variety or patients and chief complaints.	42	35	8	3	1	15	104
The overall quality of the rotation was excellent.	41	34	12	1	1	15	104

Psychiatry (Outpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	10	30	15	23	9	17	104
Residents were enthusiastic and effective teachers throughout the rotation.	22	26	8	5	4	39	104
Faculty were enthusiastic and effective teachers throughout the rotation.	22	47	12	4	2	17	104
My patient care responsibilities were appropriate for my level of training.	20	36	13	12	6	17	104
I saw a wide variety or patients and chief complaints.	16	44	10	12	5	17	104
The overall quality of the rotation was excellent.	13	38	18	12	6	17	104

Surgery (Inpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses

Conferences/lectures were appropriate and valuable.	20	52	10	5	1	16	104
Residents were enthusiastic and effective teachers throughout the rotation.	23	39	10	11	5	16	104
Faculty were enthusiastic and effective teachers throughout the rotation.	20	35	21	10	2	16	104
My patient care responsibilities were appropriate for my level of training.	23	44	13	8	0	16	104
I saw a wide variety or patients and chief complaints.	29	52	4	3	0	16	104
The overall quality of the rotation was excellent.	23	44	14	4	3	16	104

Surgery (Outpatient)

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	28	48	5	1	0	22	104
Residents were enthusiastic and effective teachers throughout the rotation.	14	26	4	2	1	57	104
Faculty were enthusiastic and effective teachers throughout the rotation.	40	32	6	5	0	21	104
My patient care responsibilities were appropriate for my level of training.	26	41	4	9	3	21	104
I saw a wide variety or patients and chief complaints.	28	40	7	6	2	21	104
The overall quality of the rotation was excellent.	31	37	8	7	0	21	104

Critical Care - Medical

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	22	9	2	0	0	71	104
Residents were enthusiastic and effective teachers throughout the rotation.	16	15	1	0	0	72	104
Faculty were enthusiastic and effective teachers throughout the rotation.	21	10	0	1	0	72	104
My patient care responsibilities were appropriate for my level of training	18	14	0	0	0	72	104
I saw a wide variety or patients and chief complaints.	20	9	2	1	0	72	104
The overall quality of the rotation was excellent.	21	10	1	0	0	72	104

Critical Care - Neonatal

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	0	0	0	0	0	104	104
Residents were enthusiastic and effective teachers throughout the rotation.	0	0	0	0	0	104	104
Faculty were enthusiastic and effective teachers throughout the rotation.	0	0	0	0	0	104	104
My patient care responsibilities were appropriate for my level of training	0	0	0	0	0	104	104
I saw a wide variety or patients and chief complaints.	0	0	0	0	0	104	104
The overall quality of the rotation was excellent.	0	0	0	0	0	104	104

Critical Care - Pediatrics

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	4	1	0	0	0	99	104
Residents were enthusiastic and effective teachers throughout the rotation.	5	0	0	0	0	99	104
Faculty were enthusiastic and effective teachers throughout the rotation.	4	1	0	0	0	99	104
My patient care responsibilities were appropriate for my level of training	5	0	0	0	0	99	104
I saw a wide variety or patients and chief complaints.	3	1	1	0	0	99	104
The overall quality of the rotation was excellent.	4	1	0	0	0	99	104

Critical Care - Surgical

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	5	3	1	0	0	95	104
Residents were enthusiastic and effective teachers throughout the rotation.	3	4	1	0	0	96	104
Faculty were enthusiastic and effective teachers throughout the rotation.	7	2	0	0	0	95	104
My patient care responsibilities were appropriate for my level of training	4	3	1	0	1	95	104
I saw a wide variety or patients and chief complaints.	4	5	0	0	0	95	104
The overall quality of the rotation was excellent.	4	4	0	1	0	95	104

Emergency Medicine

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	21	14	1	0	0	68	104
Residents were enthusiastic and effective teachers throughout the rotation.	9	6	1	0	0	88	104
Faculty were enthusiastic and effective teachers throughout the rotation.	16	18	2	0	0	68	104
My patient care responsibilities were appropriate for my level of training	17	16	2	1	0	68	104
I saw a wide variety or patients and chief complaints.	17	17	1	1	0	68	104
The overall quality of the rotation was excellent.	14	19	3	0	0	68	104

Sub-Internship Medical:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	14	15	1	0	0	74	104
Residents were enthusiastic and effective teachers throughout the rotation.	14	13	1	2	0	74	104
Faculty were enthusiastic and effective teachers throughout the rotation.	11	16	2	1	0	74	104
My patient care responsibilities were appropriate for my level of training.	18	12	0	0	0	74	104

I saw a wide variety of patients and chief complaints.	16	11	2	1	0	74	104
The overall quality of the rotation was excellent.	16	13	0	1	0	74	104

Pediatrics:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	6	2	1	0	0	95	104
Residents were enthusiastic and effective teachers throughout the rotation.	6	1	2	0	0	95	104
Faculty were enthusiastic and effective teachers throughout the rotation.	7	1	1	0	0	95	104
My patient care responsibilities were appropriate for my level of training.	5	2	1	1	0	95	104
I saw a wide variety or patients and chief complaints.	6	1	2	0	0	95	104
The overall quality of the rotation was excellent.	6	2	1	0	0	95	104

Surgical:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	5	5	1	0	0	93	104
Residents were enthusiastic and effective teachers throughout the rotation.	7	4	1	0	0	92	104
Faculty were enthusiastic and effective teachers throughout the rotation.	7	3	2	0	0	92	104
My patient care responsibilities were appropriate for my level of training.	6	5	1	0	0	92	104
I saw a wide variety or patients and chief complaints.	7	4	1	0	0	92	104
The overall quality of the rotation was excellent.	7	4	1	0	0	92	104

Electives:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	10	21	3	0	0	70	104
Residents were enthusiastic and effective teachers throughout the rotation.	14	26	0	0	0	64	104
Faculty were enthusiastic and effective teachers throughout the rotation.	18	25	0	0	0	61	104
My patient care responsibilities were appropriate for my level of training.	13	30	0	0	0	61	104
I saw a wide variety or patients and chief complaints.	13	29	1	0	0	61	104
The overall quality of the rotation was excellent.	14	28	1	0	0	61	104

Selectives:

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Responses
Conferences/lectures were appropriate and valuable.	0	3	3	0	4	94	104
Residents were enthusiastic and effective teachers throughout the rotation.	0	3	3	0	2	96	104

Faculty were enthusiastic and effective teachers throughout the rotation.	12	14	7	1	3	67	104
My patient care responsibilities were appropriate for my level of training.	5	5	3	0	3	88	104
I saw a wide variety or patients and chief complaints.	0	4	3	0	2	95	104
The overall quality of the rotation was excellent.	3	8	11	8	7	67	104

Faculty Numbers

Basic Science Departments

Department*	Full-Time Faculty					Part-Time Faculty	Volunteer Faculty
	Prof	Assoc	Asst	Inst/ Other	Vacant		
Com. Med.	7	3	7	0	3	7	68
MMSB	11	3	4	1	2	3	0
Genetics	6	4	10	4	5	3	5
Neuroscience	10	3	6	0	0	3	2
Immunology	7	7	7	0	1	3	2
Cell Biology	7	10	11	0	1	11	3

Clinical Departments

	Full-Time Faculty						
Department*	Prof	Assoc	Asst	Instructor/ Other	Vacant	Part-Time	Volunteer
Anesthesiology	1	0	0	0	0	0	108
Dermatology	1	3	9	1	3	3	23
Family Medicine	5	6	12	0	1	7	111
Internal Medicine	62	38	141	14	10	31	635
Neurology	4	2	6	0	2	5	20
Obstetrics/Gynecology	12	10	24	4	2	5	167
Orthopedics	5	5	18	2	1	1	72
Pathology/Lab Med	8	9	20	5	0	2	2
Pediatrics	26	24	63	19	0	3	156
Psychiatry	11	8	44	2	2	8	83
Diagnostic Imaging	1	3	9	2	2	1	81
Surgery	19	14	35	2	2	10	229
Traumatology/EM	1	7	34	25	1	8	49

Teaching Responsibilities

Basic Science Departments

Department	Teaching FTE
Basic Science	
Cell Biology	0.76
Community Medicine	1.10
Genetics & Dev. Biol.	0.26
Immunology	0.32
MMSB	0.17
Neuroscience	0.69

Assumptions:
Lecture: 1hour credited with 6 hours of prep
Small Group: 1 hour credited with 0.5 hour prep
Lab: 1 hour credited with 0.5 hour prep
1 FTE (full time equivalent faculty position)= 1600 hours/year; considers Salary and Fringe average for each department

Clinical Departments

Department	Teaching FTE
Clinical	
Anesthesiology	0.04
Dermatology	0.11
Diagnostic Imaging	0.34
Family Medicine	1.85
Medicine	6.32
Neurology	0.20
Ob/Gyn	0.68
Orthopedic Surg.	0.53
Pathology	0.81
Pediatrics	2.48
Psychiatry	0.89
Surgery	2.52
Traumatology	0.55

Assumptions:
Lecture: 1hour credited with 6 hours of prep
Small Group.: 1 hour credited with 0.5 hour prep
Lab: 1 hour credited with 0.5 hour prep
Clinical Precepting: 1 hour = 0.25 hour teaching
1 FTE (full time equivalent faculty position) = 1600 hours/year; Salary and fringe reflect average for each department

Faculty Committees

Committee	Number of Members	Appointed or Elected by:	Reports to:	Authority (R/A/B)
Admissions Committee	25	A, by Dean	Dean	A
Academic Advancement Committee	12	A, by Dean for Academic Affairs	Dean	A
Clinical Council	8 voting, 4 *ex-officio* & non-voting	Voting members: 6 elected, 2 *ex-officio*	Dean's Council	B
Commencement Committee	28	A, by Dean	Dean	R
Committee on Continuing Medical Education	11	Appointed by Education Council	Education Council	B
Committee on Undergraduate Medical Education (CUME)	15	Appointed by Education Council	Education Council	B
Course and Curriculum Evaluation Committee	12	CUME	CUME	R
Curriculum Operating Committee	20	*Ex-officio*- all course directors, some section heads	Education Council	B
Dean's Council	12 voting, 2 *ex-officio* & non-voting	Voting: 8 elected, 4 *ex-officio*	Dean	B
Education Council	16	10 elected, 2 *ex-officio*	Dean's Council	B
Faculty Review Board	7	elected	Provost	R
Graduate Medical Education Committee (GMEC)	22	Appointed by Associate Dean for Graduate Medical Education	Education Council	B
GMEC Educational Policy	12	Appointed by Associate Dean for Graduate Medical Education	GMEC	R
GMEC Operations	15	Appointed by Associate Dean for Graduate Medical Education	GMEC	R

GMEC Program Review	14	Appointed by Associate Dean for Graduate Medical Education	GMEC	R
Health Center Appeals Committee	3	elected	Vice-President for Health Affairs, or President, depending on the grievance	R
Health Center Research Advisory Committee	9 voting, 2 *ex-officio* & non-voting	Voting: 2 appointed by elected faculty governance groups, remaining appointed by the Vice President for Health Affairs	Senior Associate Dean for Research Planning and Coordination	B
Institutional Review Boards (there are 4)	9-10	Appointed by Director, Human Subjects Protection Office	Vice President for Health Affairs	B
Merit and Compensation Appeals Committee	7	Elected	Dean	R
Merit and Compensation Executive Committee	11	4 *ex-officio,* 7 elected	Dean	R
Oversight Committee	9	Elected	Dean, Dean's Council, Faculty	B
Public Issues Council (PIC)	14	12 elected, 1 appointed by Commissioner of Public Health, 1 community member appointed by rest of PIC	Dean's Council	R
Research Council	9 voting, 3 non-voting	Voting: 8 elected, 1 *ex-officio*	Dean's Council	R

Research Recruitment Committee	22 voting; 1 non-voting	Appointed by SOM Sr. Assoc Dean for Res Planning and Coordination and SODM Associate Dean for Research	SOM Senior Associate Dean for Research	R
Senior Appointments and Promotions (SAPC)	24	A, by Dean	Dean	B
Space Appeals Committee	7	Elected	Dean	R

Revenues and Expenditures Summary

University of Connecticut School of Medicine (190)

	FISCAL YEAR 2007	FISCAL YEAR 2008	FISCAL YEAR 2009*	PROJECTED FISCAL YEAR 2010**
REVENUES:				
Tuition and Fees:				
Medical Students	$ 8,588,500	$ 9,065,900	$ 9,713,400	$ 10,199,000
Other Students	$ 1,215,200	$ 828,400	$ 952,300	$ 925,000
Total Tuition and Fees	$ 9,803,700	$ 9,894,300	$ 10,665,700	$ 11,124,000
Government and Parent Support:				
Federal Appropriations	$ -	$ -		
Adjusted State and Parent Support	$ 65,541,853	$ 71,593,000	$ 72,902,800	$ 74,000,000
Local Appropriations	$ -	$ -		
Total Government and Parent Support	$ 65,541,853	$ 71,593,000	$ 72,902,800	$ 74,000,000
Grants and Contracts:				
Federal Direct	$ 43,429,500	$ 39,975,000	$ 38,476,400	$ 42,000,000
State & Local Direct	$ 8,039,700	$ 5,296,500	$ 5,397,000	$ 5,400,000
Private Direct	$ 12,538,400	$ 15,045,700	$ 15,865,300	$ 17,000,000
Facilities & Admin (Indirect)	$ 19,717,600	$ 18,731,100	$ 18,546,700	$ 20,500,000
Total Grants and Contracts	$ 83,725,200	$ 79,048,300	$ 78,285,400	$ 84,900,000
Practice Plans/Other Medical Services	$ 74,186,100	$ 76,487,500	$ 80,919,900	$ 85,000,000
Hospitals:				
University Owned	$ 9,066,985	$ 10,783,900	$ 11,984,000	$ 12,700,000
Veterans Administration	$ 533,109	$ 533,100	$ 308,000	$ 320,000
Other Affiliated Hospitals	$ 30,568,850	$ 35,571,700	$ 35,191,900	$ 38,066,000
Total Hospital Revenues	$ 40,168,944	$ 46,888,700	$ 47,483,900	$ 51,086,000

Gifts	$ 1,174,000	$ 1,081,000	$ 1,130,600	$ 1,200,000
Endowment Income	$ 2,044,300	$ 2,157,000	$ 2,580,000	$ 2,500,000
Other Revenues	$ 10,220,600	$ 10,000,500	$ 7,219,000	$ 7,500,000
TOTAL REVENUES	$ 286,864,697	$ 297,150,300	$ 301,187,300	$ 317,310,000
	$ 289,846,897	$ 309,056,500	$ 317,802,400	$ 331,762,300
TOTAL EXPENDITURES & TRANSFERS				
NET REVENUES OVER EXPENDITURES	$ (2,982,200)	$ (11,906,200)	$ (16,615,100)	$ (14,452,300)
	Change	($8,924,000)	($4,708,900)	$ 2,162,800

Teaching Facilities

Basic Science

Building: A (Academic), Ground Floor		
Year Constructed: 1971		**Year of Last Major Renovation:** 2008
Type of Room	**Seating Capacity**	**Main Educational Use(s)**
Patterson Auditorium	154	Lectures and whole class conferences
Massey Auditorium	154	Lectures and whole class conferences
Building: A (Academic), Main Floor		
Year Constructed: 1971		**Year of Last Major Renovation:** 1995 – 1997
Type of Room	**Seating Capacity**	**Main Educational Use(s)****
14 small classrooms	12-18	small group conferences and problem based learning
5 histology labs/conference rooms	28-32	Large Group Conferences, Histology Laboratories, and Wet Labs (Microbiology, Hematology)
2 gross anatomy rooms	64-68 (each)	Gross Anatomy Dissection
Prosection Room	8-12	Prosection/Procedures Room

Clinical

Inpatient teaching sites where students take one or more of the listed required clerkships

Inpatient Facility Name	**Family Med**	**Int. Med.**	**OB GYN**	**Peds**	**Psych.**	**Surg**
John Dempsey Hospital*		✓	✓		✓	✓
Hartford Hospital*		✓	✓		✓	✓
The Hospital of Central Connecticut*		✓	✓			✓
St. Francis Hospital & Medical Center*	✓	✓	✓			✓
Central CT Children's Hospital*				✓		
Waterbury Hospital						✓
Manchester Hospital					✓	
Middlesex Hospital	✓					
Norwalk Hospital		✓				
St. Raphael's Hospital		✓				

* Primary affiliated partners. The remaining hospitals listed offer required inpatient rotations in one discipline each.

Faculty Offices, Research Labs, and Net Square Footage

Department Name	# Offices	Total Net Sq Ft (offices)	#Research Labs	Total Net Sq Ft (labs)
Anesthesiology	6	3487	0	0
Cell Biology	36	3960	32	9,646
Comm. Med.	29	7831	0	0
Dermatology	56	7065	13	2900
Diagnostic Imaging	7	1340	0	0
Family Medicine[1]	9	1636	0	0
Genetics and Dev. Biology	19	3000	24	20,135
Immunology	24	3248	26	20,089
Medicine	11	1256	19	7935
MMSB	21	4395	27	19,193
Neurology[2]	11	4581	0	0
Neuroscience	21	3,929	25	15,723
OBGYN	14	2368	1	890
Ortho. Surg.	19	2267	7	4279
Path/Lab Med	4	446	13	989
Pediatrics[3]	22	3306	9	1771
Psychiatry	47	10,197	4	1,468
Surgery	34	4,080	8	3,830
Trauma/EM[4]	5	1344	0	0

[1] Most of our Department of Family Medicine is located at St. Francis Hospital and Medical Center. The number in this table is UCHC space only.

[2] The Department of Neurology is a joint department, with Hartford Hospital. The number in this table is UCHC space only.

[3] Most of our Department of Pediatrics is located at the Connecticut Children's Medical Center. The number in this table is UCHC space only.

[4] The Department of Traumatology and Emergency medicine is a joint department, with Hartford Hospital. The number in this table is UCHC space only.

Inpatient Sites

Facility Name: John Dempsey Hospital
Name of Chief Executive Officer: Mike Summerer, MD, MS, interim hospital director
Year Appointed: 2009

Number of beds	204 beds & 20 bassinets
Average occupancy rate	69.8%
Average length of stay	5.91 days
Number of annual admissions	9,761
Number of outpatient visits/year	296,583
Number of ER visits per year	28,676

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	0	---	--	0
Internal Medicine	29	22.7	1	0
Obstetrics/Gynecology	20	12.4	2	1
Pediatrics (NICU and newborn nursery)	50	40.8	--	--
Psychiatry	34	25.6	5	0
Surgery	28	19.3	1	0

Facility Name: Hartford Hospital
Name of Chief Executive Officer: Elliot Joseph
Year Appointed: 2008

Number of beds	742
Average occupancy rate	78.10%
Average length of stay	5.32
Number of annual admissions	39,936
Number of outpatient visits/year	103,744
Number of ER visits per year	82,327

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	0	--	--	--
Internal Medicine	270	226.5	2-5	0
Obstetrics/Gynecology	75	49.7	3-6	2
Pediatrics	0	--	--	--
Psychiatry	124	96.3	1-2	0
Surgery	225	178.4	2	0

Facility Name: The Hospital of Central Connecticut
Name of Chief Executive Officer: Lawrence A. Tanner
Year Appointed: 1987

Number of beds	446
Average occupancy rate	85%
Average length of stay	5 days
Number of annual admissions	24000
Number of outpatient visits/year	422,649
Number of ER visits per year	102,400

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	--	--	--	--
Internal Medicine	140	120	2-5	0
Obstetrics/Gynecology	20	20	4-5	0
Pediatrics	--	--	--	--
Psychiatry	--	--	--	--
Surgery	80	60	1	0

Facility Name: St. Francis Hospital and Medical Center
Name of Chief Executive Officer: Christopher M. Dadlez
Year Appointed: 2004

Number of beds	617
Average occupancy rate	77.2%
Average length of stay	5.02
Number of annual admissions	32,807
Number of outpatient visits/year	304,410
Number of ER visits per year	66,208

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	Variable-Not assigned	15	1-2	Maximum of 1
Internal Medicine		77	5-7	1
Obstetrics/Gynecology	30	24	4-6	1-2
Pediatrics	0	--	--	--
Psychiatry	0	--	--	--
Surgery	56	45-70	2	3

Facility Name: Connecticut Children's Medical Center
Name of Chief Executive Officer: Martin J. Galvin
Year Appointed: 2006

Number of beds	147 (115 beds, 32 bassinets)
Average occupancy rate	75.4% of licensed beds; 80% of staffed beds; 70% of med/surg beds
Average length of stay	6.4 total; 5.1 med/surg
Number of annual admissions	5081 + 2300 inpatient observation = 7381
Number of outpatient visits/year	Approximately 100,000
Number of ER visits per year	46,782

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	0	--	--	--
Internal Medicine	0	--	--	--
Obstetrics/Gynecology	0	--	--	--
Pediatrics	135	102	5-8	1
Psychiatry	0	--	--	--
Surgery	0	--	--	--

Facility Name: Waterbury Hospital
Name of Chief Executive Officer: John Tobin
Year Appointed: 1986

Number of beds	235
Average occupancy rate	90%
Average length of stay	4.8
Number of annual admissions	14,800
Number of outpatient visits/year	75,000
Number of ER visits per year	55,000

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	0	--	--	--
Internal Medicine	95	90	--	--
Obstetrics/Gynecology	30	14.9	--	--
Pediatrics	8	3	--	--
Psychiatry	28	25	--	--
Surgery	30	30	2	0

Facility Name: Manchester Hospital
Name of Chief Executive Officer: Peter J. Karl
Year Appointed: 2004

Number of beds	249
Average occupancy rate	42.5%
Average length of stay	4.8
Number of annual admissions	9109
Number of outpatient visits/year	351,115
Number of ER visits per year	43,852

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	N/A	N/A	--	--
Internal Medicine	N/A	N/A	--	--
Obstetrics/Gynecology	N/A	N/A	--	--
Pediatrics	N/A	N/A	--	--
Psychiatry	36	24.7	1	0
Surgery	N/A	N/A	--	--

Facility Name: Middlesex Hospital
Name of Chief Executive Officer: Robert Kiely
Year Appointed: 1990

Number of beds	297 Licensed (incl. 22 bassinets) 194 Available
Average occupancy rate	83.5% (of avail beds)
Average length of stay	4.18
Number of annual admissions	14,201
Number of outpatient visits/year	**468,896**
Number of ER visits per year	84,743

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	open	10	1-2	2-3
Internal Medicine	--	--	--	--
Obstetrics/Gynecology	--	--	--	--
Pediatrics	--	--	--	--
Psychiatry	--	--	--	--
Surgery	--	--	--	--

Facility Name: Norwalk Hospital
Name of Chief Executive Officer: Geoff Cole
Year Appointed: 2005

Number of beds	230 staffed; 275 licensed
Average occupancy rate	90%
Average length of stay	4.8
Number of annual admissions	15,418
Number of outpatient visits/year	132,000
Number of ER visits per year	42,000

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	--	--	--	--
Internal Medicine	105	94	0-2	15-20
Obstetrics/Gynecology	--	--	--	--
Pediatrics	--	--	--	--
Psychiatry	---	--	--	--
Surgery	--	--	--	--

Facility Name: St. Raphael's Hospital
Name of Chief Executive Officer: Christopher M. O'Connor
Year Appointed: 2009 (eff. 10/1/09)

Number of beds	419 staffed beds
Average occupancy rate	78.46%
Average length of stay	5.4 days
Number of annual admissions	24,969
Number of outpatient visits/year	**176,000**
Number of ER visits per year	49,084

Clinical Service	Number of Beds	Avg Daily Census	Number of Students per Rotation	
			Your School's Medical Students	Visiting Medical Students
Family Medicine	included	in medicine		
Internal Medicine	201	158.4	1 per academic year *	1 per rotation
Obstetrics/Gynecology	15	12.4	--	--
Pediatrics	20 incl. newborn	14.7	--	--
Psychiatry	42	37	--	--
Surgery	125	89.8	--	--

*The Hospital of Saint Raphael is able to accept two students **per rotation** if requested by UConn.

Ambulatory Sites

Site Name: UCHC	**Site Type**:** University Physicians Practice		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Medicine (3 sites)	3rd year	6	1 per site
OBGYN	3rd year	6	2
Pediatrics (2 sites)	3rd year	6	2 (1 at each site)
Psychiatry (2 sites)	3rd year	½ day/wk x 14 wks	12 (six at each site)
Surgery	3rd year	3	1
Otolaryngology	3rd year	1	1
Orthopaedics	3rd year	1	1-4
Emergency Medicine	4th year	4	2
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	8

Site Name: Hartford Hospital	**Site Type**:** Hospital		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Medicine	3rd year	6	2
OBGYN	3rd year	6	4
Psychiatry (Institute of Living at HH)	3rd year	½ day/wk x 14 wks	5
Emergency Medicine	4th year	4	2
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	4

Site Name: SFHMC	**Site Type**:** Hospital		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Medicine (at SFH and the Burghdorf clinic)	3rd year	6	2 2
Family Medicine (Asylum Hills)	3rd year	6	2
OBGYN	3rd year	6	4
Pediatrics (at SFH and Burghdorf clinic)	3rd year	6	2-3 at SFH 2 at Burghdorf
Psychiatry	3rd year	½ day/wk x 14 wks	1
Surgery	3rd year	3	2
Emergency Medicine	4th year	4	2
SCP at SFH and Asylum Hills	1st, 2nd, & 3rd	½ day/wk x 3 yrs	6 4

Site Name: The Hospital of Central Connecticut		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Medicine	3rd year	6	2
OBGYN	3rd year	6	4
Pediatrics	3rd year	6	1
Emergency Medicine	4th year	4	2
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	1

Site Name: CCMC		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Pediatrics	3rd year	6	2
Otolaryngology	3rd year	1	1
Orthopaedics	3rd year	1	1

Site Name: VAMC- Newington		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Medicine	3rd year	6	1-2

Site Name: Middlesex Hospital		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Family Medicine	3rd year	6	1
Psychiatry	3rd year	½ day/wk x 14 wks	1

Site Name: Stamford Hospital		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Family Medicine	3rd year	6	1-2

Site Name: St Mary's Hospital		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Surgery	3rd year	1	1
Emergency Medicine	4th year	4	1

Site Name: Waterbury Hospital		**Site Type**:** Hospital	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Surgery	3rd year	1	1

Site Name: Manchester Memorial Hospital	**Site Type**:** Hospital		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Emergency Medicine	4th year	4	1

Site Name: Windham Hospital	**Site Type**:** Hospital		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Emergency Medicine	4th year	4	1

Site Name: St. Vincent's Hospital	**Site Type**:** Hospital		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	2

Site Name: Backus Hospital	**Site Type**:** Hospital		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	1

Site Name: Community Health Centers	**Site Type**:** Stand alone clinic		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Medicine	3rd year	6	1-2*
Pediatrics	3rd year	6	1
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	34(2 per site on average)

*not always utilized; takes only Spanish speaking students for MAX Medicine

Site Name: Grove Hill Medical Center	**Site Type**:** Stand alone clinic		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Otolaryngology	3rd year	1	1
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	4

Site Name: Connecticut ENT	**Site Type**:** Stand alone clinic		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Otolaryngology	3rd year	1	1

Site Name: UCONN (Storrs) Student Health Service	**Site Type**:** Student health service		
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	2

Site Name: Family Medical Association of East Hartford		**Site Type**:** Stand alone clinic	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	3

Site Name: East Hartford Community Health Care		**Site Type**:** Stand alone clinic	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	2

Site Name: Charter Oak Health Center		**Site Type**:** Stand alone clinic	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	4

Site Name: United Community Health Center		**Site Type**:** Stand alone clinic	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	7

Site Name: Generations Health Care		**Site Type**:** Stand alone clinic	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
SCP	1st, 2nd, & 3rd	½ day/wk x 3 yrs	1

Site Name:		**Site Type**:** Private doctor's offices	
Course or Clerkship Offered	**Academic Period (Year) When Offered**	**Duration (weeks)**	**No. Students per Rotation**
Family Medicine- 39 sites	3rd year	6	1 per site
Pediatrics- 3 sites	3rd year	6	3 (one per site)
Psychiatry- 8 sites	3rd year	½ day/wk x 14 weeks	Maximum of 1 per site
Otolaryngology- 3 sites	3rd year	1	Maximum of 1 per site
Orthopaedics - 6 sites	3rd year	1	Maximum of 1 per site
Surgery – 14 sites	4th year	3	Generally 1 per site, but one site takes 2 students
SCP- approx. 142 sites	1st, 2nd, & 3rd	½ day/wk x 3 yrs	Generally 1 per site, but some sites take as many as 5 (one site as many as 7) students depending upon how many physicians act as preceptors at the site.

Library and IT Facilities:

Total user seating	240
Number of small-group study rooms	14
Number of public workstations	18
Number of computer classrooms	3
Number of computers or workstations in computer classrooms	39
Ubiquitous network in library spaces (yes or no)	yes
Ubiquitous network in classrooms and study spaces? (yes or no)	yes

Library Holdings

	FY 08	FY 07	FY 06
Total current journal subscriptions (all formats)	9,360	4,608	1,540
Total journal subscriptions (print only)	606	687	714
Number of book titles (all formats)	40,568	55,986	55,815
Number of book titles (print only)	35,970	39,936	40,217
Number of databases	310	301	267
Number of external documents provided to users	926	1090	1463
Total collection expenditures	1,904,875	1,765,690	1,620,714

Library and IT Staff units:

	Library	Info. Technology Services
Professional staff	13	5
Technical and paraprofessional staff	9	2
Clerical support staff	2	
Student or hourly support staff	3	1