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From: **The Professional Identity Formation Working Group (PIFWG)**

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To: The Stony Brook University School of Medicine Curriculum Strategic Planning Committee

A COMPREHENSIVE EDUCATIONAL INVENTORY OF THE CURRENT PROFESSIONAL IDENTITY FORMATION CURRICULUM ACROSS ALL PHASES OF THE STONY BROOK SCHOOL OF MEDICINE

Purpose: A diverse and committed group of 25 educators and students have convened over a six month period in 2016 to offer a complete written overview of the curriculum over all three LEARN phases over four years to form professional identity. This summary will (a) do much to *raise our collective awareness of the current activities around identity formation* that are widely considered definitive of Stony Brook medical education, (b) allow us to *engage in more substantive dialogue with the goal of enhancing these activities* in years to come, and (c) *better measure professional identity formation over time at carefully considered points in all LEARN phases*. Our Professional Identity Formation Working Group (PIFWG), which includes members from the Stony Brook Campus and at its Regional Campus at Winthrop University Hospital, will meet quarterly with specific tasks, the first of which is the collaborative production of this summary document of activities at both sites over four years. This document will be (a) posted on the medical school website, (b) updated annually, and (c) reviewed by all entering students.

PREAMBLE

Medical students form their professional identity during all four years of training from the initial White Coat ceremony through the formal swearing of the Hippocratic Oath at graduation. The process of formation really pertains to a student's very being: attitudes and biases, affective self-awareness, empathy, emotional intelligence, communicative skills, and virtues ranging from humility and diligence to altruism and self-care. Stony Brook has from inception produced physician humanists who are empathically attentive to the illness experience

of patients to complement their technological and scientific skills. Professional identity formation (PIF) refers to the growth over time in becoming a “good” physician.

The Stony Brook School of Medicine focus on professional identity formation goes back to its founding dean, Dr. Edmund D. Pellegrino, MD. Pellegrino was an innovator in medical and interdisciplinary health science education who renowned for his scholarship in philosophy of medicine, virtue theory, and medical humanities. He arrived at Stony Brook in 1966 as Vice President for Health Sciences and Dean of Medicine, becoming the Dean of the School of Medicine in 1968. Dr. Jordan J. Cohen, MD, who served as dean from 1988-1994, instituted a four-year Medicine in Contemporary Society Course that became a national model for professional formation, emphasizing medical humanism as the pathway to professional growth. Dr. Cohen returned to Stony Brook in 2006 and encouraged the 117 graduates of the medical school to become “true professionals with character, honor and integrity in medicine in the face of a changing healthcare landscape where there is an erosion of trust between the doctor and the patient.” Cohen challenged the graduating class to be the sort of doctors who are trusted by their patients based on empathy, beneficence, and competence. In his classic article “Viewpoint: Linking Professionalism to Humanism: What it Means and Why it Matters” (*Academic Medicine, Vol. 82, 2007, pp. 1029-1032*) Cohen defined humanism as a “**way of being**” that concerns obligations others, especially those in need, and personal attributes such as altruism, duty, integrity, respect, and compassion. “*Humanism,*” he wrote, “*provides the passion that animates authentic professionalism.*” Many others, including Dean Marvin Kushner, contributed to this legacy as well.

After its 2011 April 10-13 site visit, the LCME identified this legacy of professional identity formation as one of our institutional strengths: “The medical school has made a strong commitment to strengthening its emphasis on humanities, ethics, and professionalism” with “required coursework and focus on these subjects throughout the curriculum; and an ongoing assessment and tracking of professionalism, ethics, and personal values as one of the core domains in the school’s competency framework.” While the curriculum has undergone revision since 2011, this strength remains fully intact and continues to be enhanced.

We submit this document as both a repository of ongoing activities and as a locus for the galvanizing of commitment for future generations of Stony Brook medical students and faculty. It includes the following:

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APPENDIX (INCLUDING STUDENT HONOR CODE)

DEFINITION OF PROFESSIONALISM AND FORMATION

Professionalism: We do not believe that professionalism is difficult to define. Classically defined, *professio* refers to the public profession by oath of a commitment to the good of an identifiable constituency, in this case, the good (beneficence) of patients, as a matter of primary concern and diligent activity. This is something more than *occupare* or *careo*. The patient's good is the ultimate goal of medicine, and therefore of medical education. As Leo Strauss of the University of Chicago noted, education is about inner "formation" as well as about the learning of technique. "Identity" is malleable and shaped by clear expectations, role models, and many other social dynamics.

But more precisely do we at Stony Brook expect to see in the "being" of students when we refer to professionalism formation? Through 2015 a Professionalism Subgroup of 20 faculty and students working under the rubric of a committee to examine Entrustable Professional Activities and building on all existing Stony Brook documents of relevance including the Student Honor Code, formulated over the course of a half year a set of **nine Stony Brook School of Medicine professional expectations and duties** as follows:

1. Students learn technical skills and achieve observable competence to the benefit of patients, and they know when to request help in this process so as to avoid patient harms.
2. Students develop communication skills: respectful, empathic, and honest communication reduces patient non-adherence, stress, and dissatisfaction, as well as physician error and premature diagnostic closure.
3. Students respect confidentiality to ensure that patients have a sense of security and control over information as they experience illness.
4. Students form habits of life-long learning in order to keep abreast of evolving treatments.
5. Students form emotional and social intelligence working in inter-professional teams in order to prevent medical errors and enhance patient confidence in his or her providers.
6. Students learn to give and receive constructive feedback to peers and to hold fellow providers accountable for behaviors and attitudes that may imperil the patient.
7. Students will view themselves as role models responsible for the transmission of professional identity and integrity.
8. Students make the good of the patient their priority at all times, and treat all patients with equal regard regardless of race, class, religion, gender, and ethnicity.
9. Students practice good self-care, knowing that optimal patient-centered care is only possible when professionals manifest well-being, meaning, and wellness. This includes adequate "balance" in life, and the processing of the human and emotional side of provider experience.

Measurement: Any attempted measurement of development in these areas of expectation is a complex undertaking that we will treat more thoroughly in a future document devoted to it. Clearly formation is not simply a matter of cognitive sophistication, but of the fuller aspects of a student's deeper being with regard to virtues, interactions, and affective self-awareness. Formation occurs over some window of chronological time, and may not lend itself to any

simple stage theories. Cognitive dimensions of formation would be perhaps both the easiest to measure and also the most superficial.

Formation: Matriculation into medical school marks the beginning of an important chapter in the formation of the student’s professional identity. However, the young adult student enters medical school with a personal identity already taking shape. He or she has been richly influenced by the last two to three decades (not the “almost two,” curiously suggested by Cruess et al.) of past experiences, personal beliefs, important relationships, and memberships to any number of cultural or social groups. Theories of identity suggest most students’ core identities will have “stabilized” by young adulthood, but all will continue to transform their identities throughout life.^{i,iii} To be wholly embraced by the student, so that they truly come to “think, act, and feel like a physician,”ⁱⁱⁱ professional identity formation (PIF) should take place in the context of the broader personal identity formation, or transformation, of the student.^{iv}

Cruess et al. neatly summarize the influences on and development of a medical student’s identity:

Those entering medical school arrive with a personal identity formed since birth. As they proceed through the educational continuum, they successively develop the identity of a medical student, a resident, and a physician. Each individual’s journey from layperson to skilled professional is unique and is affected by ‘who they are’ at the beginning and ‘who they wish to become.’⁴

This curricular content is based on the idea that supporting students in elucidating ‘who they are,’ ‘who they wish to become,’ *and why* will support them in forming self-aware professional identities. Engaging in the formation of their professional identities in the context of their personal identity formation should ultimately lead students to a clearer, more organic understanding of their motivations and personal ethical principles.

PRE-PHASE I LEARN

(A) Admissions

We will not focus here on Stony Brook admission, other than to suggest two possibilities for the future: (1) The use of an empathy or emotional intelligence scale at interview day in large part to convey to applicants that we take these dimensions of professionalism seriously, and (2) the transition to a multiple mini interview (MMI) or even an OSCE-like venue.

(B) Renewed Cultural Emphasis on PIF in Public Presentation (*Lindsey Pang, Student*)

An important goal of PIF is to explicitly provide a title, rubric, framework, and platform for Stony Brook Medicine to discuss and deliver teachings of professionalism and medical

humanism. PIF organizes the many elements of Stony Brook Medicine education under one unifying PIF title. *It is critical for PIF to be an explicit organizational concept, a tangible component of the formal curriculum, and a significant educational concept in Stony Brook education that is part of the common vocabulary of students and faculty.* In this format, students and faculty can be more aware of the institution’s longstanding commitment to professional formation, medical humanism, and ethics.

Two actionable item to be immediately considered are these:

(1) Create a unique webpage on the Stony Brook Medicine website. At the web address <https://medicine.stonybrookmedicine.edu/ugme/education/MD>, under the left hand side link menu, “Professional Identity Formation” will be added in. The PIF webpage may include a statement on the school’s focus on professionalism and humanism, a document or description of the different elements of the curriculum that encompass this goal, and links to navigate to the specific webpage and description of each component.

The screenshot shows a website interface with a top navigation bar labeled 'Education' and three accessibility icons (A, A, A). Below the navigation bar is a left-hand menu under the heading 'MD Program'. The menu items are: 'LEARN Curriculum', 'SOM Competencies and ILOs', 'Phase I', 'Phase II', 'Phase III', 'Themes in Medical Education', 'Translation Pillars', 'Longitudinal Learning Communities', 'Scholarly Concentrations', 'Global Health', 'Course Directors', 'Academic Policy and Procedures', and 'Combined Degree Programs'. A red arrow points to 'Translation Pillars'. To the right of the menu is the main content area titled 'The LEARN Curriculum'. The text in this area describes the curriculum's introduction in August 2014, its goals, and its structure. It states that LEARN is an acronym for Learning Centered, Experiential, Adaptive, Rigorous and Novel, and is divided into three phases: 1. An 18-month foundational phase, 2. A one-year primary clinical phase, and 3. A 16-month advanced clinical phase. It also lists five themes that run throughout the curriculum: 1. Patient and family-centered care, 2. Evidence-based care, 3. Patient safety and quality care, 4. Ethical and professional care, and 5. Health promotion and preventive care.

PIF goals and concepts can be explicitly integrated into the educational dialogue, providing a deeper level of understanding about *why* students are learning the material that is provided and engaging in the exercises assigned. When the overarching goal can be visualized and referred back to by its name and its tangible components, students and faculty are empowered knowing that each small component of the curriculum contributes positively towards the process of becoming a competent, professional doctor. To create an educational “space” that actively acknowledges the PIF curriculum it is important to highlight the *idea of PIF itself* throughout the four years in a deliberate manner.

PHASE I LEARN

(A) Transition to Medical School (TTMS)

During **Transition to Medical and Dental School (TMDS)**, new students will engage in two sessions pertaining to PIG.

First, there will be a *significant faculty/student panel* highlighting the PIF elements in the curriculum over four years to establish this aspect of culture, education and clinical care immediately in the entering student body. This panel can facilitate a dialogue of several hours with a title such as “Identifying the Goals and Elements of PIF and Medical Humanism.” The panel will allow PIF to be enunciated and mapped out with leadership representing all four years at Stony Brook and Winthrop, replete with a discussion of why the PIF curriculum and medical humanism is in fact essential for good clinician/student well-being, patient satisfaction, and inter-professional flourishing.

Second, in a follow-up session, students will have read this summary document and will be asked to consider (a) the qualities of a “good” doctor, (b) our set of nine professional expectations (above), (c) and how PIF might best be measured. They might also be given time to fill out a survey scale (TBD).

B. The White Coat Ceremony

First year medical students at Stony Brook University School of Medicine initiate the transition to the profession of medicine during the **White Coat Ceremony** that occurs at the beginning of the Transition to Medical School course, their first course in medical school. During this ceremony, the students sign our *Compact between Teachers and Learners of Medicine*, derived from the AAMC. The ceremony culminates with the students reciting the Hippocratic Oath along with other physicians in the audience.

(C) Medicine in Contemporary Society (MCS) (*Michael Vetrano PhD, Course Director; Stephen Post PhD*)

This curriculum dates back to Dean Jordan Cohen MD. There was a time when MCS existed in the forms of MCS1, MCS2, MCS3 and MCS4, serving as the major venue for professionalism and ethics considerations, and was noted as an institutional strength by the LCME visiting committee in 2011. Currently, MCS topics and activities continue to be amply manifest across all four years, but beyond the Phase One period these are expressed in a manner more closely integrated into the clinical curriculum. MCS PHASE I LEARN is based in small group learning beginning with a carefully designed syllabus and attached readings sent out at least one week before the session, a 30-minute session presentation (lecture, panel, and/or video) followed by 1.5 hour small group SESSION (9 students and 2 faculty facilitators one of whom is a clinician) that is facilitated by a student who has selected the topic of the day as of special interest at the beginning of the course. All lectures and small group activities are required and attendance is fully adhered to by all students because the small groups integrate the lecture

material into their sessions. Currently there are 20 sessions in Phase I LEARN, and 4 sessions of the popular “selectives” (2 hours per week for 4 weeks), covering a range of topics taught by faculty experts and several exceptional Year 4 students based on their MD with Scholarly Concentration in Education or Humanities & Ethics.

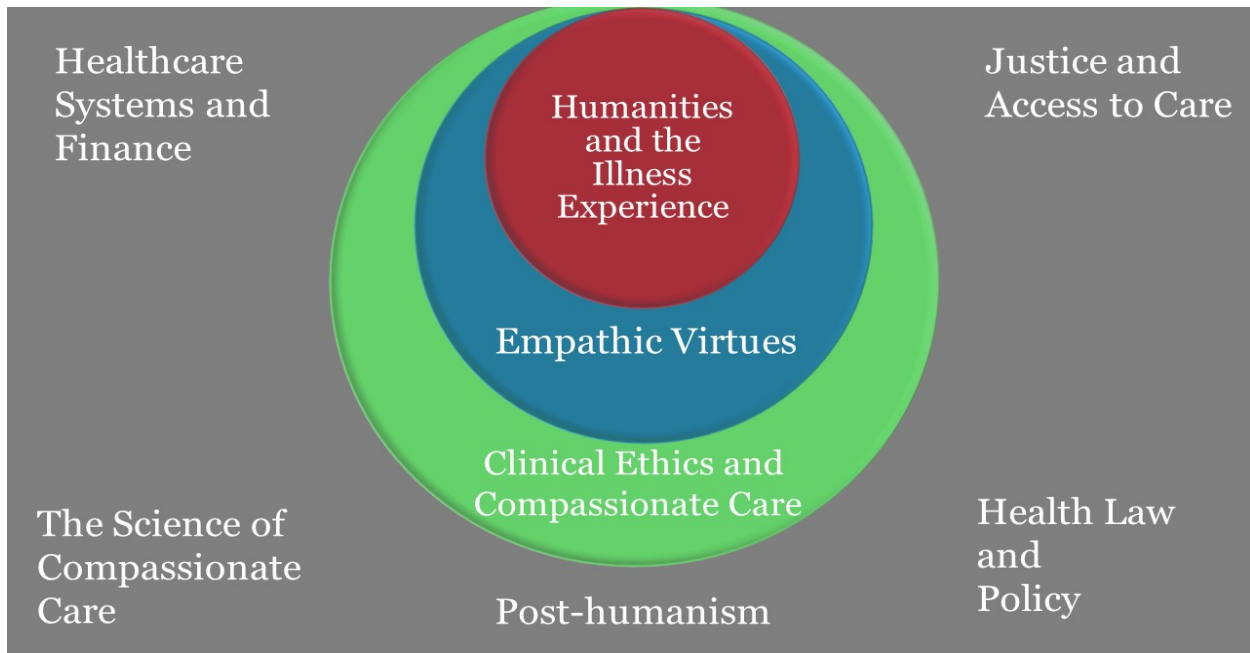
MCS, along with ICM, is one of two longitudinal courses that run through the entirety of Phase One from September to the following December; the five TIME blocks can also be broadly described as such. This longitudinal method keeps the professional formation of the physician as a patient centered, compassionate, and dutiful physician constantly in focus during the pre-clinical learning process. MCS is a course in which the human side of medicine is elevated, examined, and revered.

The course itself follows a trajectory which begins with the illness experience. We name this first circle of awareness Humanities because the genre of literature, film, creative arts, poetry, narrative medicine, and others are intended to elevate student appreciation of the subjective experience of illness in the lives of patients, their families, and caregivers. Only by closely observing the illness experience can students begin to connect with patients as persons, replete with narratives of hope, anxiety, fear, love, loss, meaning, goals, culture, and treatment preferences. Student attentiveness to this narrative opens up the possibility of their encountering patients not just biologically, but as persons rather than mere puzzles. This awareness is at the very center of the art of medicine, and it naturally enlivens deeper empathic capacities.

MCS then turns its attention to Compassionate Care teaching virtues of empathy, attentive listening, humility, integrity, gratitude, self-care, benevolence, and loyalty. These all unfold from the uptick in narrative consciousness made possible through detailed humanistic observation. For empathic care to be sustained over the course of a career the professional virtue of self-care is also important. The humanistic virtues build the secure relational foundation of trust that is needed for good communication with patients, and for effective ethical decision making.

Next, MCS turns its attention to Clinical Ethics. Professional skills of communication, compassionate care, integrity, gratitude, self-care, equanimity, respect for autonomy, confidentiality, and wisdom are more than the application of a set of principles or procedures for approaching the challenging decisions that patients, families, and caregivers confront daily. Empathic virtues as habits of daily clinical interaction create a safe space for meaningful dialogue with patients around their values, goals, and choices in which their autonomy is respected. These humanistic assets can be developed as workable communicative skill sets with both cognitive and affective dimensions. Clinical outcomes, patient satisfaction, and provider meaning and well-being are all enhanced when ethical decision making proceeds in the context of the humanistic virtues.

Finally MCS focuses on the wider societal context of medicine. Here we examine the social milieu in which medicine is practiced. Health disparities, population medicine, problems of allocation and distribution are examined. This is also where we can focus attention on issues such as Health Care and the Law, Economics and Medical Finance, Justice and Access to Care. In particular, we address racial disparities.



An active and highly inter-professional and interdisciplinary group of 24 (est.) faculty serve as small group facilitators, although the primary facilitator for each session is a student.

MCS provides students with access to recognized experts in the fields of medical ethics, compassionate care, and bioethics. The overall course goals mirror the mission and goals of the Center for Medical Humanities, Compassionate Care, and Bioethics, and the faculty of this division are the primary leaders for the course. Presentations by these experts and the readings and research require for each class provide a rigorous approach to learning. Instructional strategies for this course include:

1. Case-Based Small Group Classes. All MCS units are one week long and the basic structure follows a pattern. An hour-long presentation is followed by an hour-long small group discussion. Each student prepares for class by reviewing a case and/or topic and selected readings for the unit. In class, students improve their ability to engage in professional discourse by making relevant and insightful contributions to class discussions. One student acts as the leader each week with responsibility to prepare framing questions, monitor the discussion, and bring the session to conclusion.

2. Exercises in Professional Writing and Reflection. MCS assists students to develop their professional writing skills through two major exercises. The first is learning to write an ethics chart note - a way of summarizing the issues and options toward resolving a clinical dilemma. The second is learning to write a letter of advocacy to assist a patient in obtaining benefits. Students occasionally will also be asked to provide a written reflection in preparation for a class.

3. Independent Learning. Students are encouraged and directed to take advantage of the many learning opportunities that are part of a teaching hospital. These include, but are not limited to: Grand Rounds on Social and Ethical issues; colloquia sponsored by the Center for

Medical Humanities, Compassionate Care, and Bioethics; M and M conferences; Schwartz rounds; and student interest group presentations. Students keep written reflections on their independent learning.

4. Selectives. Mini-courses or selective of the students' choice take place during the last four weeks of MCS. Selectives offered students the opportunity for in-depth exploration of topics such as the sociology of medicine, the Ethics of Hope, 9-11 Anatomy of a Healthcare Disaster, Decision Making in the ICU, Core Concepts in Geriatrics, Health Care Economics, Children and Ethics, Spirituality and Healthcare, Hospice as Palliative Care, Becoming a Better MD Through Poetry, History of Medicine, and Implications of Antenatal Testing. Below is a sample of MCS Phase I LEARN topics from the year 2014.

Medical Humanities and Bioethics			
9-Sep-14	1	What is the Illness experience First Class Organizational Meeting	Dr. Vetrano Dr. Paul Levin
23-Sep-14	2	Medicine as a Profession The History of Medicine as a Profession and Into to Professionalism	Dr. John Coulehan
7-Oct-14	3	How Ethicists Think Principles and Reasoning in Medical Ethics	Dr. Vetrano
21-Oct-14	4	Law and Ethics Legal vs. Ethical Responsibilities. Malpractice and Negligence	Dr. McCrary
4-Nov-14	5	Physician Patient Relationship Lessons from the ER: Why the Professional Relationship is Crucial	Dr. Viccellio
9-Dec-14	6	Beneficence and Non Maleficence Professional Boundaries / Patient Rights / Best Interests	Dr. Vetrano
16-Dec-14	7	Autonomy Autonomy / Informed Consent / Capacity and Competence	Dr. McCrary
6-Jan-15	8	Truth Telling, Confidentiality, and Candor The Ethics and Practice of Disclosure and Truth Telling in Medicine	Dr. Vetrano
20-Jan-15	9	Respect for Human Subjects History and current practice in protecting patients	Dr. Post
3-Feb-15	10	Directives and Agents Health care proxy law, Advance Directives, Surrogates	Dr. McCrary
24-Mar-15	11	Medical Humanities and Doctoring Reflecting on Medical Practice	Dr. Coulehan
31-Mar-15	12	Medical Finance The History and Present Concerns	
14-Apr-15	13	Advocacy and Justice How Doctors Assist Patients with the Social and Economic Problems	Dr. Snow
21-Apr-15	14	Open Time is from 3 to 5	
28-Apr-15	15	Personal Conscience OB Gyn Medical Staff Members Discuss Issues of Conscience	Dr. Vetrano
12-May-15	16	Coping With Mistakes How Doctors Cope with Imperfection in Medicine	Team
19-May-15	17	Ethical Issues in End of Life Care Spirituality, Hospice, Decision Making at End of Life	TBA
27-May-15		Spring Team Event No Leader Required!	

(D) Six TIME Weeks (Themes in Medical Education) (*Iris Granek MD, Mary Kritzer PhD, Course Directors*)

The Themes in Medical Education Course (TIME) occurs over 6 week-long blocks that span LEARN Phases 1a and 1b. The blocks are situated in between other major courses of the Phase 1 curriculum. Each block is organized around a major life stage or patient population (e.g., infants and children, women, elderly, at-risk populations) and focuses on medical topics and conditions that relate to prior coursework. One purpose of the course is to teach epi- and biostatistics, principles of nutrition and elements of human behavior including development, goal setting and implementing behavioral change. Each TIME block incorporates a variety of active learning approaches, including a Team Based Learning (TBL) session, guided self-study and assessment to facilitate learning in these fundamental areas. In addition, each block includes patient contact, OSCEs, written reflections, self-audits, group write-ups and inter-professional site visits to encourage students' recognition and applications of the five themes of medical education:

- Patient and family centered care
- Ethical and professional care
- Evidence based care
- Patient safety and quality care
- Health promoting and preventive care

All of the activities of these week-long experiences reinforce concepts of professionalism and guide them in professional identity formation. For example, the students have significant responsibilities as individuals in terms of organizing independent work and meeting strict deadlines. They also have significant obligations to their peers in the form of group learning and group write-up activities. Additionally, many activities involve both self, peer and team assessment. In addition to self-assessments described below, students have the opportunity to review a personal nutrition assignment completed by one of their peers. At the end of the final block, they evaluate their team's performance, based on specific criteria, through the 1 1/2 years that they worked together. In the sections below, we highlight some of the additional and more unique features of the TIME blocks that speak to professional identity formation.

Meet the Patient Sessions. The TIME blocks begin with an unscripted, interactive session that includes health care providers and individual patients who have come to share their stories and experiences. Students are provided with required readings beforehand to orient them to patients' conditions and/or circumstances. During these 90 minute sessions, students are able to interact, freely ask questions and take in the patients' stories. The students also get a chance to observe interactions between patient and health care provider, and often to hear from additional family members about the strengths and weaknesses of this and other relationships they have experienced. *These sessions thus include modeling of professional identity and first hand experience in interacting with patients.* These sessions conclude with write-ups that students work on in teams. These write ups include questions that integrate themes of patient and family centered care, patient safety and others.

Inter-professional Site Visits. Students are assigned a number of site visits (usually 1-2 per TIME Block) that take them to designated sites on and off of the SBU campus. The sites are

selected to acquaint students with aspects of health care and with deliverers of health care beyond the level of the physician. *These experiences typically include shadowing/modeling, with a focus on nursing staff, rehabilitation therapists and other professionals who are integral to teamwork approaches to patient well-being.*

SBU Family Video and AAMC Hot Topics Sessions. Students work in groups to evaluate scripted, video-taped interactions between doctor and patient or among other health care providers. The videos that the students assess also include a simulated ‘Deep Dive’ that follows the occurrence of a preventable medical error. *Students work in groups to address questions that include those that probe aspects of the professionalism they witness on the tapes, and that call for speculation as to how they might respond in similar circumstances.* In a follow up session student groups are tasked with leading further, full-class and more in depth discussion of the videos in relation to an assigned AAMC Hot Topic.

Self-Awareness/Ethical and Professional Written Reflections/Small Group Discussion Sessions: During each TIME Block, students are required to complete several self-assessments which encourage development of self-awareness and reflective skills with the aim of realizing new insights and setting goals for the future behavior. These activities include assessments of both study and health habits, as well as the competencies and associated ILOs. *With each TIME block’s focus on a specific age group, the reflective writing assignment and faculty facilitated small group discussion prompt students to reflect on any biases, counter-transference, and/or transference issues that could potentially influence their interactions as future professionals with patients from the age group.*

Communication OSCEs. Each TIME Block includes an OSCE that typically includes 12 min with the standardized patient in the clinical setting, 5 min of feedback sessions with standardized patients, a self-evaluation and availability of a video key. These scenarios involve communication of prescribed pieces of often difficult information in settings where communications with the patient are challenging in some way. Students receive practice in interacting with patients in meaningful, effective and professional ways. The required preparation provides them with diagnoses and other information that they may be called upon to convey. *Here the emphasis is mainly on whether professional standards are maintained during the encounter and whether professionalism is shown during the delivery of information. The video keys that are taped in advance by fourth year students or health care providers, and that are required viewing for the students, provide vivid models of professional behavior, and offer important and explicit tips for success.*

Grand Rounds Reflections: Students are required to attend a Grand Rounds session of the department or discipline of their choosing. *This is designed to give them real world experience in ‘living the life’ of a health care professional, ideally one who is engaged in an area of medicine that they themselves are considering pursuing. Students are required to write a reflection that describes their experiences and impressions of this key part of professionalism and life long learning in the SBU medical community.*

(E) General Behavioral Expectations in Lecture Halls *(Howard Fleit PhD)*

Professional Identity Formation in Phase 1 of the Learn Curriculum. Following the week-long Transition to Medical School course, medical students begin Phase 1 of the curriculum. A major component of this phase includes an introduction to the biomedical sciences that are foundational to clinical science and clinical care. Running as a thread throughout Phase 1 are three longitudinal courses: Introduction to Clinical Medicine (ICM), Medicine in Contemporary Society (MCS) and Themes in Medical Education (TiME). Descriptions of the activities devoted to developing medical students' professional identity in these courses are described in separate components of this Summary Statement.

Respect for Cadavers. Phase 1 of the Learn Curriculum begins with two concurrent courses: The Body and Molecular Foundations of Medicine. The Body course is the introduction to human anatomy and as such represents the medical student's introduction to their 'first patient' which is the cadaver that they will dissect during this course. The Body has an explicit Professionalism Institutional Learning Objective: "Demonstrate integrity, respect and sensitivity towards the cadavers in the dissection room." In the Spring following the Body course, students organized a Donor Memorial Service where selected students present narrative reflections and donor family members are invited to speak at this service.

Explicit Statements of Behavioral Expectation. During the Basic Mechanisms of Disease course, there is an explicit Professional Institutional Learning Objective: "Demonstrate behaviors that are in a professional, respectful and cooperative manner during small group case discussions (CPCs)." Similarly, the Integrated Organ Pathophysiology course: Gastrointestinal/Nutrition has the following Professionalism Learning Objective: "Behave in a professional, respectful and cooperative manner during small group case-based discussions." The Integrated Organ Pathophysiology course: Endocrine/Reproductive posts the **Honor Code** of the Stony Brook University School of Medicine which includes a statement on Professional conduct: "Establishing and maintaining the highest concepts of honor and personal integrity during medical school are critical to our training as physicians. It is our responsibility to actively support these standards and it is reasonable to expect that our colleagues will do the same."

As described above, currently there are explicit statements regarding professionalism and professional conduct and values in some, but not all, courses in Phase 1. As such, we propose adopting the tenets of the **AAMC Compact between Teachers and Learners of Medicine** as a preamble (posted on C-Base) to all of the biomedical sciences courses in Phase 1. These tenets would begin with the following statement of philosophy:

- Stony Brook University School of Medicine is committed to upholding an environment that promotes academic and professional success in learners and teachers at all levels.
- The achievement of success is dependent on an environment free of behaviors which can undermine important missions of our institution.
- We wish to promote an atmosphere of respect, collegiality, fairness and trust.

The following tenets would guide professional behaviors and values in the lecture hall, small group discussions, laboratory and interpersonal communications. As an overarching principle, the faculty must serve as role models for the learners and create an appropriate learning environment. The learning environment should be free from distractors (such as social media interactions), maintain respect when fellow learners and teachers speak in small group sessions or larger venues, and maintain respect for specimens presented in pathology-based sessions consistent with the respect provided to their cadavers at the beginning of their medical education.

- Treat all fellow learners and teachers of medicine with respect and fairness
- Treat all fellow learners and teachers of medicine equally regardless of age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation
- Commit the time and energy to your studies necessary to achieve the goals and objectives of each course
- Be on time for didactic, investigational, and clinical encounters
- Communicate concerns/suggestions about the curriculum, didactic methods, teachers, or the learning environment in a respectful, professional manner

(F) Introduction to Clinical Medicine (ICM) *(Andrew Wackett MD)*

The Introduction to Clinical Medicine Course (ICM) is a Phase 1 longitudinal course offered by the School of Medicine at Stony Brook which runs from September of the first year through December of the second year of medical school. The purpose of the course on the surface is to teach medical interviewing, physical examination and clinical reasoning skills. At a deeper level, the course introduces students to their professional development.

The design of the ICM course provides the perfect backdrop for professional development. The course includes self-study preparatory materials (lectures, syllabus and videos), history and physical exam practice sessions with standardized patients, sessions dedicated to documentation and presentation skills, small group case-based clinical reasoning exercises, physical exam pathology sessions on real patients, and bedside teaching with clinical preceptors.

The course begins with the steps of the history. Students are told that they must learn the material on their own by reviewing carefully crafted lectures, syllabus and videos. Then, they are scheduled to practice what they have learned on Standardized Patients. They are told to arrive on time, which I explain is actually 5 minutes early. Furthermore, they are expected to dress like a physician, white coats and business attire.

Next, students learn the steps of the physical exam. Again, they must learn the material on their own initially, come to the Clinical Simulation Center ready to practice the skills, arrive on time and professionally dressed with their medical equipment. Eventually, they are trained to perform the rectal exam, male genital exam, female breast exam and pelvic exam on Standardized Patient Models. These portions of the exam are often stressful for the students and they quickly realize that there is a level of intimacy in medicine which is truly different than any other profession.

Finally, six months after the course begins, students start seeing “real” patients. Two students work with one clinical preceptor and over the course of ten sessions, they interview and examine at least ten patients. During these sessions, in addition to developing data gathering skills, students are critiqued on their professional appearance, their rapport with patients and their attitude to the task at hand. They also, have the opportunity to become part of the sometimes tragic lives of many patients. This again helps the student to identify that they are becoming part of a profession that is separate from others.

PHASE II LEARN

(A) Clerkship Reflection Rounds *(Lisa Strano-Paul MD & Stephen Post PhD)*

The Liaison Committee for Medical Education requires that the curriculum of a medical education program must include behavioral subjects in addition to basic science and clinical disciplines. Most curricular changes implemented to comply with these accreditation requirements occur in the preclinical years. Doctors in training feel poorly prepared to cope with spiritual and emotional issues faced by patients and their families. The informal or hidden curriculum reinforces the concept that as physicians we concern ourselves with the scientific aspect of patient care and ignore the spiritual while remaining strictly emotionally detached in order not to violate equanimity and imperturbability. Students seek role models in attending and residents to affirm that these human emotions are an important part of their emerging professional personas and in fact enhance patient-centered care. When spiritual and emotional content is delivered in the pre-clinical years, the educational impact is not as strong as that seen during the experiential clinical learning phase. The lack of reinforcement of spirituality and emotional presence during the clinical training misses an important opportunity to enable students to integrate these concepts into their emerging professional personas.

The third year of medical school is a time of experiential learning that often stimulates questions within students about their attitudes, values, beliefs, and goals that impact their call to serve and their relationships with patients, peers, and the clinical team. This occurs because health caring is stressful and requires engaging in deep relationships with patients, family and staff. Patients’ suffering brings up issues in ourselves while at the same time the core principle of altruism makes it hard for healthcare professionals to care for ourselves. The education of medical students in general does not focus on formation of whole student which requires cognitive as well as personal and spiritual, pathways to growth. To fully develop a balanced professional, students must form “habits of heart and mind”. This balance is an essential part of professional formation.

In an effort to counter these deficiencies we have provided students with the opportunity to reflection on their patient encounters as a way to develop their own inner resources for addressing the suffering of others. This has resulted in the inclusion of Reflection Rounds for SB campus medical students during the Primary Care, Internal Medicine, Pediatric, OB/GYN and Surgery clerkships. This program was initially sponsored by a grant from the GW-ish institute for spirituality, then supported by the Donoho Academy of Clinical and Educational Scholars.

The Reflection Rounds provide a tool that students can use to remain authentic to themselves in patient relationships. The Reflection Rounds are designed to integrate students' professional experiences with patients and their own spirituality or inner life. The rounds are a regularly scheduled required part of clerkship activities and encourage students to reflect on their patient care experiences through sharing their own experiences and listening to the experiences and perspectives of others. The rounds are facilitated by trained faculty who do not participate in any clerkship related grading. The rounds provide a space to reflect, talk and explore personal, emotional, and spiritual meaning in mainstream medical culture. Students sharing and listening as others share their experiences, and thereby learn from one another. A Circle of Trust is developed and it is a safe haven for the expression of the emotional and/or spiritual dimensions of our interactions with patients. In creating a safe and confidential learning environment with no grading or judgment from the team, students learn by experience and role modeling that understanding the inner life is critical to practicing with integrity, accountability, compassion, and respect for others. The experience also fosters active learning and strengthens collegial bonds as students share like experiences and facilitate their peers. Reflection rounds facilitates the formation of the Psycho-Social-Spiritual aspects of a physician's professional identity and together with the learned biological knowledge results in a completely formed compassionate physician.

Initiated in 2015 by Lisa Strano-Paul MD and Stephen Post PhD in the Primary Care Clerkship, Reflection Rounds (RR) have now spread to Internal Medicine, Ob/Gyn, Ped, and Surgery. RR provides students with the opportunity, through reflection on their patient/ team/role model clinical encounters, to develop their own inner resources for addressing matters that they may find challenging. These groups are not facilitated by faculty in the specific clerkship itself because students feel inhibited due to concerns about clerkship evaluation. Facilitators must have psychological skill sets, and are never allowed to take the narrative away from the students, who come to sessions with cases and challenges that have weighed on their minds but that are otherwise left out in the parking lot. Themes raised vary: the patient unfairly labelled or even dehumanized, the patient who fails to care for self and is non-adherent, the problem of maintaining student integrity when role modeling and team interactions are sometimes deeply flawed, cases of perceived overtreatment, absence of empathy and compassion in interaction, balance in professional-personal life, experiences of humiliation, foul or depersonalizing humor or language directed at patients, etc. By processing these challenges, which often leave students troubled and even sleepless, they are able to galvanize and re-center around their PIF and integrity with renewed commitment.

(B) Winthrop Longitudinal Learning Communities *(Susan Guralnick MD, Steve Shelov MD)*

Winthrop Campus succeeded with the Longitudinal Learning Communities (initiated 2014) because they were structured (a year before Reflection Rounds at the SM Campus) to allow students engaged in clinical clerkships the opportunity to process and reflect on the various themes alluded to above (Section B), and others as well. The Winthrop Learning Communities were created in response to student request in the spring of 2013. The initiative was developed with student input for the initial scope and breadth of the Learning Community (LC) program at

Winthrop.

The purpose of these communities is to allow a safe, confidential forum for Third and Fourth year medical students at Winthrop to engage in discussions and reflections that reflect the multitude of “human” experiences they are having during their clinical training years at Winthrop. Each LC consists of 6 third and 6 fourth year students and two faculty mentors. Guralnick and Shelov selected the mentors who appeared to be committed to this activity and were natural mentors for medical students in their estimation. The range of expertise was from a Chair of a Department to more junior faculty across the spectrum. Disciplines represented include Internal Medicine, Pediatrics, ObGyn, Radiology, and Surgery. Each of the groups meet every other week on a schedule decided by the LC. The methodology for each group varies according to the wishes of the LC, but in general they include opportunities for:

1. written reflection and sharing
2. verbal sharing of difficult experiences
3. developing peer response to perceived difficulties by students through the various clerkships and electives
4. developing strategies for career choice, finding each students passion
5. working with Peers and mentors to sort out career challenges and fears and concerns
6. engaging peers and mentors in mutual support exercises

The overall thrust of this LC commitment is to foster a healthier learning environment for our students and to enhance faculty/student mentoring relationships. It is our overall impression that many aspects of PIF are touched upon throughout these sessions and enhance the overall strategy of the Medical Schools focus on promoting the wellness of our students.

(C) Clerkship Intersession Role Modeling Small Group Sessions (Stephen Post PhD, Latha Chandran MD, Andrew Wackett MD, Doreen Olvet PhD).

Since 2012, clerkship students convene small group sessions in the intersession program at the Stony Brook site as all clerkship students from Stony Brook Medical School gather. This exercise will draw on student clinical experiences during the Year 3 (now Phase 2) clerkships, with a special focus on clinical role modeling, ethics, and students’ professional development. (The cases presented in this exercise are confidential and unidentifiable.) Each student is asked to write up one ethics/role modeling case that they have encountered in their clinical clerkships year to date. The case might present a dilemma that was handled well, or one that was handled poorly. This write-up requires the student to pay special attention to clinical role models with regard to their impact on the resolution of ethical dilemmas, and their influence on student professional development. These cases should be written up clearly (three double-spaced pages) and include these elements and others that the student may wish to add:

- a) Brief basic medical history and facts
- b) Description of the patient’s illness experience (i.e., how the condition impacts the patient emotionally, socially, attitudinally)
- c) Description of the ethical dilemma and the moral voices/stakeholders involved (e.g., patient, family, clinicians, nurses, institution, etc.)

- d) Ethical principles of relevance (e.g., respect for patient or professional autonomy, beneficence, non- maleficence, justice or fairness, confidentiality, truth telling, etc.)
- e) Communicative and affective processes that may have contributed to a positive/negative outcome
- f) How did the character of the clinician(s) involved impact the outcome for better or for worse (positive qualities that helped might include such things as attentive listening, empathy, respect, honesty, compassion, social intelligence, patience, etc.; *and/or* negative qualities such as abruptness, rudeness, and disrespect that were counterproductive?)
- g) What was your role in the case? How did you handle any concerns or dilemmas you faced personally, and how would you manage them differently in the future? If you faced an uncomfortable situation with regard to a case that was poorly handled, did you feel free to discuss this with your clinical faculty? Did you?
- h) What did you learn from the case about being a good doctor and a good role model (sometimes you can learn a lot from flawed role modeling), and how did this case help you gain insight into any of your own strengths or limitations?

(D) PIF-Related Assessment in Clerkship Evaluations

Each Medical student is evaluated with the common C3 form that assesses Professional Competencies with ILO 15, 16, 17. Students are assessed on these professional competencies by several evaluators per clerkship.

15. Exhibited professionalism through compassion, altruism, integrity, respect, responsibility and sensitivity in meeting obligations inherent in the practice of medicine.
16. Used sound moral reasoning and judgment to evaluate, render and defend decisions regarding patient care and health care policies.
17. Demonstrated sensitivity and responsiveness to patients' personal characteristics such as race, color, sex, age, ethnicity, religion, national origin, sexual orientation, disability, socioeconomic or marital status.

The inevitably subjective assessments of behaviors might be strengthened. Exactly how PIF should be tracked in clerkships is a matter for discussion. Is the above grid satisfactory?

Pediatric Clerkship Milestones (Susan Guralnick MD)

The Pediatric Clerkship at the Winthrop Campus utilizes the ACGME Pediatrics Milestones of (a) Patient Care 12 – “Provide Appropriate Role Modeling” and (b) “Personal and Professional Development” (<https://www.abp.org/sites/abp/files/pdf/milestones.pdf>) as follows:

Provide Appropriate Role Modeling

- 1 - Demonstrate Humanism
- 2 - Show responsiveness to patient needs that supersedes self-interest
- 3 - Show respect for patient privacy and autonomy
- 4 - Demonstrate a sense of duty and accountability to patients, society and the profession
- 5 - Demonstrate sensitivity and responsiveness to a diverse patient population

Personal and Professional Development

- 1 - Develop the ability to use self-Awarenessto engage in appropriate help-seeking behaviors
- 2 - Use healthy coping mechanisms to respond to stress
- 3 - Manage conflict between personal and professional responsibilities
- 4 - Practice flexibility and maturity in adjusting to change...
- 5 - Demonstrate trustworthiness that makes colleagues feel secure....
- 6 - Provide leadership that enhances team functioning, the learning environment and/or health care system/environment....
- 7 - Demonstrate self-confidence that puts patients, families, and members of the health care team at ease
- 8 - Recognize that ambiguity is a part of clinical medicine.....

Internal Medicine and Consult Service (*Lloyd D. Lense MD*)

While times, tools and demands may have changed we should all have transitioned from “Medical Student” to “Student of Medicine”. It is a community endeavor. This life work starts before Medical School as you yourself form your own identity. Previous experiences of family, school, religion, sports, music and organizations will influence your identity and professional framework.

Transitioning from Medical Student to Physician is a journey similar to other professional skill set developments. However the one thing that makes Physician so special is inherent in its definition. To be a Physician is to engage in healing. There are qualities and accomplishments that can be encouraged and fostered by you the student and your teachers. I will select a few that can make a difference in your effectiveness both personally and professionally. First, achieve the highest level of competency. Second, the importance of caring cannot be overstated. Third, communication is essential both in written and oral forms for patient care and education on all levels. Think of this as the 3Cs. This fabric can be strengthened by weaving in durable threads of empathy, emotional intelligence, good listening skills, ethical behavior, respect, honesty when you do not know, sharing with colleagues, seeking help, understand the difference in cultures and remember to practice to continue to improve. While we are in a device- centered era, reinforce your lessons and experiences by writing down what you learned from each case. Keep a log or a diary of your clinical experiences and rotations.

The clinical world is a different type of classroom. It is different in structure, activity level and predictability. It is a team and how you function on that team may be uncertain. Every student needs a set of Expectations. This is not unique to the student but also important for the house staff and Attending. The leader of the Cardiology Service provides students and house staff an appraisal sheet for them to list their weaknesses, strengths, where they improved and by what tools or mechanisms. He also includes a Reading List to help with the education and build on the importance of evidence based Medicine. While “Knowledge is Power,” Wisdom is gained through understanding the literature and how it applies to the patients. Also recommended are problem solving brochures or guides to assist the daily efforts of gaining knowledge, interpretation of the knowledge and application of the knowledge. (An example of a brochure is attached in the appendix of this document).

The clinical world in the hospital is conducted through Medical Rounds. Medical Rounds have been present for years. It is a community or in a sense the village for the Medical Student, House Staff, Attending Physicians, Nurses, Technologists, Consultants, Administrators and Patients. It is a meeting of the minds, expressions of the known and not yet known, planning and education of all. For you the student it is your journey to learn, interpret and apply the information of the health sciences and its humanitarian accompaniments. The following pillars can bolster your experience.

Pillar One: Efficiency – Accuracy plus Speed. Remember the Accuracy but do not be imprisoned by “Paralysis by Analysis.”

Pillar Two: Equity – Ownership. A key concept for much of life but for you it is ownership of the material to give you confidence to make intelligent decisions, teach the information to colleagues and those who follow (legacy) and to help your patients to the best of your ability.

Pillar Three: Humility – Remain humble. Be supportive. Remember there is always something new to learn.

Pillar Four: Personal Health both Physical and Emotional. Take care of yourself through sleep, nutrition, exercise and community so you can gain the most from the Clinical World Experience and make a meaningful difference for your patients.

The clinical world is different in that it is a Physician and a Patient. It is one to one. Students should enjoy the experience. Sit down and engage the patient face to face. Be prepared by having an understanding of why the patient is seeking your professional help. Perfect that Physical Examination to learn from your different senses and allow you to make a meaningful professional and confident connection.

Cardiac Clerkship Stated Behavioral Expectations:

1. CACU is a **LEARNING & TEACHING** Experience
 - A. First class History and Physical Examination
 - B. Learn from all the patients and colleagues
 - C. Challenge yourself

- D. Skill set development: ECG, Radiology, Treatment Regimens
 - E. Medical and Scientific literature reading
 - F. Participation on Rounds and listening skills
2. CACU is an **EFFICIENCY** Experience
 - A. Accuracy plus promptness plus preparation
 - B. Teamwork
 - C. Smart use of Technology and Resources. **PRIVACY/HIPPA ISSUES**
 - D. Efficient and Intelligent Discharge Planning
 3. CACU is a **SOCIAL** Experience
 - A. WASH YOUR HANDS**
 - B. READ THE SIGNS – ISOLATION PRECAUTIONS AWARENESS**
 - C. Patient and Staff Introduction
 - D. Take care of YOURSELF:
 - Smile
 - Rest and Exercise
 - Nutrition & Hydration: **BUT NOT ON THE FLOOR OR ON ROUNDS**
 4. CACU is a **GROWING** Experience
 - A. Be a better physician at the end of each day
 - B. Inquisitive – Ask questions and take notes
 - C. Grow, Integrate and Apply your knowledge and skill set
 - D. RESULTS = Actions plus Relationships**

PHASE III LEARN

(A) Two-Week Psychiatry in Medicine Course (*Eduardo A. Constantino MD*)

Our PIF Working Group strongly endorses the content of this course, and recognizes that after 2016-2017 it will no longer be offered. We therefore have established with Working Group member Dr. Andrew Wackett that its contents will be transferred into Transition to Residency (TTR, directed by Dr. Wackett. (It is possible that a small fraction of this content will be incorporated into the extended 3rd year psychiatry clerkship.) Seminar leaders have offered to teach these classes in alternate venues such as TTR.

Psychiatry in Medicine was, through 2016-2017, a mandatory, two-week course for 4th year medical students with a small group format (15-18 students) that runs 8 times per year. Over recent years, several new seminars have been added that focus more specifically on professional identity formation and help transition the 4th year students to their upcoming roles and responsibilities as resident physicians. These include the following:

Uncomfortable Interactions offers students the choice of completing two online modules: Intimate Partner Violence or Professional Boundaries. The students submit a writing assignment that incorporates their specific experiences with the topic and these examples are included in the seminar discussion. For the IPV module, the focus of discussion is not on identifying domestic violence (which the students have previously learned), but on the specific potential statements and “next steps” once the violence has been uncovered. This includes a discussion of relevant laws and reporting mandates. The Professional Boundaries module and subsequent group discussion reviews the various boundary violations the students have encountered in medical school, but again focuses more on how to reset those boundaries and get the doctor-patient interaction back on track. In both cases (as in much of the Psychiatry in Medicine course), the goal is to make the students feel more comfortable in the physician role.

That physician role also includes the potential for systemic and individual errors that may harm patients. The seminar on **Unexpected Outcomes and Medical Errors** addresses these situations by reviewing episodes that the students have already encountered and scenarios that may come up for them as residents. In group discussion and using video of doctor-patient scenarios, the students look at the best ways to have these difficult discussions with patients and the feelings associated with harmful errors or “near misses.” This is often the first time students see these discussions since they are almost always excluded from these meetings with patients and families after these event occur. Invariably, the discourse includes the students’ views on the professionalism (both positive and negative) of the attending and resident physicians with whom they have worked in their clinical rotations.

Unlike most of the other seminars in the course which review aspects of the doctor-patient relationship, **The Impaired Physician** seminar looks at interactions between physician colleagues. Students discuss potential solutions to a scenario where an attending physician on their team displays signs of a substance use disorder. Solutions discussed include saying nothing in fear of possible reprisal to reporting the physician to the NYS Committee for Physicians Health. The students speak about competing pressures as resident physicians in this scenario including the potential harm to patients by the impaired physician, the possible threat to the supervising physician’s career, and the ramifications to their own careers as resident physicians (including possible “evaluation retaliation” by the impaired attending MD).

Finally, the **Stress Management** lecture looks at how the work of a physician may negatively affect the students’ mental and physical health. Students discuss potential stressors that include heavy work load, exposure to traumatic situations, and difficulty managing the hospital hierarchy as physician trainees. This seminar reviews strategies that can decrease stress (and its untoward effects) and focuses on the importance of work-life balance as physicians.

In all the seminars in the Psychiatry in Medicine course, the teachers try not to ignore the many positive aspects of a medical career. Our goal is not to scare students about their upcoming progression to resident MD, but to further prepare them for the challenges that may arise and reassure them that they have the skills to successfully make the transition to healthy, responsible, and competent physicians.

In summary, this course contributes to PIF in a manner than helps them with the transition to their upcoming residencies. Directed by Eduardo A. Constantino, relevant classes that address PIF include:

- a) Uncomfortable interactions: Domestic violence and professional boundaries – uses on-line modules and written reflections
- b) Capacity evaluations and ethical dilemmas
- c) Unexpected outcomes and medical errors – focusing on how to speak to patients when these problems arise
- d) The impaired physician – with discussion about whether to and how to handle a colleague with a potential problem
- e) Managing difficult patients
- f) Stress management
- g) OSCE of a psychotic patient presenting to ED with medical complaints – with focus on the stigma and possible divergent work-up/treatment of patients with mental illness.

(B) Medicine in Contemporary Society 4 Elective

MCS4 is still available and students in Phase III continue to sign up for it in the form of one-month independent studies in humanities and ethics.

(C) Year 4 Electives (*Latha Chandran MD*)

Medicine and Law Course (*Judge Arthur Diamond JD*)

This one month elective includes 12 sessions and covers the latest legal-ethical dimensions of clinical practice in New York State. It is taught by Judge Arthur Diamond, a distinguished Justice of the New York State Supreme Court, at both the Winthrop and Stony Brook campuses.

Other PIF relevant courses include **Palliative Care, Gerontology, Nutrition/ & Obesity Prevention**, and others. We can consider new courses as needed, such as a course on **Disparities in Healthcare** (as Related to Race, Economic Class, Ethnicity, Culture, System Structures, etc.).

(D) Residency Program (*Susan Lane MD*)

While not an intervention for medical students directly, Susan Lane MD has initiated Reflection Rounds in the Department of Internal medicine residency program as of January 2016. This is important because residents are typically in need of opportunity to express aspects of their lives that can be discussed nowhere else, and that need to be processed in order for them to flourish as individuals and as clinical instructors for medical students.

Moreover, residents serve as role models for medical students, often more regularly than attending physicians. We hope to make PIF a big part of residency training, simply because these are individuals from whom students learn attitudes and behaviors. In general, we need to develop PIF in residency training.

(E) Schwartz Rounds (*Rina Meyer MD, Rahul Panesar MD, Stephen Post PhD, Maureen Cole DN*)

Stony Brook Children's Hospital initiated Schwartz Rounds in July of 2015. These rounds allow healthcare providers to process the human and affective side of difficult cases through a unique structure. The results have been stunning, and evaluations excellent. SBCH is officially sanctioned as a Schwartz Round site via the Schwartz Center for Compassionate Care in Cambridge, Ma.

Medical students on pediatrics clerkship and residents are expected to attend Schwartz Rounds.

(F) 13 Entrustable Professional Activities Evaluations of All Students (*Latha Chandran MD*)

Starting from the matrix presented Appendix D of "Curriculum Developers Guide for Core EPAs for entering Residency," Stony Brook School of Medicine is proceeding to validate that all graduate achieve the 13 Core EPAs.

ITEMS ACROSS ALL PHASES (I, II & III)

(A) Clinical Simulation Center Activities (*Perrilynn Baldelli*)

Students participate in simulation activities in the Clinical Simulation Center (CSC) during each Phase of medical school. The activities they perform help them develop skills in history taking, physical examination, diagnosis, treatment plans, critical thinking as well as professional behavior, interaction and communication. Each simulation activity incorporates several of these skills at various difficulty depending on the level of the student learner.

Items evaluated for communication in these activities include the following:

- Greeted patient appropriately- introduced themselves name & title/addressed patient by name
- Expressed interest in patient as a person not just the condition/ explored patient's reaction to illness/problem/impact on patient's life
- Listened and paid attention to patient – note taking balanced with eye contact, did not talk down to patient, summarized information for patient/ non-verbal expression like nodding, eye contact
- Encouraged patient to tell their story – collected information in an organized fashion, used combination of open and closed ended questions, avoided technical jargon, did not unnecessarily interrupt
- The examinee provided me with information regarding the differential diagnosis and next steps.
- Included patient in decision making/encouraged questions/explored concerns

- Was emotionally supportive/offered statements of empathy, validated concerns, or showed nonverbal expressions of concern/empathy

Items evaluated for professionalism/physical exam behavior are:

- Professionally dressed, white lab coat, student ID badge
- Washed hands upon entering the room/prior to patient contact.
- Appropriately draped patient during the physical exam.
- Described the physical exam to the patient (what they were doing).
- Explained the physical exam findings to you (what they found)
- Considered patient's comfort during the physical exam.
- Conducted the exam on the skin

Phase 1 Activities

Phase 1 students are involved in activities initially with standardized patients (SPs) in a series of sessions that help them develop history taking and communication skills. During this time, they work in pairs and watch and evaluate peers and provide feedback to each other. This activity also helps them develop note-writing and patient presentation skills as they interact with Phase 3 students to develop these skills. This is followed by a series of activities that helps them develop physical examination skills. This section concludes with a full history and physical examination final summative OSCE. They also participate in a series of basic science OSCEs that allow them to combine their skills of history taking with diagnosis. The second half of Phase 1 concentrates on students learning to focus their history and physical exam skills while continuing to work on communication, differential diagnosis and diagnostic plans. Students interview and exam a series of patients with different chief complaints based on the body system courses they are completing. They continue to evaluate each other and provide feedback as well as work with Phase 3 students to develop note writing and presentation skills. Additionally, they are exposed to some experiences in the CSC that expose them to real patients with attending preceptors to develop their history and physical examination skills. Throughout Phase 1 there are five TIME OSCEs that help the students to develop communication and interaction skills including patient counseling, breaking difficult news and dealing with challenging patients. Phase 1 ends with the End of Phase 1 OSCE Examination that is a summative high stakes OSCE exam that evaluates the skills taught during this phase.

Phase 2 Activities

Phase 2 students complete SP experiences during each clerkship. These experiences help the students develop skills in focused history, focused physical exam, communication, interaction, diagnosis, diagnostic and treatment plans. The OSCEs include more challenging patients and involve difficult communication issues such as breaking bad news, discussion of brain death, non-compliant patients, psychotic patients, and domestic issues. The students also begin to participate in high fidelity manikin simulation to learn procedural skills as well as participate in interprofessional exercises that allows them to learn teamwork, communication and leadership skills.

Phase 3 Activities

Phase 3 begins with the Clinical Practice Exam (CPX) which is a high stakes summative OSCE exam that evaluates skills developed during Phase 2 and assists them in preparation for the CS Step 2 exam. These students also participate in the Psychiatry in Medicine OSCE that presents them with difficult patients described in the Phase 3 LEARN section of this document. During this time, many participate as preceptors for the Phase 1 students and serve as role models as they assist them in learning the skills of patient note-writing, patient presentation, and physical exam. Finally, they participate in the Transitions to Residency program where they participate in several high fidelity manikin simulations and partial task trainers to develop and hone their clinical procedural skills, critical thinking, diagnosis and treatment plans of acute patient problems and critical situations. Several of these activities are interprofessional allowing them to further develop their teamwork, communication and leadership skills.

Virtually all activities with simulated patients involve PIF dimensions. Many involve feedback on cognitive and affective empathy, verbal communication and clarity, and other aspects of interaction now captured in the HCAHPS survey. Such things as informed consent, ethical decision making, professional presentation and affect, and other dynamics are included.

(B) WE SMILE (*Howard Fleit PhD*)

The **WE SMILE** (*We can eradicate student mistreatment in the learning environment*) is a School of Medicine program designed to educate students, residents, faculty and staff about appropriate and inappropriate behaviors in the clinical learning environment. It is a five-pronged program that includes the following:

- **Education-** understanding examples of inappropriate behaviors in the learning environment
- **Reporting-** understanding where to submit reports
- **Review and adjudication** – understand the process of review of alleged mistreatment
- **Enforcement-** enforcement ultimately rests with the Dean of the School of Medicine and appropriate University offices.
- **Communication-** the Committee on Student Affairs provides periodic reports to the Dean's Office, the Faculty Senate, educational committees, and the student body

The educational component of this program includes a PowerPoint presentation of the values of the institution along with types of behaviors that are viewed as inappropriate and unprofessional. Six case scenarios with accompanying videos have been developed to illustrate the range of behaviors from appropriate to inappropriate actions and provide the rationale for the disposition of the case. Since the implementation of the program, nearly 100% of our students report awareness of the program on the AAMC GQ as well as with internal surveys and focus groups. In addition, reports of inappropriate behaviors (student mistreatment) has declined to lower than the national average since the program has been put in place.

(C) The Stony Brook Home (“SB Home”) & Winthrop Student Health Clinic (WiSH) at Winthrop University: Social Justice and Advocacy for the Underserved in Healthcare Delivery

SB Home

Mission Statement. Stony Brook HOME is dedicated to improving the health and well-being of the underserved community in Suffolk County by increasing access to free, dependable, and comprehensive health services; empowering individuals and families through education and social services; and training future clinicians in culturally competent and compassionate care.

Clinic History. At the end of 2005, medical students from the classes of 2008 and 2009 gathered around a shared interest in starting a student-run health clinic at Stony Brook. The Dean of the Medical School supported the establishment of a student-run health clinic as one of his proposed educational initiatives, and a steering committee consisting of 6 medical students and Dean Aldustus Jordan was formed in the beginning of 2006. In October of 2008, the clinic opened its doors for the first clinic session.

The Stony Brook Home engages students in serving the underserved, advocating for justice in healthcare access, and developing their empathic communication skills in a setting that fosters a professional attitude of human equality regardless of class, race, language, or ethnicity. A significant percentage of patients are Spanish speaking immigrants.

Winthrop WiSH

Mission Statement. Thanks to a unique collaboration between Winthrop-University Hospital, RotaCare (a free appointment-only health clinic under the medical direction of Roman Urbanczyk, MD), and Stony Brook Health Outreach and Medical Education (HOME), the Winthrop Student Health (WiSH) Clinic has recently opened, helping to better serve the healthcare needs of the community.

This free, student-run clinic - a vision of the fourth year medical students that has received support of Winthrop's Senior Administration and Office of Academic Affairs - is helping to provide comprehensive primary and preventative care to the uninsured patient population of Nassau County at the A. Holly Patterson Extended Care Facility in Uniondale.

"We are pleased to partner with RotaCare and Stony Brook HOME to offer this important health service to the community," said Francis Faustino, MD, WiSH Clinic Medical Director and Chairman of the Department of Family Medicine at Winthrop.

The Clinic is staffed by fourth year medical student volunteers who live and study at Winthrop as part of the Clinical Campus of Stony Brook University School of Medicine. At the clinic, Dr. Faustino, as well as other health-care professionals, are guiding the medical student

volunteers and providing constructive input to help them develop the skills necessary to become model physicians.

(D) Peer and Self-Assessment Program

Importance of Peer and Self-Assessment

Peer and self-assessment is an integral component of the **LEARN** curriculum. Students' ability to provide, receive and reflect upon constructive peer feedback about team skills and professionalism is an essential professional competency. The regular peer and self-assessments integrated throughout the **LEARN** curriculum are designed to encourage self-reflection and promote personal and professional growth and development.

Program Objectives

- 1) Develop constructive feedback and communication skills for the physicians we graduate, and develop a culture of open, constructive communication within the School of Medicine.
- 2) Encourage continuous improvement of self-reflective practice skills.
- 3) Encourage lifelong learning in medical students.

Program Details

- 1) Students regularly provide peer-to-peer feedback in team-based or small-group activities in courses and clerkships
- 2) Team-based and small-group activities include, but are not limited to, TBLs, OSCEs, anatomy dissections, laboratories, CPCs, and MCS small-group discussions.
- 3) Students provide peer feedback approximately once every 4-5 weeks during curriculum blocks.
- 4) Students conduct self-reflections on feedback they have both received and given on a bi-monthly basis.
- 5) Students complete the Peer and Self-Assessment Questionnaire on CBase.
- 6) The PSA Questionnaire asks students to provide feedback on their assigned peer's role in and contributions to small-group or team-based activities, ability to work with other members of the team, and level of professionalism.
- 7) CBase is the repository for all completed feedback and self-reflections.
- 8) Peer-to-peer feedback is anonymous during Phase I of the **LEARN** curriculum. Beginning in Phase II, peer-to-peer feedback is non-anonymous. This anonymous to non-anonymous transition provides a developmental process.
- 9) Should a recipient receive peer feedback that is in anyway threatening, discriminatory or unprofessional, the recipient should contact her/his POD advisor or the Associate Dean of Student Affairs.

Responsible, Effective Feedback is SMART

Responsible, effective feedback is SMART – Specific, Measurable, Achievable, Relevant and Timely:

- 1) Describe **S**pecific concrete skills and behaviors that you observed. Generalizations are particularly unhelpful.
 - Focus on skills and behaviors that are **M**easurable. A measurable skill or behavior is one that can be placed along a continuum of level of development.
 - Direct your comments towards skills and behaviors on which the person can act – that is, **A**chievable. Don't make suggestions which are outside the scope of what the person can do.
 - Stick to commenting on skills and behaviors that are **R**elevant to learning activity. If you can't think of a constructive purpose of your feedback, then do not give it.
 - Be **T**imely. Effective feedback must be well-timed. It is of no use offering feedback after the person receiving it has moved on to other things.

Student-POD Advisor Review of Peer Feedback and Self-Reflections

- 1) Students meet with their POD advisor twice each academic year (November/December and April/May) to review feedback both received and given and a student's own self-reflections on that feedback.
- 2) During these meetings, the student and her/his POD advisor synthesize the overall message of the feedback the student has received in the interim, the progress she/he has made in light of prior feedback, plans for addressing current feedback, improvements for giving feedback to peers, and the concordance of her/his self-reflections with received feedback.

(E) Student Well-Being and Wellness: The Duty of Self Care (Medical Student Health, Happiness, and Humanism, or MeSH) (*Katarzyna Zabroka MD/MA Candidate Medical Humanities, Class of 2017; Nora Stillman MD Candidate, Class of 2017*)

We address here the 9th professional expectation above: “Students practice good self-care, knowing that optimal patient-centered care is only possible when professionals manifest well-being, meaning, and wellness. This includes adequate balance in life, and the processing of the human and emotional side of provider experience.”

Medical school is a time of psychological distress for many students, leading to a decline in health and wellbeing over the course of training. Stress places students at risk for burnout and contributes to an erosion of empathy towards patients. For medical students to successfully undergo professional transformation into compassionate, resilient physicians, medical schools must take an active role in promoting self-care. In order to support students' current physical and psychological health, and instruct students in positive self-care practices they may rely on throughout their careers, we have implemented a comprehensive wellness program for Stony Brook University medical students at the Stony Brook and Winthrop-University Hospital (WUH) campuses.

Physicians in training face significant challenges to their health and wellbeing starting early on in their professional education. Financial concerns, academic pressure, sleep deprivation, and experiences of patients' sickness and death all contribute to the toll on students' wellbeing. During the first year alone, medical students show negative changes to their health habits, including increases in alcohol consumption and decreases in exercise and socialization.¹ By the end of their training, medical students report higher rates of anxiety and depression than their age-matched peers.^{2,3} The decline in wellbeing that occurs during medical school likely sets the stage for the high rates of depression, substance abuse, and suicide disproportionately affecting fully trained physicians today.^{4,5} In addition to causing personal psychological distress, stress and "burnout" lead to an erosion of empathy towards patients and delivery of poorer quality care.^{2,6,7}

Fortunately, the reverse is also true. Increased wellbeing among medical students has been shown to enhance empathy.⁸ A 2009 survey of 2,682 medical students from seven U.S. medical schools found that students with positive mental health were less likely to report suicidal ideation and unprofessional behavior than their peers with moderate or languishing mental health. The survey also revealed that medical students with positive mental health held more altruistic beliefs regarding the role of a physician in society.⁹ Likewise, residents with better mental wellbeing score higher on validated empathy scales.¹⁰ Empathy is related to positive outcomes in patient care. Patients of physicians with higher empathy scores have been shown to fair better than patients of physicians with low empathy scores.^{11,12} Sound mental health therefore allows for the personal and professional development of competent physicians, and facilitates safe and compassionate patient care.

The path to wellbeing is accessible. Physicians identified as having positive mental health report a variety of simple self-care practices which improve their psychological wellbeing,¹³ such as seeking support in healthy relationships, making time for spiritual practice, and receiving medical treatment for depression. Interventions to enhance trainee wellbeing and promote self-care have been implemented in graduate and undergraduate medical centers across the United States.¹⁴⁻¹⁶

Medical Student Health, Happiness, and Humanism, or **MeSH**, is a student-led and faculty-backed initiative for a comprehensive wellness program to promote self-awareness, self-care, resilience, and capacity for joy. The MeSH student board works collaboratively with students and faculty to support programs and materials that are most desired and needed by students to facilitate self-care. Wellness assessments amongst all classes help pinpoint these needs. Besides coordinating and planning activities for students such as a park picnic or bowling, MeSH also works to collate resources in and outside the student community. This can range from bringing together classmates for a weekly run to providing healthy recipes or sharing stories in medicine.

Professional identity formation is highly influenced by self-care but also by our peers. Many resources for student wellness and professional development are already available. MeSH seeks to bring these resources and students together in order to emphasize care for the self, and care for others. As Stony Brook students, we support maintaining a community of medical

students who are supportive of each other's wellbeing in order to build a foundation for professional camaraderie, respect, and caring.

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(F) The Importance of Self-awareness in Professional Identity Formation

(Nora Stillman, M.D. Candidate, Class of 2017)

Self-awareness in professional identity formation allows us to be present for the remarkable transition we experience starting in medical school. Without it, we may reflect on this interaction with a patient or that challenging discussion, but we risk missing what these pieces mean for the larger process of our becoming medical professionals. Add self-awareness to our experiences of medical education, and we observe internally the effect of these experiences on the formation of our principles; we are aware of how our *way of being with* patients, colleagues, and our own successes and failures changes over time. In other words, we are awake to our professional identity developing.

Self-awareness is often thought of as a trait, something we have or do not have; whose benefits we enjoy or do not enjoy. This person is self-aware, while that person is not. But, self-awareness is also a dynamic, intentional practice. We can actually say, now I am going to practice self-awareness. We can and should teach this practice to all medical students so that they may call on it as needed, to process a singular event *and* to be active participants in their professional identity formation.

How? We start by introducing two fundamental techniques in the practice of self-awareness: paying attention to the breath and paying attention to the mind.

1. Paying attention to breath. When we pay attention to our breath, we are inviting internal signals into our awareness. These signals range from the very obvious – *my inhale is longer than my exhale today* – to the subtle and/or unexpected – *I had no idea I was clenching my jaw*. By exposing students to the practice of paying attention to breath early on, they eventually become aware of increasingly subtle signals from within. For example, *this type of*

patient seems to make my abdomen clench and my breath shallow. I wonder why? The student can now work with this question, gaining insight into an otherwise unconscious “trigger.” The following are suggestions for introducing students to breath-work:

- *Phase I: “Harvard Medical School Stress Management: Approaches for Preventing and Reducing Stress” by Herbert Benson, MD: Required reading and discussion of this excellent manual on mind-body physiology and stress reduction from Harvard Medical School.*
- *Phases II and III: Exploring one’s physiologic as well as mental state on the wards: While exploring countertransference in collegiate and patient interactions, we discuss the full set of our mental and physical internal experiences.*

2. Paying attention to the mind. This practice involves paying attention to our thoughts, on purpose, and without judgment (sometimes called practicing “mindfulness.”) Here, because extended periods of meditation are impractical, we may use thoughtful self-questioning to turn a curious, investigative lens on a topic of personal growth, for example, our thoughts about a difficult situation, our belief systems around an ethical dilemma, or the process of PIF as a whole. This is similar to exercises students undertake in TIME sessions. However, it is vital to frame these important reflections as practices in a specific self-awareness technique – that of paying attention to the mind – rather than endpoints in and of themselves. The following are questions to elucidate students’ current beliefs/understanding of self-awareness and PIF. Students should have access to their answers from previous phases.

- *Phase I: What is self-awareness? What relationship, if any, do you see between self-awareness and professionalism?*
- *Phase II: How will you practice medicine? What principles will define your practice? What kind of doctor do you want to be? (beyond “which specialty”)*
- *Phase III: How will you practice medicine? How will you know if you have strayed from this ideal? How will you know if your professional development has stagnated? (internal fatigue, burn out, cynicism; external tension in relationships, with patients, making mistakes, etc.) How will you support life-long professional identity formation for yourself and your colleagues?*

Paying attention to the breath and the mind are just two of many techniques for expanding self-awareness, all originally outlined in the 3,000 year old Indian philosophical system *Yoga*. Exploring resistance, practicing discipline, and devoting ourselves to a *process* over its *objectives* are other techniques we may experiment with in the future. The LEARN curriculum offers students opportunities for reflective writing, but this must be introduced as one technique of many in the dynamic and life-long practice of self-awareness. Self-awareness is essential in professional identity formation as a way to reality-test, a way to answer the question, *Am I behaving like the physician I want to be?* Let us therefore start systematic instruction in self-awareness, first by teaching our students to look no further than their own breath and their own minds.

(G) MD with Scholarly Concentration in all Tracks (*Howard Fleit PhD*)

Humanities and Ethics Track (*Stephen G. Post PhD, Track Director*)

Medical Education Track (*Latha Chandran MD, Track Director*)

Global Health Track (*Mark Sedler MD, Track Director*)

The MD with Scholarly Concentration engages an estimate half of our students in a four-year research project in various tracks using the methods of the basic and clinical sciences, social science, educational studies, global health, and the humanities (ethics, arts, history, philosophy, literature, policy, etc.). All are important to the process of PIF.

Phase I medical students can enter the Scholarly Concentration program on several tracks, all of which pertain to PIF. In particular, the humanities & ethics track, the medical education track, and the global health track are of significance. Students develop a research project, pursue it for two months in the summer after their first year, and for two full one-month research elective periods in Phase Three. They present their research at Research Day two months before graduation.

(H) Narrative Medicine, Reflective Writing & Astonished Harvest Poetry (*Richard Bronson MD, Lisa Strano-Paul MD, Katarzyna Zabrocka*)

Physician Perspective: The Astonished Harvest Writers Group (*Richard Bronson MD, Jack Coulehan MD, Maria Basile MD and Students*). Stony Brook has a tradition in the “medical humanities,” through the efforts of a number of pioneers who recognized this need in medical education. However, the reading of poems written by physician poets, or portions of plays and short stories written by physicians, is insufficient to instill in many students emotional intelligence and self-awareness. A small subgroup will respond to these activities, but most will not. Matriculating students enter medical school with varied backgrounds based on knowledge they have acquired at home and in college. Their interests and personalities and their plans for future careers in medicine may not see these activities as credible. One can read the poems of John Stone or the short stories of Richard Selzer, check off the box, and move on. Perhaps this provides the student with a transient awareness of the interpersonal relations between doctors and patients. Nothing more. And given the intense need to absorb new knowledge and to show competence in that knowledge through a national examination, the gateway into residency training and future careers, Stone and Seltzer will be soon forgotten.

What can be done? Faculty modeling to students is important. We can amplify and build on what we already have established. Priya Misra, one of the students who was active in our *Astonished Harvest* poetry program, wrote a blog throughout the four years of medical school, which contained her reflections through prose and poetry of her experiences. She published this in an on-line medical student run magazine. This activity is not for everyone. Priya was an English major in college at Stony Brook. *Perhaps asking students to keep a diary during medical school might be one way to start to promote emotional awareness and reflection.* Developing the habit would have special value when students enter their clerkships in Phase II of the curriculum and encounter challenging situations. *Students might also be asked to volunteer to be designated bloggers from each class or subgroup of the class.* A former Suffolk County poet laureate’s

daughter did this while a medical student at University of Michigan. Duke University Medical Center has a strong tradition in promoting self-reflection through writing. Faculty, students and patients all contribute to an annual publication. Perhaps this could be established at Stony Brook. Alternatively, our student-run literary journal, *Anastomoses*, could be expanded to include more contributions from faculty. A formal annual event might be held during which people read their contributions in *Anastomoses*.

Why is this important? During the second half of the twentieth century, the Federal government invested heavily in research, expanding knowledge within the medical sciences that lead to an unprecedented increase in our understanding of disease processes and methods of treatment. Yet we have become aware that something was lost during this period. When my (Dr. Richard Bronson) father applied to medical school, he was asked during an interview to quote his favorite lines of Shakespeare. A physician was felt to be a person of learning, having acquired knowledge of human experience through the humanities, as well as a “man of science.” Familiarity with both aspects of medicine was an ideal. Although there are many paths in medicine, including fields in which there is no patient contact, this does not negate the need to empathize with the ill, to be aware that anyone may become ill. If we accept the importance of promoting the habit of introspection in our graduates through reflective writing based on our observations of the patient’s experience of illness and our own reactions to that experience, and we value this activity as playing an essential role in the professional development of a medical doctor, it becomes critical to incorporate such activities into the medical school curriculum. This is not an easy task, given the stresses placed upon students as they attempt to achieve mastery of the scientific knowledge they need to acquire.

Phase II Narrative Medicine. (*Lisa Strano-Paul MD*). Each Phase II student at Stony Brook School of Medicine (Winthrop included) does a half-day interprofessional Home Hospice Visit during the mandatory Primary Care Clerkship. Within this clerkship, interpersonal and communication skills are reinforced during classroom sessions. The format for this experience is based on the established best practices that are fundamental to the success of End of Life Care. This includes integration of lectures and experiential learning, professional role modelling, and reflection on action. Three distinct components of a home hospice experience are provided in the half-day session: orientation, experience, and reflection. Orientation includes a tour of an inpatient hospice facility and a small-group introduction to hospice care presented by an experienced hospice nurse practitioner. During the experiential component, students visit hospice patients in their homes with a hospice nurse; they actively participate in caring for the patient and in interviewing the patient and his or her family members or caregivers. The students are required to submit a narrative essay or poem articulating the personal significance the home hospice visit had for them. They are specifically instructed to reflect on the patient’s illness and on how hospice care affected the lives of the patient and the patient’s family members. Student reflections are uploaded to e-portfolio, where they stored and reviewed by clerkship directors. Each student receives written feedback on their submission.

Medical Student Perspective (*Katarzyna Zabrocka*). As medical students, we are often preoccupied with the amount of information we are tasked with mastering and memorizing throughout our four years of medical school. It is easy to lose sight of the hopes and ideals that we wrote about in our personal statements on why we wanted to get that coveted medical school

spot in order to become a doctor. Reflective writing allows us to not only remind ourselves of the reasons we went into medicine, but it also serves as an outlet for introspection on our experiences, actions, and emotions.

Transitioning from preclinical to clinical years can be particularly difficult. Emphasis on reflective writing guides us towards better self-awareness and understanding of the emotional difficulties experienced in a clinical setting. It builds on our professional identity formation by recognizing aspects of our experiences that shape our practice, priorities, and empathy as future physicians. There is more to learn from our day than just the medical facts.

Dr. Rita Charon, executive director of the Narrative Medicine program at the Columbia University College of Physicians and Surgeons, has been a champion of structuring medicine around narratives of patients and medical professionals. Emphasis on narrative medicine as a learning tool and contributor towards professional identity formation will help increase empathy and prevent burnout in a time when medicine feels dehumanized (think computers, tests, billing, insurance, paperwork).

As a student, writing can feel like an additional tedious task at the end of a long day. Despite being a proponent of reflective writing and narrative medicine, I too have sometimes neglected my writing due to a long day or too many tasks on my to-do list. Nevertheless, it has served as an appropriate outlet that I frequently returned to for organizing my thoughts about the hospital and my patients. Early emphasis on reflective writing in the preclinical years at Stony Brook, through classes such as Medicine in Contemporary Society, and further encouragement through the clinical years (humanism based reflections in Pediatrics and Primary Care) remind us not only of the important of reflecting on our experiences but also of how narrative medicine can shape how we think about our identity and how we treat our patients (not just the disease!).

(I) Transition to Residency (TTR) *(Andrew Wackett MD)*

Material from Psychiatry in Medicine is going to be transferred into TTR as of 2017. This includes burnout prevention, boundaries, dealing with error, balance, care of the self, and well-being. The TTR 2017 Schedule is as follows:

“The course consists of Basic and Advanced Life Support recertification courses, a series of lectures, self-study materials, procedure labs, simulation exercises, workshops and team-based learning sessions. There will be a midterm and cumulative final examination.

The Transition to Residency program includes recertification courses in BLS and ACLS. At this point in your training, your BLS and ACLS certification is soon expired and these courses are designed to recertify you for residency.

Next, the series of lectures, self-study materials and team-based learning sessions in the TTR course are designed to be very practical and I think fairly exciting. They will use cases to illustrate topics which are relevant to all physicians starting their respective residency.

The procedure labs are designed to give hands on training with various basic, intern level procedure skills. The skills include endotracheal intubation, lumbar puncture, vascular access, arterial blood gas sampling, nasogastric intubation and urinary catheterization.

The simulation sessions are designed to give hands on training in the management of various critical emergencies. In critical medical situations this is done in teams, each with a focused task. You will do the same during the simulations. The simulations are designed to reinforce the material taught in the lectures and self-study documents.

There are also small group sessions which cover the "Top 10 Intern Night Calls". These sessions bring up common patient scenarios that you will be called to attend. We'll work through these cases as a group, again helping to reinforce the material taught in the lectures and self-study documents.

The course also offers an electrocardiogram workshop series. It is designed to give you all the basics of EKG interpretation. We expect you to be able to interpret all but the most complex EKGs by the end of the course. The skills will be revisited frequently during practice sessions, and the final exam will include EKGs to be interpreted.

You will have two exams, a midterm and cumulative final exam. The exams will be a combination of multiple choice and brief essay questions. Questions will come directly from the lectures, self-study materials, procedure labs, simulation exercises, workshops and team-based learning sessions.

Monday 1/30	Topic	Room	Instructor
8:30-9	Introduction	LH	Wackett
9-9:45	Airway	LH	Wackett
9:45-10:30	Shock	LH	Wackett
10:30-11:15	Pressors	LH	Parnia
11:15-12	Anaphylaxis	LH	Wackett
1-4	Airway Management	Surgical Skills Center	Wackett
Tuesday 1/31			
9-5	Self-Study BLS and ACLS Shock and Resuscitation Cardiopulmonary Emergencies		Wackett
Wednesday 2/1			
9-5	BLS and ACLS	161	Stapleton
Thursday 2/2			
9-10	Altered Mental Status	LH	Morley
10-12	Small Group Cases	Small Rooms	Wackett, Bailey et al
1-4	Simulations	CSC – both simulation rooms	Wackett and Cohen
1-4	Procedures ABG, NG, LP, Chest Tube, central Lines, IO	Surgical Skills Center	Wackett et al
Monday 2/6			
9-5	Self-Study Neurological Emergencies GI Emergencies Toxic and Metabolic Emergencies		Wackett

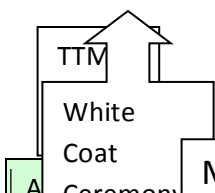
Tuesday 2/7			
9-3	Simulation (IP)	CSC – both simulation rooms	Wackett and Cohen
9-3	Procedures ABG, NG, LP, Chest Tube, central Lines, IO	Surgical Skills Center	Wackett et al
Wednesday 2/8			
10:30-12	Interpreting the CXR	LH	Yaddanapudi
1-2	Geriatric Emergencies	LH	Strano-Paul
2-3	Professional Liability	LH	Judge Garguilo
3-5	ECG Workshop #1	LH	Lense
Thursday 2/9			
9-12	Midterm	LH	Wackett
Monday 2/13			
9-5	Self-Study Pediatric Emergencies OB/GYN Emergencies Pain Management		Wackett
Tuesday 2/14			
9-5	Simulations (IP)	CSC – both simulation rooms	Wackett and Cohen
9-5	Small Group Cases	Small Rooms	Wackett, Bailey, et al
Wednesday 2/15			
9-10:30	Neonatal Resuscitation	LH	Hom
10:30-12	Managing the Critically Ill Child	LH	Kunkov
1-2:30	ABG Interpretation	161	Richman
2:30-4	Ventilator Management	161	Richman
Thursday 2/16			
9-3	Simulations	CSC – both simulation rooms	Wackett and Cohen
9-3	RUSH Exam	CSC - classroom	Morley
Tuesday 2/21			
9-11	OB/GYN Emergencies	LH	Garduno
11-12	Pain Management	LH	Hallarman
12-3	Pain Management Workshop	Small Rooms	Hallarman
12-3	OB/GYN Cases	Small Rooms	Garduno
3-5	ECG Workshop #2	LH	Lense
Wednesday 2/22			
8:30-12	Managing Finances	LH	Allen and Filosa
12:30-2	GQ Survey	LH	Wackett
2-4	Focus Groups	Small Rooms	Lu
Thursday 2/23			
9-12	Final	LH	Wackett

Monday 2/27			
8:30-9	Introduction	LH	Wackett
9-9:45	Airway	LH	Wackett
9:45-10:30	Shock	LH	Wackett
10:30-11:15	Pressors	LH	Parnia
11:15-12	Anaphylaxis	LH	Wackett
1-4	Airway Management	Surgical Skills Center	Wackett
Tuesday 2/28			
9-3	Self-Study BLS and ACLS Shock and Resuscitation Cardiopulmonary Emergencies		Wackett
3-5	ECG Workshop #1	LH	Lense

Wednesday 3/1			
9-5	BLS and ACLS	161	Stapleton
Thursday 3/2			
9-10	Altered Mental Status	LH	Morley
10-12	Small Group Cases	Small Rooms	Wackett, Bailey et al
1-4	Simulations (IP)	CSC – both simulation rooms	Wackett and Cohen
1-4	Procedures ABG, NG, LP, Chest Tube, central Lines, IO	Surgical Skills Center	Wackett et al
Monday 3/6			
9-5	Self-Study Neurological Emergencies GI Emergencies Toxic and Metabolic Emergencies		Wackett
Tuesday 3/7			
9-2	Simulation (IP)	CSC – both simulation rooms	Wackett and Cohen
9-2	Procedures ABG, NG, LP, Chest Tube, central Lines, IO	Surgical Skills Center	Wackett et al
Wednesday 3/8			
10:30-12	Interpreting the CXR	LH	Yaddanapudi
1-2	Geriatric Emergencies	LH	Strano-Paul
2-3	Professional Liability	LH	Judge Garguilo
Thursday 3/9			
9-12	Midterm	LH	Wackett
Monday 3/13			
9-5	Self-Study Pediatric Emergencies OB/GYN Emergencies Pain Management		Wackett
Tuesday 3/14			
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12-3	OB/GYN Cases	Small Rooms	Garduno
3-5	ECG Workshop #2	LH	Lense
Wednesday 3/22			
8:30-12	Managing Finances	LH	Allen and Filosa
12:30-2	GQ Survey	LH	Wackett
2-4	Focus Groups	Small Rooms	Lu
Thursday 3/23			
9-12	Final	LH	Wackett

PIF Timeline

PHASE 1



Clerkship

MCS Course 18 sessions; Time Weeks (6 weeks)

December

Phase 3

ELECTIVES INCLUDING MCS, PIF, PSYCHIATRY IN MEDICINE, SELECTIVES, SCHWARTZ ROUNDS, EMOTIONAL INTELLIGENCE EXERCISES, NUTRITION AND WELLNESS.

APPENDIX

(A) The Honor Code of the Stony Brook University School of Medicine

Preamble

We, as medical students of Stony Brook University, believe there is a need to support and cultivate the high ethical standards of honor associated with the medical community.

This Honor Code intends to make explicit minimum standards to which we, as a community, will hold our colleagues and ourselves accountable. Personal and academic integrity are the foundation of the Code, with particular focus on respectful communication among peers.

We are aware that integrity, accountability, mutual respect and trust are essential to the medical profession and we will actively support and work to achieve these ideals throughout our professional career. The environment that we create is critical to this endeavor.

As members of our community, we realize that our actions affect those around us and the quality of the community.

This Code should supplement, but not supplant, our personal, religious, moral and ethical beliefs, nor is this Code meant to supersede any policies, regulations, codes, statutes or laws that exist within the Stony Brook University Hospital System, State University of New York at Stony Brook, New York state or federal jurisdiction.

I. Professional Conduct

Establishing and maintaining the highest concepts of honor and personal integrity during medical school are critical to our training as physicians. It is our responsibility to actively support these standards and it is reasonable to expect that our colleagues will do the same.

A. Respect for Patients

1. At the Bedside

We will take the utmost care to ensure patient respect and confidentiality. As medical students, we will demonstrate respect for patients through appropriate language and behavior, including that which is non-threatening and non-judgmental. Patient privacy and modesty should be respected as much as possible during history taking, physical examinations and any other contact, to maintain professional relationships with the patients and their families. It is also important that we be truthful and not intentionally mislead or give false information. With this in mind, we should avoid disclosing information to a patient that only the patient's physician should reveal.

We should consult more experienced members of the medical team when unsure of a course of action or at the request of a patient. Appropriate medical and/or personal information about patients should only be shared with health professionals directly involved or for educational purposes.

2. Communication

The written medical record is important in communication between health care providers and effective patient care; it is also a legal document and available for patient review. As such, it is crucial that we maintain the integrity of patients' medical care through accurate reporting of all pertinent information about which we have direct knowledge. Written medical documents, including electronic correspondence pertaining to patients and their care must be legible, truthful, complete and accurate to the best of our knowledge and abilities. To avoid an accidental breach of confidentiality, we will not discuss patient care in common areas.

B. Respect for Faculty, Staff, Colleagues, and Hospital Personnel

We will exhibit respect for faculty, staff, colleagues and others, including hospital personnel, guests and members of the general public. This respect should be demonstrated by punctuality in relationships with patients and peers, prompt execution of reasonable instructions and deference to those with superior knowledge, experience or capabilities. In addition, we should make every effort to maintain an even disposition, display a judicious use of others' time and handle private information maturely.

We should express views in a calm, respectful and mature manner when in disagreement with another individual. Under this Code, “confrontation” is defined as the initiation of a constructive dialogue with another community member with the goal of reaching some common understanding by means of respectful communication. Confrontation is encouraged, though it should be understood that achieving a common understanding does not necessarily mean reaching agreement.

C. Respect for Self

We realize that a diversity of personal beliefs serves to enrich the medical profession, and therefore we encourage the upholding of personal ethics, beliefs and morals in both daily conduct and in our practice of this Code. For example, we have an obligation to inform patients and their families of all available treatment options that are consistent with acceptable standards of medical care. However, we are not required to perform procedures that conflict with our personal beliefs.

D. Respect for Laws, Policies and Regulations

Laws, policies and regulations at the University, local, state and federal levels benefit the community and are not to be disregarded or violated. Any matters under the jurisdiction of local, state or federal laws are explicitly deemed “outside the scope” of this Code.

II. Academic Standards

We are responsible for proper conduct and integrity in all scholastic and clinical work. As students, we are obligated to develop our medical knowledge and skills to the best of our ability, realizing that the health and lives of the persons committed to our charge could depend on our competence. Due to the teamwork inherent in the medical profession, we should work together and utilize all available resources. If a professor believes it is in the best interest of student learning to limit access to some of those resources then he/she must make this explicit well in advance. We will abide by such policies.

A. Examinations

1. Professors and proctors are expected to treat us respectfully; likewise we must demonstrate honor and integrity during examinations.
2. We understand that examinations are meant to reflect our individual achievement. Cheating during examinations is unethical and is defined as doing any of the following without authorization:
 - a. Looking at the answers written by another student during an examination.
 - b. Communicating with another student about topics that might help to answer a question during an examination.
 - c. Referring to notes or textual matter during an examination.
 - d. Violating any other policy of examinations.
3. During examinations, professors, proctors and students have an obligation to maintain a non-disruptive atmosphere.
4. We will take care not to communicate specific information regarding an examination to a classmate who has not yet completed that examination during that academic year. Specific information includes form, content and degree of difficulty.
5. At the end of each examination, we will provide a signed statement that affirms our conduct was in accordance with the Code.

B. Other Academic Work

1. In deference to the scientists, doctors, and patients who have shared their knowledge and experience for the betterment of medical learning, we have a responsibility to not intentionally misrepresent the work of others nor claim it as our own.
2. During medical training we will be provided with communal instructional material that will greatly aid our learning. We will therefore make every effort to protect and preserve these resources for the use of future peers and classmates.
3. Unless a professor explicitly limits us, all assignments will be considered group work.

III. Social Behavior

Our social relationships should be based on mutual respect and concern. We must consider how our words and actions may affect the sense of acceptance essential to an individual's or group's participation in the community. Upon encountering actions or values that we find degrading to ourselves or to others, we should feel comfortable confronting our peers.

Our behavior and speech should demonstrate our respect for the diversity of our colleagues. We should avoid disparaging remarks or actions with regard to a person's race, age, gender, disability, national origin, position, religion or sexual orientation. We will strive to create an environment that fosters mutual learning, dialogue and respect, while avoiding verbal, written or physical contact that could create a hostile or intimidating environment.

Since our actions reflect upon us, we should adhere to our standards of Professional Conduct when within, representing or in any way impacting our community.

IV. Honor Code Violations and Accountability

Our honor as community members and professionals is maintained through accountability. We will act in accordance with this code and we expect our peers to do the same. We will act with honor to avoid burdening our peers with a responsibility for our own integrity. Actions not in accordance with the aforementioned standards constitute a violation of this Code.

A. Self-Reflection

If there is concern that our academic or social conduct represents a violation of the Honor Code, we are obligated to report our behavior by contacting an Honor Committee member.

B. Interactions with Others

If there is concern that a peer's academic or social conduct is in violation of the Honor Code, we must privately confront that individual. It is sometimes difficult to challenge the behavior of a fellow community member. However, it is our responsibility to confront offending parties; failure to do so is a violation of the Code.

As confrontation is often a matter between two individuals or parties, we will exercise discretion and respect privacy when initiating a dialogue to address our concerns. It is essential that these steps of the confrontation involve respectful communication and interchange. During the initial confrontation, each party will attempt to achieve mutual understanding. If the parties realize that there has been no violation, the matter is dropped. If the parties realize that there has been a violation of the Code, the offending party is obligated to report his/her behavior by contacting an Honor Committee member within an agreed-upon time frame.

C. Involving an Impartial Mediator

In the event that mutual understanding is not reached during the initial confrontation, or if the offending party has neglected to report his/her actions, the confronting party must contact a member of the Honor Committee. At this time, an impartial mediator will be randomly assigned to the case, although he/she may decline this position if he/she does not believe he/she can maintain impartiality.

The goal of mediation is to reach an agreement as to whether or not a violation of the Code has occurred. If it is agreed that a violation did not occur, then both parties must feel comfortable

with that resolution. If it is agreed that a violation did occur, or if an impasse persists after mediation, the case will be brought before the Honor Committee by the mediator.

In the rare cases where the confronting party believes that his/her personal safety may be threatened, he/she may ask a member of the Honor Committee to initiate or assist in the dialogue.

In the event that a situation is being handled by an outside authority, either party may seek non-disciplinary support from an Honor Committee member.

D. Role of the Faculty

In cases of suspected Code violations, members of the faculty will follow the same procedures as outlined above; privately resolved matters do not repair the breach of trust inflicted upon the greater community.

V. The Honor Committee and the Resolution of Violations

A case of a suspected violation may be brought to the Honor Committee through self-reporting or by the mediator, at which point the case proceeds to a hearing for resolution.

A. Procedures towards Resolution

1. Assigning a Chairperson

The impartial mediator of the case will become the chairperson of the hearing. In the case of self-reporting, a Committee member will be randomly assigned the position of Chairperson and will no longer be a voting member of the case. He/she may decline if he/she does not believe he/she can maintain impartiality. When a case reaches the Honor Committee, the Chairperson will convene the Committee for a Preliminary Meeting. The details of the case will not be provided at this time.

2. The Preliminary Meeting

All committee members are expected to attend the Preliminary Meeting. At the meeting, the chairperson will present all background information in the case. Members may remove themselves from participation due to a conflict of interest. As a minimum, the following conditions must be met:

- a. At least half of the Committee must be present.
- b. One voting member from the class(es) involved in the case must be present.
- c. The parties involved in the case will not be present at this preliminary meeting.

Membership on the case will consist of those in attendance at the meeting. No additional members may join later case proceedings. In the event of extenuating circumstances, a Committee member may be excused from the Preliminary Meeting by the chairperson. Attendance at all subsequent meetings is expected; absences may constitute dismissal from the case at the discretion of the Chairperson.

At this point an Advocate will be appointed for each party, chosen from Committee members in attendance. These Advocates will no longer be voting members of the Committee for the case; rather each Advocate will aid and support his/her party and facilitate the presentation of the facts of the case. While we expect all parties will speak for themselves at the hearing, the Advocate may act on their party's behalf as necessary, to ensure that the truth is adequately communicated. The Advocates will be present throughout all phases of the hearing.

3. Hearing procedures

Subsequent to the Preliminary Meeting, a hearing will commence. It is the responsibility of the Chairperson and the Advocates to guide the parties through the hearing process.

The Chairperson will serve as the facilitator of this meeting and all related meetings subsequent to these proceedings. At the beginning of a hearing, the Chairperson will give a brief overview of the purpose of the hearing, answer any procedural questions, and ask members of the Committee whether or not they feel they can be objective.

All persons involved in the hearing, including the parties themselves, Advocates and Committee members, are expected to maintain the confidentiality of the proceedings.

a. Fact-finding

The first phase of the hearing will focus on establishing facts of the case. All parties will have the opportunity to express what they believe to be the facts of the incident. During this portion of the hearing, all Committee members are urged to ask questions in order to gain a clear understanding of the situation.

The Chairperson will then dismiss the parties and Advocates, and the voting members of the Committee will determine the following by consensus:

Has the Honor Code been violated in this case?

If no violation is found, the matter is dropped, and the relevant parties are so informed. If a violation is found, the hearing proceeds to the Evaluation phase.

b. Evaluation

The parties are asked to return, so the Committee may inquire as to the nature of the circumstances surrounding the incident in question. Each party will be asked to suggest and justify what he/she feels is a fair resolution of the problem. The Committee may also propose alternative resolutions with the parties.

c. Deliberation

When the parties and the Committee members believe that the necessary information has been shared, the parties will again be dismissed and the voting members of the Committee will determine the following by consensus:

What are the relevant circumstances in this case?

What is an appropriate resolution in this case?

After an initial consensus is reached, the Committee will adjourn for at least one day and refrain from discussing the details of the case. At this point, each Committee member will privately reconsider the issues involved in the case to reflect upon his/her endorsement of the consensus. The Committee will then reconvene and either reaffirm its position or reach consensus on another action.

d. Presentation of the Resolution

The parties will be asked to return to hear the Committee's recommendation and reasons for their decisions.

e. Recommendation to the Dean

The recommendation will be presented in writing to the parties and the Dean of the School of Medicine within a reasonable time. The offending party has the right to appeal the recommendation to the Dean. If an appeal is made, the Dean may then uphold the Committee's recommendation, send the recommendation back to the Committee for further consideration, or overturn the recommendation of the Committee. The community at large, including students, faculty and administrators, entrusts great responsibility to the Honor Committee in these matters.

4. Repairing breeches of trust

With any violation of the Code, the offending party is obligated to repair breeches of trust to the community at large. This will be accomplished by compliance with the final decision in the case and acceptable reaffirmation of the party's commitment to the standards of the community.

B. Membership of the Committee

A total of four members from each class will serve on the Honor Committee. Incoming classes will elect four of their peers to the Committee for the duration of the first half of the academic year. Before the close of this term, another election will be held to select four classmates to serve until the beginning of the clinical years. Before the close of the second academic year, students will elect four of their peers to sit as members of the Committee for the duration of the clinical years.

The results of all elections will be kept on file for the duration of the current term; in the event that a member of the Committee steps down, the first runner-up in their most recent election will serve the remainder of the term. If there is no runner-up, a special election will be held within a reasonable time to elect a new Committee member to serve the remainder of the term.

Upon ratification of the Code, each ratifying class will elect four members to the Honor Committee to serve the term appropriate to their academic year as specified above.

C. Responsibilities of the Committee Members

1. To the Community

The Honor Committee's responsibilities to the community include: educating students and faculty about the Code, providing information and literature about the Code and assisting in maintaining awareness of the Code.

Committee members will also undergo appropriate training prior to their becoming active members of the Committee.

2. Within the Committee

The Honor Committee is responsible for interpreting the Code. The Committee will consider each case individually and should be sensitive to both the community and the individual involved when making decisions.

VI. Ratification of the Code

Students of the Stony Brook University School of Medicine classes of 2004 and 2005 will ratify this Code by a two-thirds majority. All incoming classes will be subject to this Code and will sign the pledge upon acceptance of admission to the School of Medicine.

VII. Amending the Code

This Code may be amended through an annual proposal and voting process. Amendments to the Code will be accepted by a two-thirds majority vote of all classes governed under the Code.

VIII. The Pledge

Membership in the Stony Brook medical community is dependent on our commitment to the Honor Code, and confirmed by our signing the Honor Pledge card, which states: "I hereby accept the Stony Brook School of Medicine Honor Code, realizing that it is my duty to uphold the Code and the concepts of personal and collective responsibility upon which it is based."

IX. Amendments

I. The Committee has the right and responsibility to negotiate and clarify faculty policies concerning homework assignments, use of old exams and answer keys, citations in group-work and other graded and non-graded assignments whenever necessary. The results of these actions will be made known to the students.

II. A student who is governed by the Code may propose an amendment at any time. An amendment may be brought to an immediate vote if it is signed by 20 or more students who are governed by the Code. If an amendment is brought to an immediate vote, it will be discussed in an open forum and voted on within a reasonably short period of time.

III. Cases referred to the honor committee involving substance abuse/mental health that do not involve an honor code infraction will be handed over to AIMS without further action by the honor committee.

For cases referred to the honor committee that involve a substance abuse/mental health component as well as an honor code infraction, the honor committee will expedite the student's entry into the AIMS process. The honor committee will take necessary measures to clarify that participation in AIMS is NOT punitive. The honor committee will continue involvement in the case in order to fulfill its function in remediating the professional transgression.

In cases that are referred first to the AIMS committee that include an honor code violation, the honor code does not expect AIMS committee members to violate confidentiality, although we do expect them to urge the student to come forward and honorably declare the professional transgression.

We wish to acknowledge the guidance and contributions provided by the codes, texts and other references that have preceded this document.

ⁱ Erikson EH. The life cycle completed. New York, NY: Norton; 1982.

ⁱⁱ Monrouxe LV. Identities, self and medical education. In: Walsh K, ed. Oxford Textbook of Medical Education. Oxford, England: Oxford University Press; 2013.

ⁱⁱⁱ Merton RK. Some preliminaries to a sociology of medical education, In: Merton RK, Reader LG, Kendall PL, eds. The Student Physician: Introductory Studies in the Sociology of Medical Education. Cambridge, Mass: Harvard University Press; 1957.

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