School of Medicine Columbia

Curriculum Committee Handbook

2020-2021

HANDBOOK FOR CURRICULUM COMMITTEE
Table of Contents

Appendices

F. Guidelines for Conduct in Teacher/Learner Responsibilities

Handbook for Curriculum Committee Members

Introduction

The deliberations of the Curriculum Committee are crucial for determining educational policy, curricular structure, and implementation strategies for the four-year University of South Carolina School of Medicine – Columbia (USCSM-C) educational program. The **mission statement** includes the charge to the committee and an outline of the functions. This statement is reviewed yearly and revised as necessary.

Much of the Curriculum Committee's work will be performed by four standing subcommittees: 1) **M-I/M-II**, 2) **M-III/M-IV**, 3) **Interdepartmental/Interdisciplinary Integration (I3),** and 4) **Core Student Assessment**. There is one ad-hoc committee, **Curriculum Accommodations**. The tasks facing the full Curriculum Committee include annual review of outcome data, courses, clerkships, and vertical curricula along with insuring coordination of the curriculum both horizontally and vertically and encouraging/supporting curricula innovation.

Meetings

Meetings of the Curriculum Committee are held on the second Thursday of each month at 4:00 pm. The meetings are currently being held virtually. Subcommittee meetings are expected to be held monthly and as called by each Subcommittee Chair.

Approximately one week prior to each meeting, members receive an agenda for the upcoming meeting and a copy of the previous meeting's minutes. The agenda and minutes of each meeting are also available electronically via e-mail before each meeting. All interested USCSM faculty members and students are invited to attend Curriculum Committee meetings. Meetings generally last one to one-and-a-half hours. Special meetings (retreats) are usually scheduled once a year.

Appointment and Membership

Committee members are elected from each USCSM department, rather than appointed from the faculty at large. The Associate Dean for Medical Education and Academic Affairs, the Assistant Dean for Preclinical Curriculum, the Assistant Dean for Clinical Learning, the Assistant Dean for Clinical Curriculum and Assessment, and the Assistant Dean for Medical Student Education-Florence will serve the Curriculum Committee as ex officio non-voting members. Two representatives from each basic science department and one representative from each clinical department are elected from the departmental faculty. In addition there will be one representative elected at-large by the Florence Faculty. Members serve a three-year-long term on the Curriculum Committee and may be re-elected. To assure a smooth transition, a system of staggered terms of membership has been adopted for Committee members. The medical students are represented by two members from both the M-II class and the M-IV class, all of whom serve one year terms. One additional M-IV student is selected to represent the Florence Regional Campus. Course, block, clerkship, and vertical curricula directors are appointed to the respective MI/MII, MIII/MIV, and I3 subcommittees. They serve as *ex-officio* voting members of their respective subcommittees. Multiple consultants who serve *ex officio* without vote are available to the Curriculum Committee; they

include the Assistant Dean for Continuous Professional Development & Strategic Affairs, the Associate and Assistant Deans for Diversity and Inclusion, the Director of Admissions Services/Registrar, the Assistant Dean of Student and Career Services, the Director of Library Services, the Assistant Dean of Information Technology, and the Associate Dean for Graduate Education or their representatives.

Committee Chair

The Chair serves a two-year term and is elected biennially. Chairs are elected alternately from among basic science and clinical science Committee members; Chairs also serve as their department's Committee representative. A Chair may therefore serve as a Curriculum Committee member for a maximum five-year term if he/she is elected Chair in the third year of his/her Committee membership. The Chair is responsible for developing each month's agenda and for conducting Committee meetings using ***The Standard Code of Parliamentary Procedure*** by Alice Sturgis. The Chair also reviews and corrects Committee minutes before they are distributed to Committee members for discussion, corrections, and approval via e-mail prior to the next curriculum meeting.

Staff

The Associate Dean for Medical Education, the Assistant Dean for Preclinical Curriculum, the Assistant Dean for Clinical Curriculum and Assessment, and the Assistant Dean for Medical Education Florence are charged with the responsibilities of assisting the Chair in the development of the agenda; of providing Committee members with required information resources, of transmitting the decisions of the Committee to course and clerkship directors and to department chairs; and of ensuring that Committee recommendations are implemented. Administrative support is provided by the administrative assistant in the Office of Curricular Affairs and Media Resources (803-216-3610). The Curriculum Committee Chair ensures that Committee deliberations and decisions are reported regularly to the Dean and also presented to the Executive Committee for information.

Functions

The Liaison Committee for Medical Education (LCME), the joint accrediting agency of the American Medical Association and the Association of America Medical Colleges (AAMC), has established and promulgated extensive criteria for medical school accreditation. Curriculum Development and oversight is an important component of the medical school's function (see **LCME Educational Elements**).

Among its various responsibilities, the Curriculum Committee reviews curricular content and process at USCSM on annual basis. A "vertical curriculum" refers to the interdepartmental integration, in basic science courses and clinical rotations over the course of the four-year curriculum, of topical subject matters that transcend the purview of an individual USCSM department. "Vertical integration" of curriculum can be distinguished from "horizontal integration" in that the latter focuses on how similar topics are taught simultaneously in different required courses [e.g. the Pathology and the Introduction to Clinical Medicine II (ICM-II) courses present issues concerning the heart during the same academic time period] and how the curriculum for any one particular year integrates as a cohesive whole.

The Curriculum Committee also reviews and approves the appointments of all course, block, clerkship and vertical curriculum directors to ensure that the person being considered for the position has the experience, credentials, and protected time necessary to perform his/her responsibilities. The newly appointed directors are expected to be familiar with LCME accreditation requirements and set appropriate learning outcomes for their courses. The person selected will be expected to work closely with the Office of Curricular

Affairs in maintaining the curriculum inventory. Oversight of the appointments of site directors for the clinical clerkships on the Florence campus should be provided by the Assistant Dean for Clinical Curriculum and Assessment and the Assistant Dean for Medical Student Education-Florence as well as by the Columbia clerkship directors.

Various student evaluations of the quality of their educational experiences, USCSM Gate Exam pass rates and/or performance indices, USMLE scores, and Postgraduate Year One (PGY-1) survey data from graduates and residency program directors are reviewed yearly. Each course, clerkship and vertical curriculum director presents an annual report on their course including outcome data and changes that have occurred in the course over the past year to the committee.

Office of Curricular Affairs staff members ensure the ongoing assessment by medical students of all M-I and M-II courses (at the conclusion of each semester) and of all M-III and M-IV required clerkships (at the end of each four, six, eight, or twelve week clerkships) by means of evaluation instruments designed for those purposes. An AAMC-sponsored survey is completed by graduating senior students; comparative data for students graduating from USCSM and other medical schools nationally are published annually by the AAMC. Clerkship outcome data (OSCE grades, subject exam scores, clinical evaluations, overall grades, and overall recommendations) from Columbia and Florence are compiled and presented on an annual basis as one means of assessing the equivalency of the two programs. Results of USCSM student performance on the USCSM Gate Exam and Steps 1 and 2 CS and CK of the United States Medical Licensure Examination (USMLE) are also reviewed. Data from these various evaluations, examinations, and surveys are made available to Curriculum Committee/Subcommittee members to assist them in their work.

Of critical importance to the function of the Curriculum Committee is the incorporation of a curriculum tracking mechanism. It is imperative, before substantive changes can be made to the curriculum, that Committee members have an understanding of how, what, and where specific relevant subject matter is taught in the USCSM curriculum. The Curriculum Inventory is housed in the OASIS database. Yearly reports are uploaded to the AAMC each academic year. Every committee member and course/ clerkship director should utilize the database for review purposes.

Curricular change and innovation are crucial to maintaining the effectiveness and relevance of a medical school curriculum in a changing environment. A change to the basic science M-I/M-II curriculum is categorized as “major” if it results in any significant change in the number of credit hours assigned to a course, the deletion of topical content from a vertical curriculum (substance abuse, geriatrics, ethics and professionalism, patient quality and safety, ultrasound, or nutrition), the deletion or addition of lecture topics, or a deviation from the “block schedule” (e.g. requiring M-I or M-II students to meet prior to 8:00 am or after 5:00 pm on weekdays or on weekends). A “major” change in the clinical M-III/M-IV curriculum would include the deletion of topical content involving a vertical curriculum area, an increase in the number of evenings/nights students are on call, or any change in the amount of inpatient vs. outpatient experience in a required clerkship.

Additionally, policies previously adopted and published in the Student Handbook and the School of Medicine Bulletin concerning the academic life of USCSM students are reviewed and updated annually to reflect changes in medical practice, pedagogy, educational law, and society. University of South Carolina policies relevant to any University student, including medical students, are published annually by the University Division of Student Affairs in the Carolina Community: Student Handbook and Policy Guide.

The Curriculum Committee's role is crucial to the well-being and continuing development of the educational program at USCSM. The oversight it provides is required for continuing accreditation of USCSM by the LCME and for maintaining the continuing excellence and effectiveness of the USCSM curriculum. Recent national trends in the revision and reform of medical education have included: a reduction in hours of lecture and passive learning; an increase in small-group instruction, problem-based learning, and other active learning exercises; enhanced interdisciplinary and interdepartmental teaching efforts; integration of basic science and clinical science topics; stimulation of independent learning skills; an emphasis on computer literacy; the development and implementation of more objective methods of medical student assessment [e.g., via Objective Standardized Clinical Examinations (OSCEs) and the use of standardized and simulated patients]; the use of patient simulators; inter-professional education; patient safety and quality; and the development and implementation of **Guidelines for Conduct in Teacher/Learner Relationship** and of more specifically defined and measurable educational goals and objectives for courses and clinical clerkships.

Implementation

Decisions of the Curriculum Committee are transmitted to the Dean and the Executive Committee for information and comment. Decisions are also transmitted to course and clerkship directors and to department chairs for consideration and implementation. The Committee continually seeks input from course directors, clerkship directors, department chairs, faculty consultants, and medical students so that a broad consensus may be reached.

Revised.
08/14
09/16
09/20

School of Medicine Columbia

2020-2021 Meeting Dates
USC School of Medicine
Curriculum Committee

Day	Date	Location	Time
Thursday	August 13	Web Ex Meeting	4:00 PM
Thursday	September 10	Web Ex Meeting	4:00 PM
Thursday	October 15	Web Ex Meeting	4:00 PM
Thursday	November 12	Web Ex Meeting	4:00 PM
Thursday	December 10	Web Ex Meeting	4:00 PM
Thursday	January 14	Web Ex Meeting	4:00 PM
Thursday	February 11	Web Ex Meeting	4:00 PM
Thursday	March 11	Web Ex Meeting	4:00 PM
Thursday	April 8	Web Ex Meeting	4:00 PM
Thursday	May 13	Web Ex Meeting	4:00 PM
Thursday	June 10	Web Ex Meeting	4:00 PM

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

Mission of the Curriculum Committee

Preamble: The Curriculum Committee of the University of South Carolina School of Medicine (USCSM) is empowered by the Dean and faculty with the responsibility (1) for the development of and oversight over the content, structure, and pedagogy of the curriculum leading to the M.D. degree and (2) for ensuring that students learn the knowledge, skills, attitudes, and behaviors necessary for the successful practice of medicine.

Functions of the Curriculum Committee:

I. To ensure coverage of all content appropriate for a medical education and elimination of unnecessary duplication, as well as temporal (vertical), inter-disciplinary (horizontal), and inter-departmental (across basic sciences, across clinical sciences, and between basic sciences and clinical sciences) integration of curricular material.

> The Curriculum Committee strives for excellence in curricular content, relevance, integration, and methodology. The medical curriculum, with its rapidly expanding and changing scientific basis, is continuously updated to reflect changes in the current body of knowledge and to prepare students for the modern practice of medicine. It is essential that information and outcome data be supplied regularly and in response to requests by the Curriculum Committee.

II. To encourage presentation of basic science and clinical science content by multiple techniques in order to stimulate patterns of self-initiated and self-directed life-long learning and effective problem-solving among students, including, but not limited to, computer-assisted instruction, small group discussion, conferences, and laboratories; the use of standardized and simulated patients; case-based instruction; and problem-based learning.

> Because students vary widely in the techniques and modalities by which they learn most effectively, innovation is both desirable and necessary. New educational technologies are constantly being developed which can assist basic science and clinical science faculties to accomplish their goals. The fact that current modes of assessment of medical students and physicians (e.g., for medical licensure) are being revised to include interdisciplinary questions, computerized formats, and objective assessment of clinical skills requires medical schools to prepare students accordingly.

III. To ensure coordinated oversight, internal and external assessment, and tracking of the curriculum.

> Information about the impact of the curriculum on student and alumni performance is sought regularly. The impact of curricular revisions is assessed in a

timely fashion. Curricular tracking of both content and integration of material among the basic sciences, among the clinical sciences, and between the basic and clinical sciences, as well as for the detection and elimination of unnecessary repetition is central to the mission of the Curriculum Committee and its administrative staff.

IV. To encourage educational innovation and experimentation and to foster a dynamic curriculum.

Course/clerkship directors are encouraged to experiment with innovative curricular changes within an overall coordinated plan that takes into account the best interests of members of the School of Medicine community.

The Curriculum Committee bears the responsibility for, and is the ideal forum for, collegial discussion about the means to achieve curricular and educational excellence. To function optimally and to facilitate this discussion, the Curriculum Committee must be well informed about the faculty's plans, ideas, goals, needs and experiments.

Reviewed (last 3 years): 08/13/15
08/11/16
09/14/17
09/10/2020

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE CURRICULUM COMMITTEE
M-I/M-II SUBCOMMITTEE

I. RESPONSIBILITY

The purposes of the M-I/M-II Subcommittee of the Curriculum Committee are to:

1. Perform, under the supervision of the Curriculum Committee, periodic reviews and assessments of all required M-I and M-II courses for medical students.
2. Make reports and recommendations, based upon the findings of the periodic reviews and assessments of required M-I and M-II courses, to the Curriculum Committee.
3. Evaluate and assist in the horizontal and vertical integration of course material.
4. Review the academic workload in the first two years including time for independent study.

II. AUTHORITY

This subcommittee is advisory to the Curriculum Committee.

III. MEMBERSHIP

Representation from both basic science and clinical science departments is essential; the Subcommittee may also invite as non-voting consultants other faculty members who are not Curriculum Committee members.

A. At least four faculty members appointed by the Curriculum Committee Chair to three-year staggered terms.
B. At least one M-II medical student member of the Curriculum Committee.
C. Course Directors serve as ex-officio voting members.
D. Assistant Dean for Preclinical Curriculum serves an ex-officio, non-voting member.

IV. FUNCTIONS

A. The Chair will be elected from among voting Subcommittee members by Subcommittee members at the beginning of each academic year.
B. The chair will convene the Subcommittee monthly or at his/her discretion or at the direction of the Curriculum Committee Chair.
C. The M-I/M-II Subcommittee will function as a subcommittee of the Curriculum Committee.
D. The Subcommittee will review annually its committee description and charge and make recommendations regarding any proposed revisions to the Curriculum Committee.

V. REVIEW

Recommendations of the M-I/M-II Subcommittee are forwarded by the Chair to the Curriculum Committee for review and approval.

VI. IMPLEMENTATION

A. Recommendations of the M-I/M-II Subcommittee that have been approved by the Curriculum Committee will be implemented by personnel in the Office of Medical Education and Academic Affairs and/or School of Medicine departments.
B. Minutes will be kept of all Subcommittee meetings.

Approved: Curriculum Committee October 12, 2000
Revised: June 2, 2015 Reviewed with updates: September 14, 2016.

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE CURRICULUM COMMITTEE
M-III/M-IV SUBCOMMITTEE

I. RESPONSIBILITY

The purposes of the M-III/M-IV Subcommittee of the Curriculum Committee are to:

A. Perform, under the supervision of the Curriculum Committee, periodic reviews and assessments of all required M-III and M-IV clerkships for medical students.
B. Make reports and recommendations, based upon the findings of the periodic reviews and assessments of required M-III and M-IV clerkships, to the Curriculum Committee.
C. Evaluate and assist in the horizontal and vertical integration of course material.
D. Review and recommend revisions to the Technical Standards as needed.

II. AUTHORITY

This subcommittee is advisory to the Curriculum Committee.

III. MEMBERSHIP

Representation from both basic science and clinical science departments is essential; the Subcommittee may also invite as non-voting consultants other faculty members who are not Curriculum Committee members.

A. At least four faculty members appointed by the Curriculum Committee Chair to three-year staggered terms.
B. At least one M-IV medical student member of the Curriculum Committee.
C. Clerkship Directors serve as ex-officio voting members.
D. Assistant Deans for Clinical Curriculum and Assessment and Medical Student Education-Florence, ex-officio, non-voting.

IV. FUNCTIONS

A. The Chair will be elected from among voting Subcommittee members by Subcommittee members at the beginning of each academic year.
B. The chair will convene the Subcommittee monthly or at his/her discretion or at the direction of the Curriculum Committee Chair.
C. The M-III/M-IV Subcommittee will function as a subcommittee of the Curriculum Committee.
D. The Subcommittee will review annually its committee description and charge and make recommendations regarding any proposed revisions to the Curriculum Committee.

V. REVIEW

Recommendations of the M-III/M-IV Subcommittee are forwarded by the Chair to the Curriculum Committee for review and approval.

VI. IMPLEMENTATION

A. Recommendations of the M-III/M-IV Subcommittee that have been approved by the Curriculum Committee will be implemented by personnel in the Office of Medical Education and Academic Affairs and/or School of Medicine departments.
B. Minutes will be kept of all Subcommittee meetings.

Approved: Curriculum Committee October 12, 2000 Revised: June 2, 2015 Reviewed and updated: September 14, 2016

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE CURRICULUM COMMITTEE
INTERDEPARTMENTAL/INTERDISCIPLINARY
INTEGRATION SUBCOMMITTEE

I. RESPONSIBILITY

The purposes of the Interdepartmental/Interdisciplinary Integration Subcommittee of the Curriculum Committee are to:

A. Conduct periodic reviews and updates of vertical curricula.
B. Ensure the integration of interdepartmental and interdisciplinary educational efforts.

II. AUTHORITY

This subcommittee is advisory to the Curriculum Committee.

III. MEMBERSHIP

Representation from both basic science and clinical science departments is essential; the Subcommittee may also invite as non-voting consultants other faculty members who are not Curriculum Committee members.

A. Four faculty members appointed by the Curriculum Committee Chair to three-year staggered terms.
B. Vertical Curriculum Directors, ex-officio, non-voting.

IV. FUNCTIONS

A. The Chair will be elected by Subcommittee members at the beginning of each academic year.
B. The chair will convene the Subcommittee at his/her discretion or at the direction of the Curriculum Committee Chair.
C. The Interdepartmental/Interdisciplinary Integration Subcommittee will function as a subcommittee of the Curriculum Committee.
D. The Subcommittee will review annually its committee description and charge and make recommendations regarding any proposed revisions to the Curriculum Committee.

V. REVIEW

Recommendations of the Interdepartmental/Interdisciplinary Integration Subcommittee are forwarded by the Chair to the Curriculum Committee for review and approval.

VI. IMPLEMENTATION

A. Recommendations of the Interdepartmental/Interdisciplinary Integration Subcommittee that have been approved by the Curriculum Committee and the Dean will be implemented by personnel in the Office of Medical Education and Academic Affairs and/or School of Medicine departments.
B. Minutes will be kept of all Subcommittee meetings

Approved: Curriculum Committee October 12, 2000
Revised: June 2, 2015 Reviewed and updated: September 14, 2016

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE CURRICULUM COMMITTEE
CORE STUDENT ASSESSMENT SUBCOMMITTEE

I. RESPONSIBILITY

The purposes of the Core Student Assessment Subcommittee of the Curriculum Committee are to:

A. Serve as consultants for assessment projects and otherwise serve as leaders to support a culture of assessment throughout the SOM.
B. Regularly review SOM assessment policies and procedures and recommend improvements to the SOM Curriculum Committee.
C. Support SOM assessors with information and resources, including technology recommendations, to maintain and carry out assessment plans. This includes recommending or providing assistance in the development of specific assessments of student learning outcomes.

II. AUTHORITY

This subcommittee is advisory to the Curriculum Committee.

III. MEMBERSHIP

Representation from both basic science and clinical science departments is important; the Subcommittee may also invite as non-voting consultants other faculty members who are not Curriculum Committee members.

A. The chairs of the Curriculum Committee's four Subcommittees will serve three-year staggered terms.
B. One medical student member of the Curriculum Committee.
C. Assistant Dean for Pre-Clinical Curriculum, ex-officio
D. Assistant Dean for Clinical Curriculum and Assessment, ex-officio
E. Assistant Dean for Medical Student Education-Florence, ex-officio
F. Director of Program Assessment and Quality Improvement, ex-officio

IV. FUNCTIONS

A. The Chair will be elected from among voting Subcommittee members by Subcommittee members at the beginning of each academic year.
B. The chair will convene the Subcommittee monthly or at his/her discretion or at the direction of the Curriculum Committee Chair.
C. The Core Student Assessment Subcommittee will function as a subcommittee of the Curriculum Committee.
D. The Subcommittee will review annually its committee description and charge and make recommendations regarding any proposed revisions to the Curriculum Committee.

V. REVIEW

Recommendations of the Core Student Assessment Subcommittee are forwarded by the Chair to the Curriculum Committee for review and approval.

VI. IMPLEMENTATION

A. Recommendations of the Core Student Assessment Subcommittee that have been approved by the Curriculum Committee will be implemented by personnel in the Office of Medical Education and Academic Affairs and/or School of Medicine departments.

B. Minutes will be kept of all Subcommittee meetings.

Approved October 13, 2016

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE CURRICULUM COMMITTEE
CURRICULAR ACCOMMODATIONS SUBCOMMITTEE

I. RESPONSIBILITY

The purposes of the Curricular Accommodations Subcommittee of the Curriculum Committee are to:

A. Review and approve recommendations for academic accommodations received from USC Disability Services.
B. Review and make recommendations for the modifications of the SOM's technical standards

II. AUTHORITY

This subcommittee is advisory to the Curriculum Committee through the Assistant Dean for Preclinical Curriculum.

III. MEMBERSHIP

A. One faculty member who teaches in the M-I year appointed by the Chair of the Curriculum Committee
B. One faculty member who teaches in the M-II year appointed by the Chair of the Curriculum Committee
C. One faculty member who teaches in the M-III year appointed by the Chair of the Curriculum Committee
D. Assistant Dean for Preclinical Curriculum, ex-officio, Chair

IV. FUNCTIONS

A. The Assistant Dean for Preclinical Curriculum will serve as Subcommittee Chair.
B. The chair will convene the Subcommittee at his/her discretion.
C. The Curricular Accommodations Subcommittee will function as a subcommittee of the Curriculum Committee.
D. The Subcommittee will review annually its committee description and charge and make recommendations regarding any proposed revisions to the Curriculum Committee.

V. REVIEW

Recommendations of the Curricular Accommodations Subcommittee will be implemented by the Assistant Dean for Preclinical Curriculum.

VI. IMPLEMENTATION

A. Recommendations of the Curricular Accommodations Subcommittee will be implemented by the Assistant Dean for Preclinical Curriculum.
B. Minutes will be kept of all Subcommittee meetings

Revised: June 2, 2015
Reviewed: September 14, 2016

Appendices

Appendix A

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

Clinical Skills Attainment Documentation (CSAD)

The Curriculum Committee supports the Technical Standards for Admission and Graduation previously approved by the Executive Committee. The Committee acknowledges the recommendations of the *GPEP Report* of 1984, the LCME ***Functions and Structure of a Medical School,*** the LCME Accreditation Database, and LCME Annual Questionnaire. These recommendations propose that all students should be assessed during or at the end of the educational process to ensure that the basic knowledge and skills needed by a generalist physician, and established as criteria for graduation by the faculty of the medical school, have been mastered. The methodology of this assessment is left to the individual schools. Therefore, the Committee acknowledges the need to document achievement of student technical proficiency at USCSOM. To that end the Technical Standards Attainment Document (TSAD) was created. In 2006, this document was renamed the "Clinical Skills Attainment Document" (CSAD). In the creation of the CSAD, course and clerkship directors, in communication with department chairs, agreed to a group of academic accomplishments, observational experiences, and technical skills which all graduates of this school should master.

Departmental Skills

To document accomplishment of certain technical skills, the CSAD cards were created. For the Introduction to Clinical Medicine courses in the M-I and M-II years, the cards are green and yellow, respectively. The cards are blue in color for each one of the six MIII clerkships. The technical skills that are **required** to be completed during each clerkship/rotation are listed on the front of the card; other departmental requirements, such as core concepts and patient encounter information, can also be listed on the card. Students must complete the required skills or they will receive an "Incomplete" grade for the clerkship/rotation. To document completion of the required skills and any other requirements, students should receive a copy of the card on the first day of the course/clerkship/rotation. When a student has the opportunity to accomplish one of the required skills, a faculty member or senior resident (in the case of the clinical rotations, and **not** a PGY-1/first year resident/intern) must observe him/her performing the skill, then date and initial the card showing that the student was successful in performing the particular skill. At the end of the course or clerkship, the cards are to be collected by the Course or Clerkship Director and submitted to the Registrar's Office along with the students' academic grades. The Office of Curricular Affairs and Media Services enters the accomplishment of these skills into a database which keeps track of which students have accomplished which skills. **Forgery of a CSAD card is a violation of Personal and Professional Conduct Standards.**

Updated 08-24-2010
Updated 06-05-2015
Reviewed: September 14, 2016

Appendix B

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
Relationship of the Technical Standards for Admission/Graduation to the Clinical Skills Attainment Documentation Procedures

Revised Technical Standards for Admission, Retention, and Graduation

Technical Standards

The School of Medicine has adopted the following technical standards:

Technical Standards for Admission, Retention and Graduation. The curriculum of the University of South Carolina School of Medicine has been designed to provide a general professional education leading to the medical doctor (M.D.) degree and to prepare undifferentiated students to enter graduate medical training in a wide variety of medical specialties and sub-specialties. All candidates for admission to, and all current students at the School of Medicine – herein after designated as candidates for the M.D. degree should possess sufficient intellectual capacity, physical ability, emotional and psychological stability, interpersonal sensitivity, and communication skills to acquire the scientific knowledge, interpersonal and technical competencies, professional attitudes, and clinical abilities required to pursue any pathway of graduate medical education and to enter the independent practice of medicine -with or without reasonable accommodation. All candidates should be aware that the academic and clinical responsibilities of medical students may, at times, require their presence during day and evening hours, seven days per week. Candidates should be able to tolerate physically taxing workloads and to function effectively under stress.

While the School of Medicine fully endorses the spirit and intent of Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1992, and the ADA Amendments Act of 2008; it also acknowledges that certain minimum technical standards must be present in candidates for admission, retention and graduation. Those individuals who would constitute a direct threat to the health or safety of themselves, patients, or others are not considered suitable candidates for admission or retention in medical school. The delineation of technical standards is required by the Liaison Committee on Medical Education to confirm that accreditation standards are being met. Therefore, the School of Medicine has established the following technical standards for admission to, retention in, and graduation from, the M.D. program:

1. All candidates for admission must fulfill the minimum requirements for admission and all candidates for the M.D. degree must complete all required courses and clerkships as indicated in the School of Medicine Bulletin.

2. All candidates for admission and all candidates for the M.D. degree should possess sufficient physical, intellectual, interpersonal, social, emotional, psychological, and communication abilities to:

(a) establish appropriate relationships with a wide range of faculty members, professional colleagues, and patients. Candidates should possess the personal qualities of integrity, empathy, concern for the

welfare of others, interest, and motivation. They should possess the emotional and psychological health required for the full use of their intellectual abilities; the exercise of good judgment; the prompt completion of all responsibilities associated with the diagnosis and care of patients; and the development of mature, sensitive, and effective relationships with patients, patients' families, and professional colleagues. They must be able to adapt to changing environments, to be flexible, and to function in the face of ambiguities inherent in the clinical situation. Candidates should be able to speak, to hear, to read, to write, and to observe patients in order to elicit information, to describe changes in mood, activity, posture, and behavior, and to perceive nonverbal communications. Candidates should be able to communicate effectively and efficiently in the English language in oral and written form with all members of the health care team. Candidates must be mobile and able to function independently within the clinical environment.

(b) obtain a medical history and perform physical and mental examinations with a wide variety of patients. Candidates must be able to observe patients accurately both close at hand and at a distance. Observation requires the functional use of the sense of vision and other sensory modalities and is enhanced by the functional use of the sense of smell. Candidates should have sufficient exteroceptive sense (touch, pain, and temperature), proprioceptive sense (position, pressure, movement, stereognosis, and vibratory), and motor function to carry out the requirements of the physical examination. Candidates should have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic operations. They should be able to use effectively and in a coordinated manner those standard instruments necessary for a physical examination (e.g., stethoscope, otoscope, sphygmomanometer, ophthalmoscope, and reflex hammer). Candidates should be able to execute motor movements required to provide general and emergency treatment to patients, including cardiopulmonary resuscitation, the administration of intravenous medication, the application of pressure to stop bleeding, the opening of obstructed airways, the suturing of simple wounds, and the performance of simple obstetrical maneuvers; such actions require coordination of both fine and gross muscular movements, equilibrium, and functional use of the senses of touch and vision.

(c) conduct tests and perform laboratory work. Candidates must be able to observe demonstrations, collect data, and participate in experiments and dissections in the basic sciences, including, but not limited to, demonstrations in animals, microbiologic cultures, and microscopic studies of microorganisms and tissues in normal and pathologic states. They should be able to understand basic laboratory studies and interpret their results, draw arterial and venous blood, and carry out diagnostic procedures (e.g., proctoscopy, and paracentesis).

(d) ultimately make logical diagnostic and therapeutic judgments. Candidates should be able to make measurements, calculate, and reason; to analyze, integrate, and synthesize data; and to problem-solve. Candidates should be able to comprehend three-dimensional relationships and to understand the spatial relationships of structures. Candidates should be able to integrate rapidly, consistently, and accurately all data received by whatever sense(s) employed.

In evaluating candidates for admission and candidates for the M.D. degree, it is essential that the integrity of the curriculum be maintained, that those elements deemed necessary for the education of a physician be preserved, and that the health and safety of patients be maintained. While compensation, modification, and accommodation can be made for some disabilities on the part of candidates, candidates must be able

to perform the duties of a student and of a physician in a reasonably independent manner. An accommodation is not reasonable if it requires a substantial modification in an element of the curriculum that is considered essential, the use of the accommodation would lower academic standards, or if it poses an undue administrative or financial burden. The use of a trained intermediary would result in mediation of a candidate's judgment by another person's powers of selection and observation. Therefore, the use of trained intermediaries to assist students in meeting the technical standards for admission, retention, or graduation is not permitted.

The School of Medicine will consider for admission any candidate who has the ability to perform or to learn to perform the skills and abilities specified in these technical standards. Candidates for the M.D. degree will be assessed at regular intervals not only on the basis of their academic abilities, but also on the basis of their non-academic (physical, interpersonal, communication, psychological, and emotional) abilities to meet the requirements of the curriculum and to graduate as skilled and effective medical practitioners.

Candidates who have a disability and use accommodations should begin discussions with the USC Office of Disability Services (http://www.sa.sc.edu/sds) as soon as the offer of admission is received and accepted. The candidate with the disability bears the responsibility of providing that office with current information documenting the general nature of the disability and proposed accommodations.

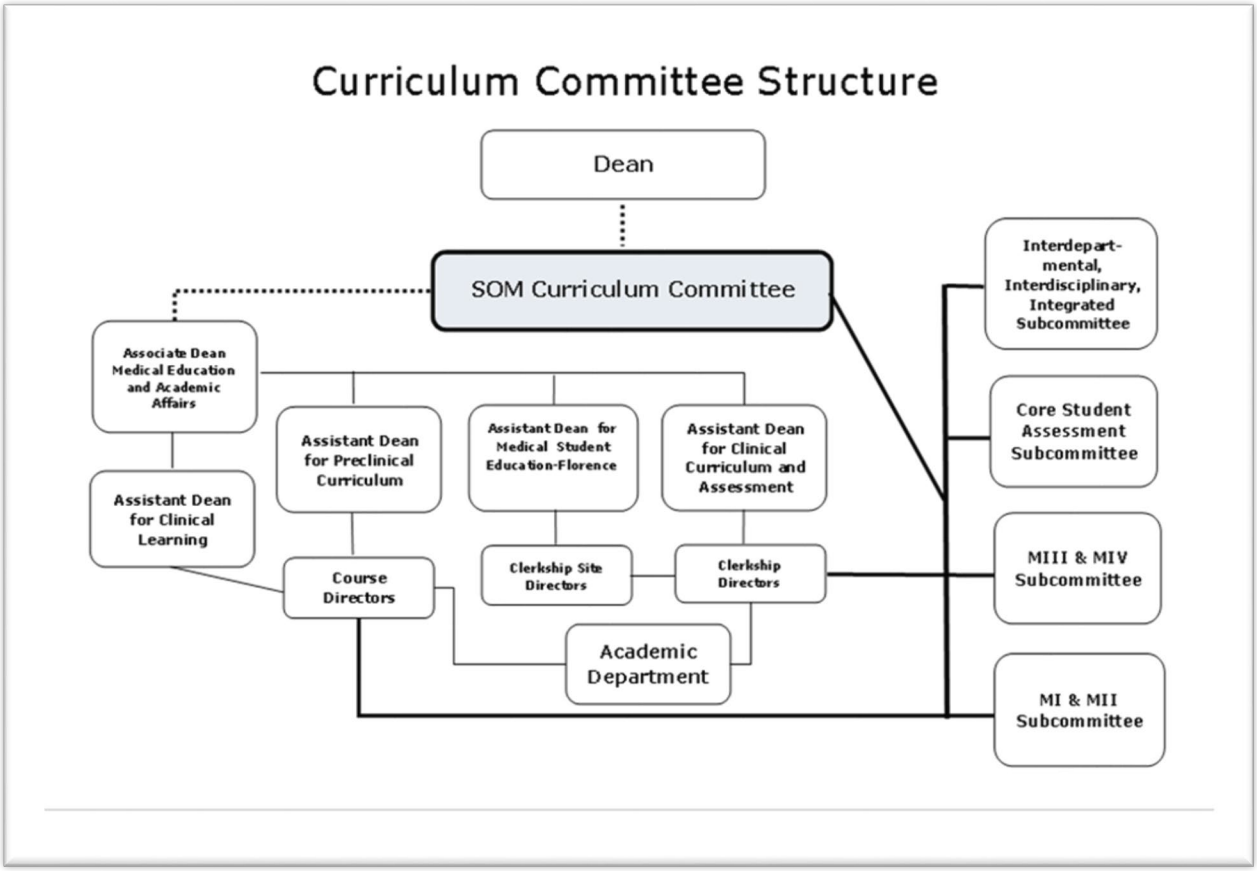
Reference to Attainment Documentation

1. All courses and clerkships
2. M-III Surgery clerkship
3. M-II ICM-II
4. M-III Pediatrics clerkship
5. M-III Family Medicine clerkship
6. M-III Internal Medicine/ Neurology clerkship
7. M-III Psychiatry clerkship
8. M-III OB/GYN clerkship
9. M-I ICM-I
10. M-II ICM-II
11. M-I Physiology course
12. M-I Embryology/Gross Anatomy course
13. M-I Microscopic Anatomy course
14. M-II Pathology course
15. M-II Microbiology course
16. USMLE exams

Updated 08-24-2010
Reviewed: 08-902012
Updated 06-15-2015
Reviewed: 09-14-2016

Appendix C

CURRICULUM MANAGEMENT STRUCTURE



Appendix D

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

Nomination and Voting Procedure
for
Florence Faculty Representatives

There will be one representative elected at-large by the Florence faculty via the following procedure:

1) The Florence faculty will be solicited by the Faculty Representation Committee (FRC) to self-nominate to serve as an at-large representative on the curriculum committee.

2) The FRC then will make a recommendation to the dean from the list of self-nominees to serve.

3) A three (3) year term will be granted to the faculty member receiving the nomination.

4) The Assistant Dean for Medical Student Education – Florence Campus will remain as an ex-officio, non-voting, member of the Curriculum Committee throughout his/her tenure.

5) The Florence member of the committee will be expected to attend, either in Columbia or via teleconference, at least 75% of all meetings. The Florence committee member will be required to travel to Columbia to attend the annual curriculum committee retreat.

Created: June 2, 2015
Reviewed: September 14, 2016

Appendix E

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

Guiding Principles, Program and Educational Objectives, and Physician Competencies

Guiding Principles

The medical education program in the School of Medicine is conducted in accordance with a set of guiding principles. These principles, as follows, are based upon a commitment to meeting societal expectations regarding the attributes of practicing physicians and can be used as a screen for periodic review and renewal of the medical education program. The educational program in the School of Medicine should:

1. be centrally coordinated by the Curriculum Committee;
2. foster interdisciplinary and interdepartmental collaboration;
3. promote curricular flexibility;
4. respond to changing societal needs and conditions;
5. recognize students' individual talents, interests, and needs;
6. foster students' abilities to be independent and lifelong learners;
7. promote a highly professional and mutually respectful learning environment;
8. prepare students for the ethical challenges of medical practice;
9. recognize the educational importance of diversity within the student population and the faculty.

Program Objectives

USC School of Medicine Program Objectives
The educational program in the School of Medicine shall:

1. ensure the integration of foundational and clinical sciences;
2. promote students' mastery of scientific and clinical knowledge;
3. provide an understanding of the biopsychosocial model of health and health care;
4. ensure the modeling of high value care that is cost-effective and evidence-based;
5. encourage students' personal and professional development through regular feedback and formative and summative assessments;
6. foster team-building and interprofessional practice models through students' self and peer engagement and evaluation to nurture students' collaboration with other health care team members
7. foster students' acquisition of necessary clinical, communication, and problem-solving skills;
8. utilize best evidence regarding education to foster learning and retention;
9. provide a variety of experiences in clinical settings with diverse patient populations and healthy clinical learning environments;
10. set appropriate and realistic performance standards for students;
11. utilize both formative and summative evaluation methods for students;
12. increase the use of competency-based student assessments;
13. promote students' interest in translational research and scientific exploration;
14. provide a range of elective opportunities for students;
15. educate generalist physicians who are potentially eligible for practice in South Carolina;

16. prepare altruistic, knowledgeable, skillful, and dutiful physicians;

So that we graduate physicians who are life-long learners who attend equally well to all aspects of health care.

The following objectives have been developed to ensure excellence:

1. As a member of an interprofessional health care team *(EPAs 9, 12),* strive to consistently provide appropriate care for patients and populations by applying best evidence as related to the following:
   - normal structure and function of the body as an intact organism and each of its major organ systems.
   - molecular, biochemical, and cellular mechanisms that are important in maintaining the body's homeostasis.
   - various causes of disease (genetic, developmental, metabolic, toxic, microbiologic, autoimmune, neoplastic, degenerative, traumatic, and psychosocial) and of the ways in which they affect the body (pathogenesis).
   - altered structure and function (pathology and pathophysiology) of the body and its major organ systems seen in various diseases and conditions.
   - frequent clinical laboratory, roentgenologic, and pathologic manifestations of common maladies.
   - important non-biological determinants of health and the economic, psychological, social, and cultural factors including violence and abuse that contribute to the development and/or continuation of maladies.
   - epidemiology of common health conditions within defined populations and systematic approaches to reduce their incidence and prevalence.
   - pain assessment and amelioration including the use of medication and alternative or adjunctive therapies.
   - various approaches to, and implications of, the organization, financing, and delivery of health care.
   - exercise, nutrition and lifestyle in maintaining health and well-being
   - gender, ethnic and age-specific issues that affect disease across the lifespan with particular emphasis on pregnant, newborn, child and geriatric patients
   - principles of preventive medicine
   - principles of patient safety, quality improvement and health care professional safety
   - clinical and translational research findings with attention to emerging therapies

2. Retrieve, manage, and utilize information – to include critical review of medical literature when needed – to solve problems, consider differential diagnostic possibilities and make care decisions. *(EPAs 2 &7)*

3. Use critical judgment based on evidence and experience in solving clinical problems.

4. Demonstrate the personal and emotional characteristics necessary to become a competent physician including: *(professional identity formation)*
   - Honesty, integrity and respect in interactions with patients, families, coworkers and colleagues
   - Accountability for own actions
   - Appropriate awareness and concern for the needs of patients and families
   - Sensitivity and respect for patients from diverse gender, cultural, economic, educational, and family backgrounds.
   - Ethical obligations inherent in the role of physician
   - Advocacy for patient and population needs for health and well-being
   - Identifying ethical dilemmas and applying ethical decision-making when faced with both common and uncommon issues faced in medical practice.
   - Identifying threats to medical professionalism posed by the conflicts of interest inherent in various financial and organizational arrangements for medical practice.

- Recognition and acceptance of limitations in his/her own knowledge and clinical skills and commitment to improve his/her knowledge and ability toward best practices in care through self-assessment and lifelong learning

5. Obtain an accurate and complete medical history with special attention to relevant health issues related to age, gender, sexual orientation, and factors such as socio-economic status for patient health and document appropriately. *(EPAs 1 & 5)*

6. Be technologically proficient in the acquisition and documentation of that information for provision of high value healthcare. *(EPA 1)*

7. Perform both complete and problem focused physical examinations including mental status examination and fully document that information as part of a medical record. (*EPA 1)*

8. Perform basic technical procedures. Examples include: venipuncture, inserting an intravenous catheter, arterial puncture, lumbar puncture, inserting a nasogastric tube, inserting a Foley catheter, and suturing lacerations. *(EPA 12)*

9. Adhering to patient confidentiality and autonomy, effectively communicate - both orally and in writing - with patients and families, colleagues and others with whom information must be exchanged when carrying out duties of patient care. Examples include:
    - Discussing orders *(EPA 4)*
    - Providing an oral presentation of a patient encounter *(EPA6)*
    - Giving and receiving a patient handover to transition care responsibly *(EPA 8)*
    - Obtaining informed consent *(EPA 11)*

10. Identify factors placing individuals at risk for disease or injury, select appropriate tests for detecting patients at risk for specific diseases or in the early stages of diseases, and determine appropriate response strategies.

11. Interpret the results of commonly used diagnostic procedures. *(EPA3)*

12. Apply appropriate management strategies - both diagnostic and therapeutic - for patients with common acute and chronic medical, psychiatric, surgical conditions and conditions requiring short-and long-term rehabilitation therapy.

13. Recognize when a patient requires urgent or emergent care due to immediate life threatening conditions – whether cardiac, pulmonary, neurologic or other cause – and initiate evaluation and critical management. *(EPA 10)*

14. Adhere to state and federal regulations regarding reporting of domestic violence, child abuse, criminal activity, fraud, and the Health Insurance Portability (HIPAA).

15. Contribute to a culture of safety and improvement through applying skills in teaming and leadership and in the identification and reporting of system failures or errors. *(EPA 13)*

Physician Competencies

1. **Patient Care** – ability to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health
2. **Medical Knowledge** – demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to the patient
3. **Practice Based Learning and Improvement** – investigate and evaluate the care of patients, appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning
4. **Systems Based Practice** – demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optional health care
5. **Professionalism** – demonstrate a commitment to carry out professional responsibilities and an adherence to ethical principles
6. **Interpersonal Skills and Communication** – possess skills that are effective in the exchange of information and collaboration with patients, their families, and health professionals

Educational Objectives and Competencies for Graduates

A set of educational objectives has been established for students of the School of Medicine. After completion of the four-year medical education program in the School of Medicine, a graduate shall have demonstrated to the satisfaction of the faculty the following knowledge, skills, and attitudes and behaviors.

1. Knowledge:
    a. knowledge of the normal structure and function of the body and its major organ systems; Medical Knowledge, Patient Care
    b. knowledge of the molecular, biochemical, and cellular mechanisms that are important in maintaining the body's homeostasis; Medical Knowledge, Patient Care
    c. knowledge of the various causes (genetic, developmental, metabolic, toxic, microbiologic, autoimmune, neoplastic, degenerative, psychosocial, and traumatic) of maladies and of the pathogenesis of maladies; Medical Knowledge, Patient Care
    d. knowledge of the altered structure and function (pathology and pathophysiology) of the body and its major organ systems seen in various diseases and conditions; Medical Knowledge, Patient Care
    e. knowledge of the frequent clinical, laboratory, roentgenologic, and pathologic manifestations of common maladies; Medical Knowledge, Patient Care
    f. knowledge of the important non-biological determinants of health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies; Medical Knowledge, Patient Care, Systems Based Practice
    g. knowledge of the epidemiology of common maladies within a defined population and systematic approaches to reduce the incidence and prevalence of those maladies; Medical Knowledge, Patient Care, Systems Based Practice

h. knowledge of various approaches to, and implications of, the organization, financing, and delivery of health care; Patient Care, Systems Based Practice
i. knowledge of the theories and principles that govern ethical decision-making and of the major ethical dilemmas encountered in medical practice, particularly at the beginning and end of life and resulting from the rapid expansion of knowledge in genetics; Medical Knowledge, Patient Care, Professionalism
j. knowledge about relieving pain and ameliorating the suffering of patients; Medical Knowledge, Patient Care
k. knowledge of the threats to medical professionalism posed by the conflicts of interest inherent in various financial and organizational arrangements for medical practice; Patient Care, Professionalism
l. knowledge of the quality improvement methods and the factors associated with increased patient safety. Medical Knowledge, Patient Care, Practice Based Learning and Improvement

2. Skills:
   a. the ability to obtain an accurate and complete medical history, with special attention to issues related to age, gender, sexual orientation, and socio-economic status and fully document that information as part of a medical record: Medical Knowledge, Patient Care, Interpersonal Skills and Communications
   b. the ability to perform both a complete and organ-specific examination, including a mental status examination and fully document that information as part of a medical record; Medical Knowledge, Patient Care, Interpersonal Skills and Communication
   c. the ability to perform routine technical procedures; Medical Knowledge, Patient Care
   d. the ability to interpret the results of commonly used diagnostic procedures; Medical Knowledge, Patient Care
   e. the ability to communicate effectively, orally and in writing, with patients and their families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities; Patient Care, Interpersonal Skills and Communication
   f. the ability to retrieve, manage, and utilize information for solving problems and making decisions relevant to the care of individuals and populations; Medical Knowledge, Patient Care, Practice Based Learning and Improvement
   g. the ability to identify factors placing individuals at risk for disease or injury, select appropriate tests for detecting patients at risk for specific diseases or in the early stage of diseases, and determine appropriate response strategies; Medical Knowledge, Patient Care
   h. the ability to construct appropriate management strategies, both diagnostic and therapeutic, for patients with common acute and chronic medical and psychiatric conditions, surgical conditions, and conditions requiring short- and long-term rehabilitation therapy; Medical Knowledge, Patient Care
   i. the ability to recognize and institute appropriate initial therapy for patients with immediately life-threatening cardiac, pulmonary, or neurological conditions, regardless of causation; Medical Knowledge, Patient Care
   j. the ability to recognize and outline an initial course of management for patients with serious conditions requiring critical care; Medical Knowledge, Patient Care
   k. the ability to reason deductively in solving clinical problems; Medical Knowledge, Practice Based Learning and Improvement

l. the ability to access and evaluate critically medical literature; Medical Knowledge, Practice Based Learning and Improvement
m. the ability to understand the power of the scientific method in establishing the causation of disease and efficacy of traditional and non-traditional therapies; Practice Based Learning and Improvement
n. the ability to function as part of an interprofessional healthcare team and/or serve in a leadership role; Patient Care, Systems Based Practice, Interpersonal Skills and Communication
o. the ability to demonstrate technologic proficiency when it comes to the acquisition, documentation, and delivery of healthcare. Patient Care, Systems Based Practice

3. Attitudes and Behaviors
    a. compassionate treatment of patients and respect for their privacy and dignity; Professionalism, Interpersonal Skills and Communication
    b. honesty and integrity in all interactions with patients and their families, colleagues, and others with whom physicians must interact in their professional lives; Professionalism
    c. commitment to advocate at all times for the interest of patients over personal interests; Systems Based Practice, Professionalism
    d. commitment to provide care to patients unable to pay for medical services and to advocate for access to health care for members of traditionally underserved populations; Systems Based Practice, Professionalism
    e. commitment to engage in life-long learning in order to stay abreast of relevant scientific advances; Practice Based Learning and Improvement, Professionalism
    f. the capacity to recognize and accept limitations in one's knowledge and clinical skills and a commitment to improve that knowledge and ability through self- assessment; Medical Knowledge, Practice Based Learning and Improvement, Professionalism
    g. understanding of, and respect for, the roles of other health care professionals and of the need for collaboration with them in caring for patients and promoting the health of defined populations. Systems Based Practice, Interpersonal Skills and Communication

---

Appendix F

The University of South Carolina
School of Medicine

Guidelines for Conduct in Teacher/Learner Relationships

I. Statement of Philosophy

The University of South Carolina School of Medicine is committed to fostering an environment that promotes academic and professional success in learners and teachers at all levels. The achievement of such success is dependent on an environment free of behaviors which can undermine the important mission of our institution. An atmosphere of mutual respect, collegiality, fairness, and trust is essential. Although both teachers and learners bear significant responsibility in creating and maintaining this atmosphere, teachers also bear particular responsibility with respect to their evaluative roles relative to student work and with respect to modeling appropriate professional behaviors. Teachers must be ever mindful of this responsibility in their interactions with their colleagues, their patients, and those whose education has been entrusted to them.

II. Responsibilities in the Teacher/Learner Relationship

A. Responsibilities of Teachers

1. Treat all learners with respect and fairness
2. Treat all learners equally regardless of age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation.
3. Provide current material in an effective format for learning.
4. Be on time for didactic, investigational, and clinical encounters.
5. Provide timely feedback with constructive suggestions and opportunities for improvement/remediation when needed.

B. Responsibilities of learners

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

III. Behaviors Inappropriate to the Teacher-Learner Relationship

These behaviors are those which demonstrate disrespect for others or lack of professionalism in interpersonal conduct. Although there is inevitably a subjective element in the witnessing or

experiencing of such behaviors, certain actions are clearly inappropriate and will not be tolerated by the institution. These include, but are not limited to, the following:

- unwanted physical contact (e.g. hitting, slapping, kicking, pushing) or the threat of the same;
- sexual harassment (including romantic relationships between teachers and learners in which the teacher has authority over the learner's academic progress) or harassment based on age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation;
- loss of personal civility including shouting, personal attacks or insults, displays of temper (such as throwing objects), use of culturally insensitive language;
- discrimination of any form including in teaching and assessment based upon age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation;
- requests for other to perform inappropriate personal errands unrelated to the didactic, investigational, or clinical situation at hand;
- grading/evaluation on factors unrelated to performance, effort, or level of achievement.

IV. Avenues for Addressing Inappropriate Behavior in the Teacher/Learner Context

A. Learners' Concerns

Learners may address situations in which they feel that they have been the object of inappropriate behavior at various levels. At the most basic level, the most effective way to handle a situation may be to address it immediately and non-confrontationally. Oftentimes, a person is simply unaware that his/her behavior has offended someone, or even if aware, will correct the behavior appropriately if given the opportunity to do so in a way that is not threatening. The way to raise such an issue is to describe the behavior factually ("When you said…") describe how the behavior made you feel ("I felt…"), and state that the behavior needs to stop or not be repeated ("Please, don't do that again.")

Sometimes, such a request is not successful, or the person repeats the behavior, or the learner does not feel comfortable speaking directly to the teacher about his/her behavior. In those cases, it may be helpful to discuss the behavior with course/clerkship directors, laboratory mentors, program directors or department chairs. Students may also elect to speak to any one of the Assistant Deans or the Associate Dean in the Office of Medical Education and Academic Affairs, the Assistant Dean for Minority Affairs, the Director of Student Services, or one of the School of Medicine's three Ombudspersons for informal advice and counsel about these issues. These individuals may offer additional suggestions for resolving the matter informally, such as, for example, speaking to the individual on the learner's behalf or on behalf of an entire class, raising the general issue in a faculty meeting, assisting the learner with writing to the individual teacher or even direct intervention to get the behavior to stop.

If no satisfactory resolution is reached after these discussions or the learner does not feel comfortable speaking to these individuals, he/she may bring the matter formally to the attention of the School of Medicine administration. The avenues for this more formal

reporting vary depending upon the status of the reporting individual. In either case the learner always has the option of submitting a formal complaint to the University's Student Grievance Committee through the procedure outlined in the *Carolina Community*.

1. If the person reporting the behavior is a medical student:

   The student should speak with the Director of Student Services, the Associate Dean for Medical Education and Academic Affairs, or one of the school's Ombudspersons.

2. If the person reporting the behavior is a graduate student or MD/PhD student pursuing their graduate studies:

   The student should speak with the Director of Student Services or the Director of the Graduate Studies Program.

B. Teachers' Concerns

If a teacher feels that a learner has engaged in inappropriate behavior, it is likewise most effective to address the situation immediately and non-confrontationally. If the matter is not resolved satisfactorily, the teacher should contact the course/clerkship director, program director, or laboratory mentor to discuss the matter. If the teacher wishes to make a formal allegation of misconduct, they should contact the following members of the administration:

1. If the matter involves a medical student, contact one of the Assistant or Associate Deans in the Office of Medical Education and Academic Affairs;

2. If the matter involves a graduate student, contact the Director of the Graduate Studies Program.

These allegations will be handled on an individual basis by the appropriate School of Medicine official in consultation with the Dean and where applicable according to established School of Medicine and University policies.

V. Procedures for Handling Allegations of Inappropriate Behavior in the Teacher/Learner Context

A. Upon being notified of alleged inappropriate behavior, the Associate/Assistant Dean or Program Director will notify the Dean and other appropriate senior administration officials in a written report within 5 business days of the allegation.

If the complaint is lodged against a faculty member, other than those matters referred to the Office of Equal Opportunity Programs, the matter will be handled by the Dean in

consultation with the appropriate Associate Dean and Department chair and, where established, the appropriate School of Medicine and University policies. The Dean may also choose to appoint an ad hoc committee to investigate the complaint.

B. If the behavior involves unlawful discrimination or sexual or other forms of unlawful harassment, the matter will be referred to the Office of Equal Opportunity Programs and be handled through University policies established for that office. The student may also directly contact that office.

C. If the behavior involves unwanted physical contact or other forms of violent or threatening acts, the matter may be referred to the University's campus police or appropriate hospital security.

D. The School of Medicine is committed to the fair treatment of all individuals involved in this process. All efforts will be made to maintain the confidentiality of the resolution process to the extent possible and subject to the overriding concern of a prompt fair investigation and/or resolution of the complaint.

E. The School of Medicine will not tolerate any form of retaliatory behavior toward learners who make allegations in good faith. Individuals who believe that action has been taken against them in retaliation for raising concerns under this policy, may address those concerns through the procedures described in this policy or through the Student Grievance Committee.

F. Records of all communications as well as written reports of the Associate/Assistant Deans, Program Directors, and any ad hoc committee (if formed) will be kept in the Dean's Office.

G. If it is determined that the allegations from the complainant were not made in good faith, the student will be referred for disciplinary action to the Student Academic Responsibility Committee.

Approved: Curriculum Committee (September 11, 2008)
Executive Committee (October 8, 2008)
Reviewed: August 12, 2010
August 9, 2012
August 14, 2014
August 13, 2015
September 14, 2016

The Office of Curricular Affairs and Media Resources published the 2020-2021 Curriculum Committee Handbook for use by members of USCSOM Curriculum Committee members.

The Office of Curricular Affairs and Media Resources reserves the right to revise the 2020-2021 Curriculum Committee Handbook as directed by the University of South Carolina School of Medicine Curriculum Committee.

USC School of Medicine
Office of Curricular Affairs and Media Resources
Building 3, 1st floor
Columbia, SC 29208
Phone: (803)216-3610
Fax: (803)216-3619