

**CHAIR:**

Dr. Maureen Francis, MD, MACP, MS-HPED

**VOTING MEMBERS:**

Dale Quest, PhD; Biff Palmer; Khanjani Narges, MD, PhD; Munmun Chattopadhyay, PhD; Marwaha Komal, MD, PhD; Natalia Sidhu, MD; Alexandria Melendez-Zaidi, MD

**EX-OFFICIO:**

Lisa Beinhoff, PhD; Martin Charmaine, MD; Tanis Hogg, PhD; Jose Lopez; Namrata Singh, MD

**STUDENT REPRESENTATIVES:**

Asiah Himawan MS1 (Voting); Sarah Ahmed MS1 (Ex Officio); Sami Daye MS2 (Voting); Michelle Tiji MS2 (Ex Officio); Kristina Ingles MS3 (Voting); Samuel Aldous MS3 (Ex Officio); Katherine Asmis MS4 (Voting); Joshua Salisbury MS4 (Ex Officio)

**INVITED/GUESTS:**

Jessica Chacon, Thwe Htay, Priya Harindranathan, Claudia Cortez

**REVIEW AND APPROVAL OF MINUTES**

**Minutes Attached**

**ANNOUNCEMENTS**

**Presenter(s): Dr. Francis**

- Welcome of the new student representatives:
  - MS1: Asiah Himawan MS1 (Voting) and Sarah Ahmed (Ex Officio)
  - MS2: Michelle Tiji MS2 (Ex Officio)
- Foundational competencies UME

**ITEMS FROM STUDENT REPRESENTATIVES**

**Presenter(s): Students**

**ITEM I LCME Cards Process and Attendance Policy Update**

**Presenter(s): Dr. Chacon**

**ITEM II LCME Exit Survey Report – Curriculum Related Elements**



Paul L. Foster School of Medicine

**Presenter(s): Dr. Francis**

**ITEM III Clerkship Directors Update**

**Presenter(s): Dr. Singh**

- Dr. Dayle Alonso - Assistant Clerkship Director for Psychiatry
- Dr. Ira Swinney - SICU director

**ITEM IV CEPC Schedule**

**Presenter(s): Dr. Francis**

**ITEM V Policy Updates – The Common Clerkship Policies**

**Presenter(s): Dr. Francis**

**Adjourn**

**Meeting adjourned:**

**MEMBERS IN ATTENDANCE:**

Maureen Francis; Dale Quest; Biff Palmer; Narges Khanjani; Munmun Chattopadhyay; Komal Marwaha; Natalia Sidhu; Lisa Beinhoff; Charmaine Martin; Tanis Hogg; Jose Lopez; Namrata Singh; Asiah Himawan; Sarah Ahmed; Sami Daye; Michelle Tiji; Samuel Aldous; Katherine Asmis

**MEMBERS NOT IN ATTENDANCE:**

Alexandria Melendez-Zaidi; Kristina Ingles; Joshua Salisbury

**PRESENTERS/GUESTS IN ATTENDANCE:**

Jessica Chacon; Thwe Htay; Priya Harindranathan; Claudia Cortez

**INVITED/GUESTS NOT IN ATTENDANCE:**

**REVIEW AND APPROVAL OF MINUTES**

**Dr. Francis**

Meeting minutes from September 2nd were approved at the November 10th meeting.

**ANNOUNCEMENTS**

**Dr. Francis**

\*Please see attached report

Dr. Francis welcomed new student representatives, Asiah Himawan (MS1), Sarah Ahmed (MS1), and Michelle Tiji (MS2).

Dr. Francis indicated that the AAMC has published a new set of six foundational competency areas for undergraduate medical education (UME) that are intended to align UME outcomes with graduate medical education (GME) expectations. The six areas are: Professionalism; Patient Care & Procedural Skills; Medical Knowledge; Practice-Based Learning & Improvement; Interpersonal & Communication Skills; and Systems-based Practice.

The new competencies replace older UME frameworks and are intended to enhance the transition into residency. Dr. Francis additionally explained that elements such as

personal/professional development and interprofessional collaboration are integrated across rather than standing alone.

The next step is to map our school's Program Goals & Objectives (PGOs) to these six foundational competencies, identify any gaps, and convene a half-day working session with volunteers, who will report-back to CEPC.

#### **ITEMS FROM STUDENT REPRESENTATIVES**

##### **MS1/MS2/MS3/MS4**

MS3 students expressed frustration regarding scheduling issues, particularly in emergency medicine. Due to incidents that occurred during the block and a coordinator issue, EM shifts were scheduled later in the block. The clerkship director reviewed this and decreased the number of required shifts from 5 to 4 on the Mind and Medicine Block. Additionally, concerns were raised about delays in receiving completed evaluations from faculty and residents. Students noted difficulty balancing the need to follow up without being overly persistent and suggested exploring ways to improve accountability for timely evaluation completion. Katherine Asmis (MS4) suggested that providing faculty with printed evaluations and student photos, a process recently implemented in the Surgery department, has improved evaluation completion rates. She recommended that this approach be considered for other specialties to improve timely submissions. Dr. Francis acknowledged the concern and noted that several clerkships have already implemented these processes to improve completion rates. She encouraged students to report ongoing issues with specific faculty or residents to the clerkship coordinators, who can assist in ensuring evaluations are completed or escalate concerns to clerkship directors if needed.

MS1 students reported no major concerns but noted discussions about issues with Anatomy which are now improving. Lecture recording was also interrupted. Dr. Hogg acknowledged the technical challenges related to limited Kaltura storage on podium laptops and stated that a solution has been implemented, encouraging students to report any recurring problems.

MS4: No issues reported.

**ITEM I Event Cards Process and Attendance Policy Update**

**Presenter(s): Dr. Chacon**

\*Please see attached report

Dr. Chacon presented the final draft of the Pre-Clerkship Phase Student Attendance and Participation policy. The group discussed their thoughts and suggestions. Asiah Himawan (MS1) proposed creating a tiered attendance system to better address late arrivals. The suggestion includes three categories: tardy for arriving within 10 minutes, partial attendance for arriving after 10 minutes but attending over half the class, and absent for attending less than half. She also suggested that arrivals more than 10 minutes late should count as two tardies to encourage on time attendance. Katherine Asmis (MS4) expressed concern that the proposed attendance system is overly complicated and unrealistic. She emphasized that in clinical years and professional practice, punctuality is mandatory and lateness reflects on professionalism and that the policy should better align with real-world expectations.

Asiah Himawan moves the motion for approval of the three-tiered attendance system.

There was no second to the motion.

Motion failed.

Dr. Sidhu proposed approving Dr. Chacon's original attendance policy with a slight change, stating that students arriving more than 10 minutes late will be marked absent, even if it is not a time-sensitive activity. She added that late arrivals can still participate and later appeal the absence if needed and that significant tardiness disrupts the learning environment.

Dr. Sidhu moves the motion for approval.

Dr. Marwaha and Katherine Asmis second the motion.

No Objections: Motion was approved.

Dr. Chacon reviewed the definitions of absences and members had no proposed changes.

Members discussed the effective date for this policy and agreed on November 1<sup>st</sup>, 2025.

Dr. Sidhu moves the motion for approval of this timeline.

Dr. Quest seconds the motion.

No objections: Motion was approved.

#### **ITEM II CEPC Schedule Clerkship Director Updates**

**Presenter(s): Dr. Singh**

Due to time constraints, the CVs of proposed Assistant Clerkship Director (Dr. Dayle Alonso) and SICU Director (Dr. Ira Swinney) were sent out to members for review and asynchronous vote. Members subsequently voted in favor of both proposed directors on October 15<sup>th</sup>, 2025.

#### **ITEM III CEPC Schedule**

**Presenter(s): Dr. Francis**

\*Please see attached report

Dr. Francis reviewed the upcoming CEPC schedule. The November meeting will include the annual pre-clerkship phase report and The Year 1-2 Subcommittee reports. In December, the focus will shift to the clerkship phase review and The Year 3-4 Subcommittee reports.

In January, the clerkship phase review process and rubrics will be presented, along with the review of new elective proposals and reports from the Evaluation Subcommittee and Leadership Advisory Group Subcommittee. Committee work will continue from February through May, followed by the development of action plans in June.

Dr. Francis also invited student CEPC representatives to share brief summary reports if they are interested. She emphasized strict deadlines for syllabi: April for clerkship and May for pre-clerkship updates to ensure timely approval for the next academic year.

Policy updates, LCME reporting, and strategic planning will continue throughout the year.

**Item IV Policy Updates – The Common Clerkship Policies**

**Presenter(s): Dr. Francis**

Due to time constraints, the Common Clerkship Policy was sent out to members for review and asynchronous vote. Members subsequently voted in favor of the policy on October 27, 2025.

**Adjourned at 6:40pm**

# Foundational Competencies for Undergraduate Medical Education



*The AAMC (Association of American Medical Colleges), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) co-produced this publication. Due to this collaboration, the material does not represent language and usage conventions of any single organization.*

## About the AAMC

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 159 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 13 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 201,000 full-time faculty members, 97,000 medical students, 158,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers International broadened participation in the AAMC by 70 international academic health centers throughout five regional offices across the globe. Learn more at [aamc.org](https://aamc.org).

## About AACOM

Founded in 1898, the American Association of Colleges of Osteopathic Medicine (AACOM) is the leading voice for the education and training of physicians who practice osteopathic medicine in settings across the medical spectrum—from primary care to the full range of medical specialties. We support our member colleges of osteopathic medicine in their efforts to attract and train individuals who are fueled by a desire to make a difference in our healthcare system by treating the whole person and building a future emphasizing health and wellness for all people. Today, more than 36,000 future physicians—25 percent of all U.S. medical students—are being educated at one of our 42 accredited colleges of osteopathic medicine, encompassing 67 teaching locations in 36 states. [To learn more about AACOM, please visit our website.](#)

## About the ACGME

The Accreditation Council for Graduate Medical Education (ACGME) is a private, non-profit, professional organization responsible for the accreditation of approximately 13,400 residency and fellowship programs and 905 institutions that sponsor these programs in the US. Residency and fellowship programs educate approximately 162,645 resident and fellow physicians in 146 specialties and subspecialties. The ACGME's mission is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education. Learn more at [www.acgme.org](https://www.acgme.org).

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*Note: This publication was edited in October 2025 to update language in two subcompetencies on pages 11 and 13.*

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# Introduction

The Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) co-sponsored an initiative to create a common set of shared, foundational competencies for use in medical schools in the United States that recognize the unique identities and contributions of both DO- and MD-granting schools to the health care system. This report presents the product of that initiative — the Foundational Competencies for Undergraduate Medical Education (UME) — the inclusive and iterative development process, and the intended use of these competencies in advancing competency-based medical education (CBME). The framework includes six competencies: Professionalism, Patient Care and Procedural Skills, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, and Systems-Based Practice; 45 subcompetencies for all medical students; and four additional subcompetencies specific to DO students.

Competencies are “observable abilities of a health professional, integrating multiple components, such as knowledge, skills, and attitudes.”<sup>1</sup> The Foundational Competencies for UME are intended to apply to all DO and MD students in the United States, regardless of their future career plans; however, regarding what students are expected to achieve during their undergraduate medical education, these competencies are not intended to be exhaustive. Furthermore, medical schools and their faculties will approach differently how these competencies are taught and will likely want to build upon them to be more fully reflective of their own missions, principles, and communities.

This initiative aligns with a recommendation from the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee report<sup>2</sup> and is part of a comprehensive effort by all three co-sponsors of this report to improve the transition from UME to graduate medical education (GME).

In the development of the Foundational Competencies for UME, we strove to recognize the contributions and unique identities and traditions of all medical schools, including both DO and MD educational programs, and to acknowledge the shared and distinct outcomes of their learners. Our mission was not intended to create a “one-size-fits-all” system. DO-granting schools will continue to incorporate osteopathic principles and tenets throughout all competencies. Subcompetencies specific to DO education are included within three competencies; all competencies and subcompetencies, however, are broad and will need further delineation for specific teaching, learning, and assessment methods. All medical schools should consider how the competencies apply to their local missions and approaches to effective patient care, as well as how they can be further delineated for teaching and assessments. For a full list of the abbreviations and terms used in this report, please refer to the glossary.

## Brief Background on Competency-Based Medical Education

The collaborative development of the Foundational Competencies for UME represents an important evolution in the decades of work led by the three sponsoring organizations and the medical education community at large.

Although competency-based education has a very long history, the first national, modern framework developed for professional competence in medicine was released in 1996 by the Royal College of Physicians and Surgeons of Canada.<sup>3</sup> Known as the CanMEDS framework, it describes the abilities required of physicians to effectively meet the health care needs of the people they serve. It continues as the basis for the Canadian educational and practice standards of the Royal College. Also in 1996, the AAMC embarked on a major initiative, the Medical School Objectives Project,<sup>4</sup> to develop a consensus

within the MD-granting medical education community on the attributes that medical students should possess at the time of graduation and to set forth learning objectives for the medical school curriculum derived from those attributes. This work was an early effort to emphasize outcomes-based education in the United States.

A few years later, in 1999, the ACGME and American Board of Medical Specialties released the six Core Competencies framework that defined the foundational skills required of all physicians who completed an ACGME-accredited residency program, to shape and evaluate residency training.<sup>5</sup> In 2001, the ACGME Outcome Project was formally launched to support the actualization of competency-based GME.<sup>6</sup> In 2003, the American Osteopathic Association released the *Report of the Core Competency Task Force*,<sup>7</sup> which was the basis for the National Board of Osteopathic Medical Examiners' initial report on competencies in 2006.<sup>8</sup> In 2012, AACOM published *Osteopathic Core Competencies for Medical Students*<sup>9</sup> and the ACGME launched the Next Accreditation System,<sup>10</sup> which incorporated milestones to further delineate the six core competencies. The milestones described developmental *performance levels* that residents and fellows were expected to demonstrate in the six core competencies. In 2013, the AAMC published the Physician Competency Reference Set (PCRS),<sup>11</sup> a set of eight competencies intended to synthesize the expected outcomes of a UME program.

In 2014, the Coalition for Physician Accountability, a consortium of the national organizations that represent and oversee the continuum of medical education through their assessment, accreditation, licensure, and certification activities,<sup>12</sup> endorsed the six Core Competencies framework of the ACGME and American Board of Medical Specialties.<sup>13</sup> Although the coalition recognized that some constituencies, such as the DO community, may emphasize particular competencies, its endorsement focused on competencies essential for all physicians:

**“The members of the Coalition endorse a framework for professional competence that contains six general but essential domains of competence: Professionalism, Medical Knowledge, Patient Care and Procedural Skills, Interpersonal and Communication Skills, Practice-based Learning and Improvement, and System-based Practice. The Coalition member organizations are committed to ongoing, meaningful processes for assessment and evolution of the competencies to ensure that students and physicians have the knowledge and skills to provide excellent patient care as social and delivery system needs change.”**

Despite this endorsement a decade ago, the medical education community had not, until now, worked collaboratively to define a common competency framework for UME. The current work described here is to do just that: create a shared competency framework for UME in the United States.

Additional national efforts from the past decade to advance CBME are worth noting in this brief historical overview. In 2005, entrustable professional activities (EPAs) were initially defined as units of professional practice, tasks, or responsibilities that trainees were entrusted to perform, unsupervised, once they had attained sufficient competence.<sup>14</sup> In 2014, the AAMC published 13 Core Entrustable Professional Activities for Entering Residency (Core EPAs) that all medical students should be able to perform upon entering residency, under indirect supervision.<sup>15</sup> The Core EPAs were developed, aligned to the PCRS, and pilot tested to improve student transitions from UME to GME. In 2016, AACOM released its *Osteopathic Considerations for Core Entrustable Professional Activities for Entering Residency*,<sup>16</sup> and the ACGME began its efforts to update and improve GME Milestones through Milestones 2.0.<sup>5</sup> Between 2015 and 2020, the accreditation of residency and fellowship programs transitioned to a single system. The ACGME created Osteopathic Recognition for those residency or fellowship programs that integrated into their curricula formal education in Osteopathic Principles and Practice.<sup>17</sup>

Not only does the development of Foundational Competencies for UME represent an important evolution in CBME, but this work also responds to 2021 recommendations from the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee report<sup>2</sup>; specifically, recommendation 9 states: "UME and GME educators, along with representatives of the full educational continuum, should jointly define and implement a common framework and set of outcomes (competencies) to apply to learners across the UME-GME transition."

They further describe the recommendation as follows:

**"A shared mental model of competence facilitates agreement on assessment strategies used to evaluate a learner's progress, and the inferences that can be drawn from assessments. Shared outcomes language can convey information on learner competence with the patient/public trust in mind. For individual learners, defining these outcomes will facilitate learning and may promote a growth mindset. For faculty, defining outcomes will allow for the use of assessment tools aligned with performance expectations and faculty development. For residency programs, defining outcomes will be useful for resident selection and learner handovers from UME, resident training, and resident preparation for practice."**<sup>2</sup>

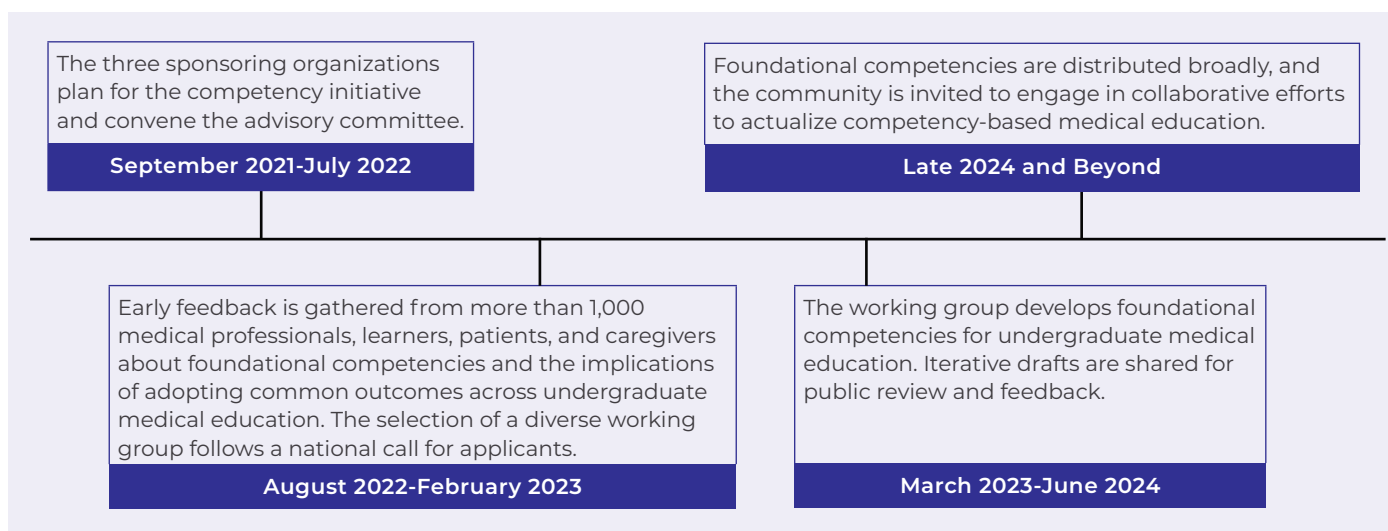
Contrasting CBME with our traditional approach to teaching and learning can be summarized, respectively and in part, as:

- Focused on outcomes versus processes.
- Learner-centered and patient-focused versus teacher-driven.
- Requiring multifaceted, formative assessments over time versus infrequent, high-stakes tests.
- Supporting flexible, time-independent learning versus a standard approach for all.

Additional details about CBME, including the voluminous research and numerous educational theories supporting this approach to medical education, are well beyond the scope of this document. Readers, however, are encouraged to familiarize themselves with the five core components described by Van Melle et al<sup>18</sup> and place the Foundational Competencies for UME within the broader context of CBME.

## The Development Process

The nearly three-year process for developing the Foundational Competencies for UME (Figure 1) was informed by the model for developing competency frameworks in the health care professions, presented by Batt et al,<sup>19</sup> and included collaborative planning, community discussions, landscape review, competency development, reporting, and dissemination. The co-leads, representing the three sponsoring organizations, were supported by an advisory committee (AC) of individuals from professional organizations across the field of academic medicine. A working group (WG) was established through a national application process to draft the Foundational Competencies for UME, and two reactor groups (RGs; one composed of patients and caregivers, the other of medical students) were created to support the WG's efforts by providing important insights. For more details about the work of these volunteers and the development process, refer to the Appendix.



**Figure 1. The timeline for the development of the Foundational Competencies for Undergraduate Medical Education.**

Throughout the community discussion phase, multiple forums were held, engaging more than 1,000 individuals with diverse perspectives on medical care and medical education. The co-leads heard perspectives from medical students, residents, fellows, faculty, patients, hospital CEOs, medical school deans, and PhD scientists. A common question posed during these forums was, “What will we expect all future physicians to be able to do, know, and value, regardless of their future specialties?” Below were some of the responses.

### Compassion

“I knew the day would come that I’d be able to express that missing link with doctors and with nurses, and they’re not taught enough about end of life. ... That’s what the world needs, a little bit more compassion there.”

—Caregiver

### Self-Care

“The goal is not just how to cope but ideally how to continually return to a baseline that values the purpose and meaning of the profession — to do good in the lives of others.”

—CEO, teaching hospital

### Quality Care

“Provide the highest level of evidence-based care for every patient in a personalized manner. This means understanding how to create systems that support high-level outcomes and process improvement to continually advance the quality of care for individual patients and populations.”

—CEO, teaching hospital

### Flexibility and Resiliency

“There are so many ways to access medicine currently and on the horizon. ... The structure of medicine will likely change rapidly as it adjusts to these changes. ... Physicians need to have flexibility and resiliency to have a successful career.”

—Faculty member

### Communication

“You can’t have science and clinical skills without communication. ... There’s so much burnout and lack of physician joy. It’s also the struggles ... working in silos that aren’t communicating. So it’s communication, leading to teamwork, care coordination, making sure that we can have difficult conversations with each other, pushing through that together and not being afraid of it.”

—Patient advocate

We also asked the community about any anticipated benefits of the Foundational Competencies for UME. They shared several ways in which this work could be beneficial, including:

- More opportunities for individualized learning.
- Improved transition from medical school to residency:
  - Residents are better prepared for the first day of residency.
  - Medical schools and residency programs speak a shared language.
  - Residency programs know what to expect from new residents and how best to assist them.
- Better patient outcomes.

During the development phase, the WG created multiple iterative drafts; feedback was sought on each draft from the RGs, AC, the medical education community, and the public via in-person convenings, surveys, and an online comment form. More than 2,000 responses in total were received after three iterative drafts were reviewed (the third draft was shared only with the AC and RGs). All feedback helped inform the final set of Foundational Competencies for UME: six competencies, 45 subcompetencies, and four additional DO-specific subcompetencies.

The Foundational Competencies for UME will periodically be reviewed and updated. Feedback from the diverse medical education community will be sought to better understand how the new competencies are being used in medical schools across the United States and will help inform the sponsoring organizations and others on how to better support their use and future adaptation.

## Important Considerations

### Comparing UME and GME Competencies

Table 1 compares the six new Foundational Competencies for UME with the current GME competencies.<sup>20</sup> An initial task of the WG was to consider whether the competency statements, created in 1999 for GME and last updated in 2019, were appropriate for UME learners. Although the two sets of competencies align, the Foundational Competencies for UME reflect developmentally appropriate language for the UME learner.

**Table 1. Six Competencies: Undergraduate Medical Education and Graduate Medical Education**

|                                                | Undergraduate Medical Education                                                                                                                                                                                                                | Graduate Medical Education                                                                                                                                                                                                                                                                  |
|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Professionalism</b>                         | Demonstrates integrity, respect, and ethical reasoning, and promotes inclusion of differences in all interactions to improve health care for patients, communities, and populations.                                                           | Demonstrates a commitment to professionalism and an adherence to ethical principles.                                                                                                                                                                                                        |
| <b>Patient Care and Procedural Skills</b>      | Demonstrates compassionate, effective, holistic, evidence-informed, equitable, and patient-centered care.                                                                                                                                      | Provides patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. Performs all medical, diagnostic, and surgical procedures considered essential for the area of practice. |
| <b>Medical Knowledge</b>                       | Applies and integrates foundational knowledge to improve health care for patients and populations.                                                                                                                                             | Demonstrates knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care.                                                                       |
| <b>Practice-Based Learning and Improvement</b> | Integrates feedback, evidence, and reflection to adapt behavior, foster improvement, and cultivate life-long learning.                                                                                                                         | Demonstrates the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.                                                              |
| <b>Interpersonal and Communication Skills</b>  | Effectively communicates and interacts with patients, caregivers, and the health care team to contribute to high-quality, patient-centered care.                                                                                               | Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.                                                                                                         |
| <b>Systems-Based Practice</b>                  | Applies knowledge of the larger context of health, including its social and structural determinants, and of systems and resources within and outside of health care, to optimize high-quality care for patients, communities, and populations. | Demonstrates an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.                                  |

## Intended Uses of the Foundational Competencies for UME

The Foundational Competencies for UME can serve multiple uses depending, in part, on one's role in academic medicine. For example, a curriculum dean and their committee may map the competencies to their current teaching and assessment practices to identify strong areas and potential gaps. They may help faculty coaches codesign learning plans with their students and design or adapt teaching experiences and assessment methods. Other uses include:

- Student self-assessment and use for individual learning plans.
- Development of learning objectives for educational experiences or courses.
- Identification of gaps in programmatic assessment.
- Development of assessment methods.
- Advancement of research and scholarship in medical education.

## How the Foundational Competencies for UME Relate to Other Frameworks

The Foundational Competencies for UME represent expected outcomes in six broad areas that were widely endorsed across the field in 2014 (Table 1).<sup>13</sup> These areas represent competencies that are foundational for all medical students, regardless of degree type or eventual specialty of practice. Other competencies, such as those in the AAMC New and Emerging Areas in Medicine Competency Series<sup>21</sup> and the AACOM Rural Medicine Core Competencies,<sup>22</sup> are intended to add depth to emerging, thematic areas and to guide curricular and professional development, especially in areas that are underrepresented in the educational program. Both thematic competencies and the Foundational Competencies for UME are intended to guide formative performance assessment and cross-continuum collaborations and, ultimately, improve health care services and outcomes.

The Foundational Competencies for UME — a more inclusive, current, and aligned framework — will replace the 2013 AAMC PCRS. Since EPAs are designed to support a broad competency framework, a future, collaborative effort is being planned to revisit the Core EPAs,<sup>15,16</sup> based on the Foundational Competencies for UME.

## Osteopathic Principles and Tenets

In developing the Foundational Competencies for UME, DO educators and others have focused on the integration of the principles and tenets of osteopathic medicine<sup>23</sup>:

1. The body is a unit; the person is a unit of body, mind, and spirit.
2. The body is capable of self-regulation, self-healing, and health maintenance.
3. Structure and function are reciprocally interrelated.
4. Rational treatment is based on an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.

The unique identities of both DO and MD educational programs continue to be recognized and valued. The integration of osteopathic principles and tenets into the delineation of all the subcompetencies is expected for DO-granting schools. The WG chose to create four subcompetencies specific to osteopathic medicine; however, they do not represent all the ways in which its principles and tenets will be realized. All subcompetencies are broad by design and will need further delineation for specific teaching, learning, and assessment methods. In other words, all DO- and MD-granting schools and their faculties should consider how the Foundational Competencies for UME apply to their local missions and communities and can be further delineated for teaching and assessment.

# Foundational Competencies for Undergraduate Medical Education

## Professionalism

Demonstrates integrity, respect, and ethical reasoning, and promotes inclusion of differences in all interactions to improve health care for patients, communities, and populations.

1. Demonstrates respect and compassion for patients, caregivers, families, and team members.
2. Safeguards patient privacy, confidentiality, and autonomy.
3. Uses ethical principles and reasoning to guide behavior.
4. Adapts actions and communication according to the situation.
5. Takes ownership of mistakes and acts to address them.
6. Identifies personal limits of knowledge and skills and seeks help appropriately.
7. Identifies biases and strategies to mitigate their effects.
8. Demonstrates humility and a willingness to learn from others with different backgrounds and experiences.
9. Recognizes and addresses personal well-being needs that may impact professional performance.
10. Completes duties and tasks in a thorough, reliable, and timely manner.
11. DO-specific: Demonstrates the philosophy of osteopathic medicine by promoting its four tenets.

## Patient Care and Procedural Skills

Demonstrates compassionate, effective, holistic, evidence-informed, equitable, and patient-centered care.

1. Integrates patient and caregiver context, needs, values, preferences, and experiences into patient care.
2. Gathers relevant patient histories from multiple data sources, as necessary.
3. Performs relevant physical examinations using appropriate techniques and tools.
4. Identifies patients in need of urgent or emergent care, seeks assistance, and recommends initial evaluation and management.
5. Creates and prioritizes differential diagnoses.
6. Proposes hypothesis-driven diagnostic testing and interprets results.
7. Formulates therapeutic management plans for commonly encountered clinical conditions.
8. Uses patient-centered language to describe common diagnostic and therapeutic interventions and plans.
9. Demonstrates basic procedural techniques.
10. Incorporates health promotion and disease prevention into patient care plans.
11. Identifies individual and structural factors that impact health and wellness.
12. DO-specific: Incorporates osteopathic principles, practices, and tenets into patient care.
13. DO-specific: Performs an osteopathic, structural examination and treats altered function of the body framework system or somatic dysfunction with osteopathic manipulative treatment (OMT).

## Medical Knowledge

Applies and integrates foundational knowledge to improve health care for patients and populations.

1. Demonstrates knowledge of basic, clinical, pathophysiologic, social, and health systems sciences, as well as humanities, needed for clinical practice.
2. Applies foundational knowledge for clinical problem-solving, diagnostic reasoning, and decision-making to clinical scenarios.
3. Discerns the accuracy of information and relevance to clinical problems.
4. Demonstrates knowledge of research design, interpretation, and application to clinical questions.
5. Accesses knowledge relevant to clinical problems using appropriate resources, including emerging technologies.
6. DO-specific: Demonstrates knowledge of how to integrate osteopathic principles, practices, and tenets into patient care.

## Practice-Based Learning and Improvement

Integrates feedback, evidence, and reflection to adapt behavior, foster improvement, and cultivate lifelong learning.

1. Actively seeks and incorporates feedback and assessment data to improve performance.
2. Identifies opportunities for growth in one's own performance through informed self-assessment and reflective practice.
3. Develops, implements, and reassesses learning and improvement goals.
4. Locates, critically appraises, and synthesizes information to support evidence-informed, patient-centered clinical decisions.
5. Demonstrates inquiry and ability to grow and seek new knowledge.

## Interpersonal and Communication Skills

Effectively communicates and interacts with patients, caregivers, and the health care team to contribute to high-quality, patient-centered care.

1. Collaborates with patients, caregivers, and team members to enhance the therapeutic relationship.
2. Collaborates with health care and administrative team members to enhance team and organizational function.
3. Demonstrates active listening.
4. Communicates clearly, accurately, and compassionately in verbal, nonverbal, written, and electronic formats.
5. Demonstrates skills in educating patients, caregivers, peers, and team members.
6. Formulates and shares feedback constructively with others.

## Systems-Based Practice

Applies knowledge of the larger context of health, including its social and structural determinants, and of systems and resources within and outside of health care, to optimize high-quality care for patients, communities, and populations.

1. Applies knowledge of social and structural drivers of health.
2. Recognizes mechanisms to reduce disparities in patient care and health care systems.
3. Adapts performance to various health care teams, delivery settings, and systems.
4. Collaborates in transitions and coordination of patient care.
5. Evaluates the risks and benefits of using current and emerging technologies in patient care.
6. Identifies patient safety concerns, systems issues, and opportunities for quality improvement.
7. Describes health policy and the financial context of health care.
8. Applies knowledge of local population and community health needs, disparities, and resources.

# Glossary

**AACOM:** American Association of Colleges of Osteopathic Medicine

**AAMC:** Association of American Medical Colleges

**ACGME:** Accreditation Council for Graduate Medical Education

**Active listening:** "... being deeply engaged in and attentive to what the speaker is saying. It requires far more listening than talking. [The goal of] an active listener is to truly understand the speaker's perspective ... and to communicate that understanding back to the speaker so that [they] can confirm the accuracy of your understanding."<sup>24</sup>

**Care plan:** "A written, [personalized] care plan, which, under the single-assessment process, details a patient's integrated health and social care needs."<sup>25</sup>

**Competence:** "The array of abilities [(knowledge, skills, and attitudes)] across multiple domains or aspects of performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stage of training. Competence is multi-dimensional and dynamic. It changes with time, experience, and setting."<sup>1</sup>

**Competency:** "An observable ability of a health professional [related to a specific activity that integrates] knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development."<sup>1</sup>

**Competency-based medical education (CBME):** "An outcomes-based approach to the design, implementation, assessment, and evaluation of medical education programs, using an organizing framework of competencies."<sup>1</sup>

**Confidentiality:** An ethical duty that prevents certain people from sharing information with third parties.

**Educational continuum/Continuum of medical education:** The span of a physician's education, from undergraduate medical education (medical school) to graduate medical education (residency and fellowship) and continuing medical education (during years in practice).

**Effective care:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).<sup>26</sup>

**Equitable care:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.<sup>26</sup>

**Evidence-informed care:** Care that integrates information from scientific research, clinical experience and judgment, and the patient's preferences and values.<sup>27</sup>

**Five core components of competency-based medical education curricula:** Outcome competencies, sequenced progression, tailored learning experiences, competency-focused instruction, and programmatic assessment.<sup>18</sup>

**Health disparity:** Refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.<sup>28</sup>

**Health equity:** "'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."<sup>29</sup>

**Patient-centered care:** "Care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."<sup>26</sup>

**Patient-centered language:** “Patient-centered communication focuses on goals that should be achieved jointly by physicians, patients and, when appropriate, families. Some features of patient-centered communication are stated as follows:

- “Reveals the patient’s perspective (beliefs, preferences, concerns, needs).
- “Explores the bio-psycho-social context of the patient’s health and well-being.
- “Builds or strengthens trust and mutual respect in the physician-patient relationship.
- “Present disease and treatment options in a way that the patient understands.
- “Supports patients’ active participation in the communication and decision-making process.
- “It is based on common sense in problem solving and action plans.
- “Allows for decisions that are evidence-based, consistent with the patient’s values and feasible to implement.”<sup>30</sup>

**Patient safety:** The practices that reduce the occurrence of preventable adverse events and medical errors.<sup>31</sup>

**Patient privacy:** “... encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).”<sup>32</sup>

**Quality improvement:** The systematic ongoing practices that lead to measurable improvement in health care services and patient outcomes.<sup>31</sup>

**Reflective practice:** “... the practice by which professionals become aware of their implicit knowledge base and learn from their experience.”<sup>33</sup>

**Social and structural drivers of health:** Both social and structural drivers of health intersect to affect many different aspects of health, including access to health care services, morbidity and mortality, and health care quality.

**Social drivers of health:** “The terms *social drivers of health* and *social determinants of health* are used interchangeably.”<sup>34</sup> “[Social drivers of health refers] to the underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age. They affect a wide range of health, functioning, and quality-of-life outcomes and risks. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair.”<sup>35</sup>

**Structural drivers of health:** *Structural drivers of health* and *structural determinants of health* are used interchangeably. “The structural drivers of health refer to the upstream social, economic, and political mechanisms that generate social inequities and therefore affect health (eg, extent a government finances healthcare).”<sup>36</sup>

**Tenets of Osteopathic Medicine:** “... express the underlying philosophy of osteopathic medicine and were approved by the AOA House of Delegates as policy.

1. “The body is a unit; the person is a unit of body, mind, and spirit.
2. “The body is capable of self-regulation, self-healing, and health maintenance.
3. “Structure and function are reciprocally interrelated.
4. “Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.”<sup>23</sup>

**Therapeutic relationship:** The relationship between a caregiver and a patient that includes the caregiver valuing the patient, and the caregiver's commitment to the patient, management of the power imbalance, and character and competencies.<sup>37</sup>

**Transition of care:** "... the movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities."<sup>38</sup>

## References

1. Frank JR, Snell LS, Cate OT, et al. Competency-based medical education: theory to practice. *Med Teach*. 2010;32(8):638-645. doi:[10.3109/0142159X.2010.501190](https://doi.org/10.3109/0142159X.2010.501190)
2. Coalition for Physician Accountability. The Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC): Recommendations for Comprehensive Improvement of the UME-GME Transition. Accessed August 30, 2024. <https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Coalition-Report-FINAL.pdf>
3. Frank, JR, ed. *The CanMEDS 2005 Physician Competency Framework: Better Standards. Better Physicians. Better Care*. The Royal College of Physicians and Surgeons of Canada; 2005. Accessed October 9, 2024. <https://www.anesthesiaprimer.com/AP/Ch1Objectives/canmeds2005.pdf>
4. The Medical School Objectives Writing Group. Learning objectives for medical student education—guidelines for medical schools: Report I of the Medical School Objectives Project. *Acad Med*. 1999;74(1):13-18. doi:[10.1097/00001888-199901000-00010](https://doi.org/10.1097/00001888-199901000-00010)
5. Edgar L, Roberts S, Holmboe E. Milestones 2.0: a step forward. *J Grad Med Educ*. 2018;10(3):367-369. doi:[10.4300/JGME-D-18-00372.1](https://doi.org/10.4300/JGME-D-18-00372.1)
6. Misra S, Iobst WF, Hauer KE, Holmboe ES. The importance of competency-based programmatic assessment in graduate medical education. *J Grad Med Educ*. 2021;13(2 suppl):113-119. doi:[10.4300/JGME-D-20-00856.1](https://doi.org/10.4300/JGME-D-20-00856.1)
7. American Osteopathic Association. *Report of the Core Competency Taskforce*. American Osteopathic Association; 2003.
8. National Board of Osteopathic Medical Examiners. *The Seven Osteopathic Medical Competencies: Considerations for Future Testing and the Practice of Osteopathic Medicine*. National Board of Osteopathic Medical Examiners; 2006.
9. AACOM. Osteopathic Core Competencies for Medical Students: Addressing the AOA Seven Core Competencies and the Healthy People Curriculum Task Force's Clinical Prevention and Population Health Curriculum Framework. Accessed September 23, 2024. [https://www.aacom.org/docs/default-source/med-ed-documents/corecompetencyreport2012.pdf?sfvrsn=53bed24b\\_1](https://www.aacom.org/docs/default-source/med-ed-documents/corecompetencyreport2012.pdf?sfvrsn=53bed24b_1)
10. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system--rationale and benefits. *N Engl J Med*. 2012;366(11):1051-1056. doi:[10.1056/NEJMsrl200117](https://doi.org/10.1056/NEJMsrl200117)
11. Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a common taxonomy of competency domains for the health professions and competencies for physicians. *Acad Med*. 2013;88(8):1088-1094. doi:[10.1097/ACM.0b013e31829a3b2b](https://doi.org/10.1097/ACM.0b013e31829a3b2b)
12. Coalition for Physician Accountability. Members. Accessed August 30, 2024. <https://physicianaccountability.org/members/>
13. Coalition for Physician Accountability. Consensus Statement on a Framework for Professional Competence by the Coalition for Physician Accountability. Accessed September 4, 2024. <https://physicianaccountability.org/wp-content/uploads/2020/05/Coalition-Competencies-Consensus-Statement-FINAL.pdf>

14. ten Cate O. Entrustability of professional activities and competency-based training. *Med Educ*. 2005;39(12):1176-1177. doi:[10.1111/j.1365-2929.2005.02341.x](https://doi.org/10.1111/j.1365-2929.2005.02341.x)
15. AAMC. The Core Entrustable Professional Activities for Entering Residency (AAMC Core EPAs). Accessed September 23, 2024. <https://www.aamc.org/about-us/mission-areas/medical-education/cbme/core-epas>
16. AACOM. Osteopathic Considerations for Core Entrustable Professional Activities (EPAs) for Entering Residency. Accessed September 4, 2024. [https://www.aacom.org/docs/default-source/med-ed-documents/core-epas.pdf?sfvrsn=b6145397\\_7](https://www.aacom.org/docs/default-source/med-ed-documents/core-epas.pdf?sfvrsn=b6145397_7)
17. ACGME. History of the transition to a single GME accreditation system. Accessed September 24, 2024. <https://www.acgme.org/about/transition-to-a-single-gme-accreditation-system-history/>
18. Van Melle E, Frank JR, Holmboe ES, et al. A core components framework for evaluating implementation of competency-based medical education programs. *Acad Med*. 2019;94(7):1002-1009. doi:[10.1097/ACM.0000000000002743](https://doi.org/10.1097/ACM.0000000000002743)
19. Batt A, Williams B, Rich J, Tavares W. A six-step model for developing competency frameworks in the healthcare professions. *Front Med (Lausanne)*. 2021;8:789828. doi:[10.3389/fmed.2021.789828](https://doi.org/10.3389/fmed.2021.789828)
20. ACGME. Common Program Requirements. Accessed November 18, 2024. <https://www.acgme.org/programs-and-institutions/programs/common-program-requirements/>
21. AAMC. AAMC New and Emerging Areas in Medicine competency series. Accessed September 4, 2024. <https://www.aamc.org/about-us/mission-areas/medical-education/cbme#new>
22. AACOM. Rural medicine core competencies. Accessed September 23, 2024. <https://www.aacom.org/medical-education/teaching-and-learning/competency-curriculum-resources#rural>
23. American Osteopathic Association. Tenets of Osteopathic Medicine. Accessed September 23, 2024. <https://osteopathic.org/about/leadership/aoa-governance-documents/tenets-of-osteopathic-medicine/>
24. Boston University Office of the Ombuds. Active Listening. Accessed September 24, 2024. <https://www.bumc.bu.edu/facdev-medicine/files/2016/10/Active-Listening-Handout.pdf>
25. Segen JC. *The Dictionary of Modern Medicine*. Parthenon Publishing Group; 1992.
26. Institute of Medicine; Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; 2021. Accessed October 10, 2024. <https://doi.org/10.17226/10027>
27. Nevo I, Slonim-Nevo V. The myth of evidence-based practice: towards evidence-informed practice. *Br J Soc Work*. 2011;41(6):1176-1197. doi:[10.1093/bjsw/bcq149](https://doi.org/10.1093/bjsw/bcq149)
28. Braveman P. What are health disparities and health equity? We need to be clear. *Public Health Rep*. 2014;129(1;suppl 2):5-8. doi:[10.1177/003335491412915203](https://doi.org/10.1177/003335491412915203)
29. World Health Organization (WHO). Social determinants of health: health equity. Accessed September 4, 2024. [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_3](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3)

30. Çakmak C, Uğurluoğlu Ö. The effects of patient-centered communication on patient engagement, health-related quality of life, service quality perception and patient satisfaction in patients with cancer: a cross-sectional study in Türkiye. *Cancer Control*. 2024;31:10732748241236327. doi:[10.1177/10732748241236327](https://doi.org/10.1177/10732748241236327)
31. AAMC. *Quality Improvement and Patient Safety Competencies Across the Learning Continuum, Version 2*. AAMC New and Emerging Areas in Medicine Series. AAMC; 2024.
32. American Medical Association (AMA). Opinion 3.1.1: Privacy in health care. In: *Code of Medical Ethics*. AMA; 2016. Accessed October 21, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/privacy-health-care>
33. Schön DA. *The Reflective Practitioner: How Professionals Think in Action*. 1st ed. Routledge; 1992. doi:[10.4324/9781315237473](https://doi.org/10.4324/9781315237473)
34. Serchen J, Doherty R, Atiq O, Hilden D; Health and Public Policy Committee of the American College of Physicians. A comprehensive policy framework to understand and address disparities and discrimination in health and health care: a policy paper from the American College of Physicians. *Ann Intern Med*. 2021;174(4):529-532. doi:[10.7326/M20-7219](https://doi.org/10.7326/M20-7219)
35. AMA, AAMC. *Advancing Health Equity: A Guide to Language, Narrative and Concepts*. AMA; 2021. Accessed August 31, 2024. <https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf>
36. WHO. *A Conceptual Framework for Action on the Social Determinants of Health*. WHO; 2010. Accessed October 21, 2024. <https://apps.who.int/iris/handle/10665/44489>
37. Razzaghi MR, Afshar L. A conceptual model of physician-patient relationships: a qualitative study. *J Med Ethics Hist Med*. 2016;9:14.
38. Agency for Healthcare Research and Quality. Chartbook on care coordination. Updated June 2018. Accessed September 4, 2024. <https://www.ahrq.gov/research/findings/nhqrd/chartbooks/carecoordination/measure1.html>

# Appendix

## Foundational Competencies for Undergraduate Medical Education: The Detailed Development Process

The development of the Foundational Competencies for Undergraduate Medical Education (UME) took place over approximately three years and included collaborative planning, community discussions, a landscape review, competency development, reporting, and dissemination (Figure 1). The co-leads, representing the three sponsoring organizations, steered the initiative; an advisory committee (AC) provided expert guidance; a working group (WG; its members were selected through an application process) developed the draft competencies; and two reactor groups (RGs; one composed of patients and caregivers, the other of medical students) provided initial feedback to the WG on the iterative drafts.

The collaborative planning phase lasted 10 months and began with the co-leads agreeing on the goals and plan for the development of the competencies, and a draft of the guiding principles. They identified and recruited 24 members to serve on the AC, who were from 16 unique organizations representing important roles in undergraduate medical education. AC members participated in six meetings over the course of the project, between July 2022 and June 2024. The AC reviewed and provided input on the plan and the WG criteria, rated WG applicants, provided input on iterative drafts of competencies, assisted with communications and promotions of related engagement opportunities, and advised on practical issues related to the release of the competencies and their future use. The co-leads, with assistance from the AC, finalized seven guiding principles to facilitate the competency development process:

1. Choose quality over speed.
2. Value diversity of perspectives (over a single small group of experts).
3. Cocreate via iterative feedback (and not offer a single short window for input or no input).
4. Apply lessons from published research as well as practical evidence from the field.
5. Value equity in how competency-based medical education (CBME) is constructed, operationalized, and supported.
6. Value well-being and commit to considering the implications of this CBME work on the health and wellness of those impacted.
7. Embrace a complementary language of CBME, grounded in the six core competencies created in 1999 and endorsed by the Coalition for Physician Accountability in 2014.<sup>13</sup>

The 20-member WG was formed after a national application process. These volunteers were carefully selected to ensure a highly qualified and representative group. Selection factors included, but were not limited to: geographic location; size and mission of the applicant's institution; their specialty; the types of degrees awarded by their institution; and the applicant's race, ethnicity, and gender. The primary responsibility of the WG was to help develop the new Foundational Competencies for UME by following a facilitated, iterative process. The two RGs were formed to ensure that perspectives from medical students, patients, and caregivers were included during the development phase. Other outcomes of this phase included: the creation of a shared website with frequently asked questions and an anonymous feedback form for ongoing questions and concerns from the community, a dossier of literature, research on CBME, and the creation of protocols for listening sessions that were held during the second phase.

The second phase — community discussions and landscape review — lasted seven months and helped inform the overall project, including the identification of major trends facing health care and the competency-based education frameworks used at various stages of physician training. This phase also included multiple listening sessions with a broad array of individuals who reflected on how health care is changing and how CBME is currently experienced within the local institution or program.

Questions posed included:

- What will we expect all future physicians to be able to do, know, and value regardless of their specialties?
- What will we need to teach and assess to ensure an ideal future workforce?
- What competency frameworks for CBME are currently being used, and what does “use” mean at the local school level?

These discussions provided valuable information to help guide the competency development process. Patients, caregivers, and patient advocates shared valuable insights on the need for future physicians to have strong communication and interpersonal skills, coordinate care within the complex health care system, value cultural differences and address biases, and inform and support patients and their caregivers at the end of life.

The development phase lasted 18 months and included the writing and revising of the Foundational Competencies for UME. Early in this phase, the WG was given a dossier of literature, research on CBME, and a summary of the feedback received during the first phase. They began by considering the current version of the Accreditation Council for Graduate Medical Education competency statements, asking whether each of the six statements were appropriate for an undergraduate learner. The WG met virtually each month for two hours, beginning in March 2023. The 20 members worked in small, facilitated groups to focus on a single competency at a time. Once drafted, the six statements were disseminated to select groups, including the RGs and the AC, for initial reactions. After review and modification, the WG began drafting the subcompetencies at monthly meetings held in the same small-group format. The members were randomly assigned to a small group at each meeting to increase the applicability of the subcompetencies across the spectrum of learning environments. The groups went to great lengths to choose the words and phrasing of the competencies and subcompetencies to ensure that knowledge, skills, and abilities were accurately identified and relevant to all learners. Early drafts of the subcompetencies were shared with medical educators, the AC, and the RGs. The work was revised based on this initial feedback and posted for public comment for three weeks, from late January to February 2024.

The results of the first draft survey included 761 responses from across the United States, representing every state except Wyoming, South Dakota, Idaho, Delaware, and Alaska. A slight majority (56%) of the respondents self-identified as serving in a leadership role at a medical school or graduate medical education-sponsoring institution, or for an educational program (e.g., clerkship or program director). Of the 718 respondents affiliated with a medical school, 90% were affiliated with MD-granting schools, and 10% were affiliated with DO-granting schools.

The first review-period survey invited feedback on the overall set, while the second review-period survey invited more granular feedback on each of the six competencies. Researchers from the sponsoring organizations analyzed the quantitative and qualitative data obtained during the first review period. Forced-choice items were aggregated, and a modified, qualitative analysis approach was used to review and synthesize the free-text responses. There were four free-text responses on each survey:

1. Are the draft competencies and subcompetencies clearly written?
2. Do the draft competencies and subcompetencies appropriately describe the expected core abilities of a medical student, regardless of where they attended medical school or their future specialty?
3. Do any of the draft competencies or subcompetencies reflect abilities that are not considered core or foundational to all medical students?
4. If you consider the entire set of draft competencies and subcompetencies to be expected of all medical students, regardless of where they attended medical school or their future specialty, what, if anything, is missing?

The number of open-ended comments for the items ranged from 86 to 253 comments for the first round and from 251 to 485 comments for the second round. Given the size and nature of the dataset, a combination of manual inspections and artificial intelligence-automated text analyses were employed to systematically categorize the feedback. Themes were then mapped to specific competency areas for targeted revisions.

The overarching themes identified included, but were not limited to, the need to: use precise language, avoid ambiguity, eliminate redundancy across subcompetencies, and establish a more effective way to integrate the unique aspects of DO training into the competencies. Based on the specific feedback that was received for all competencies, the area in need of most revision was medical knowledge. Additional recommendations included the need for more emphasis on communication, health system science and health policy, evidence-based practice, personal and professional development, procedural skills, and patient-centered care.

The WG reviewed the results of the first round of comments and revised the draft Foundational Competencies for UME in March 2024, resulting in a second draft that was released for public comment for four weeks, from April to May 2024. The results of the online survey included 1,189 valid responses from across the United States, representing every state except Alaska, Nebraska, Wyoming, and the U.S. Virgin Islands. In this review cycle, 35% of respondents self-identified as serving in a leadership role at a medical school or graduate medical education-sponsoring institution, or for an educational program (e.g., clerkship or program director). Of the 982 respondents affiliated with a medical school, 53% were affiliated with MD-granting schools, and 47% were affiliated with DO-granting schools.

Overarching themes from the second round of comments included, but were not limited to, the need for: reducing redundancy, increasing clarity, further integrating evidence-based practice, and incorporating more patient-centered care. There was significant feedback indicating the need to emphasize osteopathic principles and tenets. Other areas for consideration included inclusivity and equity, emerging technologies, lifelong learning and adaptability, population health, self-reflection, interprofessional communication, and ethical practice. Most respondents agreed that the competencies and subcompetencies were written clearly and appropriately described the expected ability of a medical student, regardless of where they attend medical school or what their future specialty is. The WG reviewed the draft and addressed any areas that were missing or of concern or increased interest. Again, each small group was assigned a competency and made needed changes to the subcompetency statements. The second public draft was completed, and each group was asked before adjournment to write a brief narrative of their time in the WG.

The third draft was reviewed by select individuals, including the AC and RGs, for any needed minor changes, such as word choice or further emphasis on osteopathic principles and tenets. The final version was approved by the co-leads in September 2024.



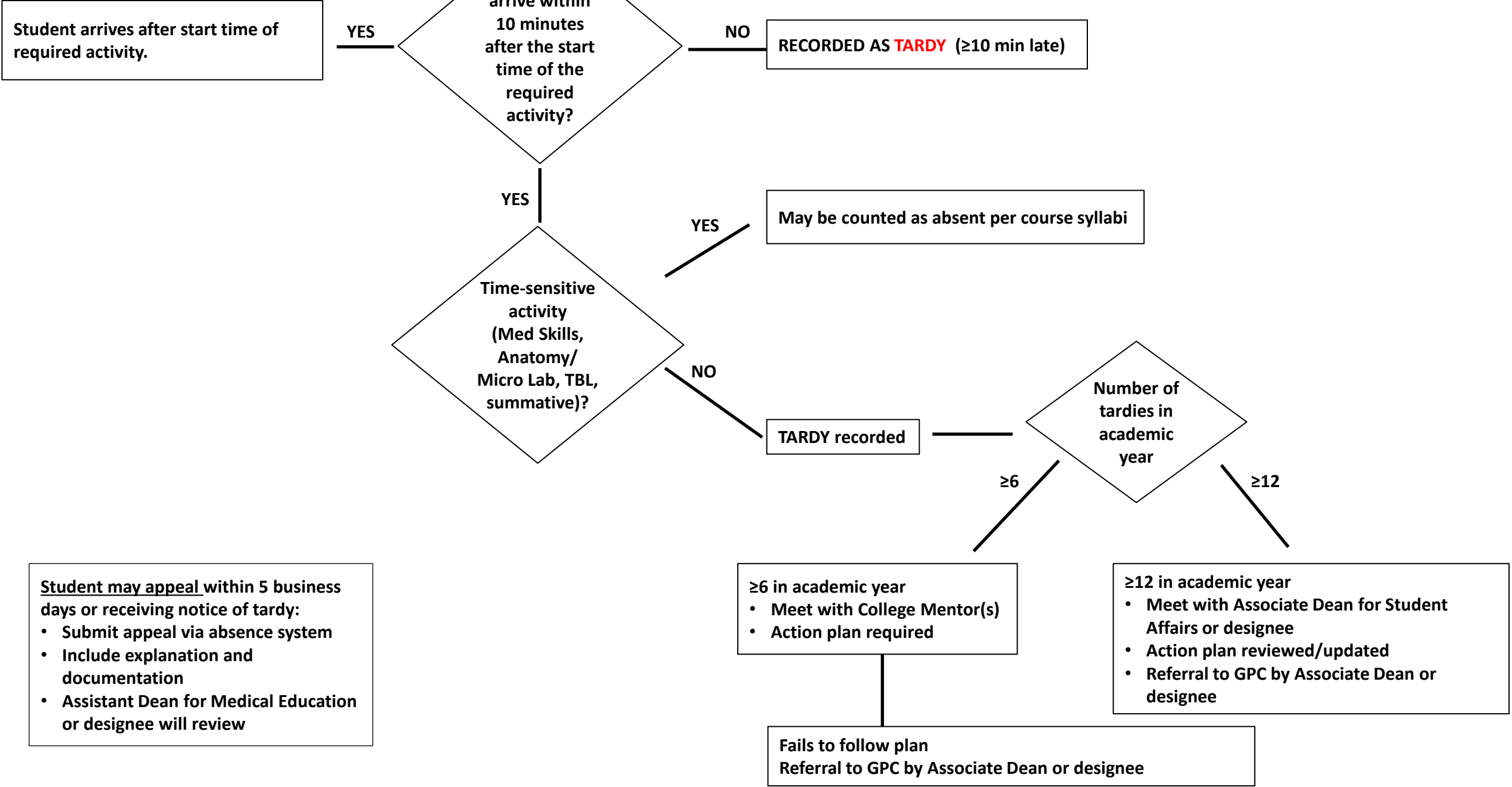
Accreditation Council for  
Graduate Medical Education

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American Association of Colleges of  
Osteopathic Medicine

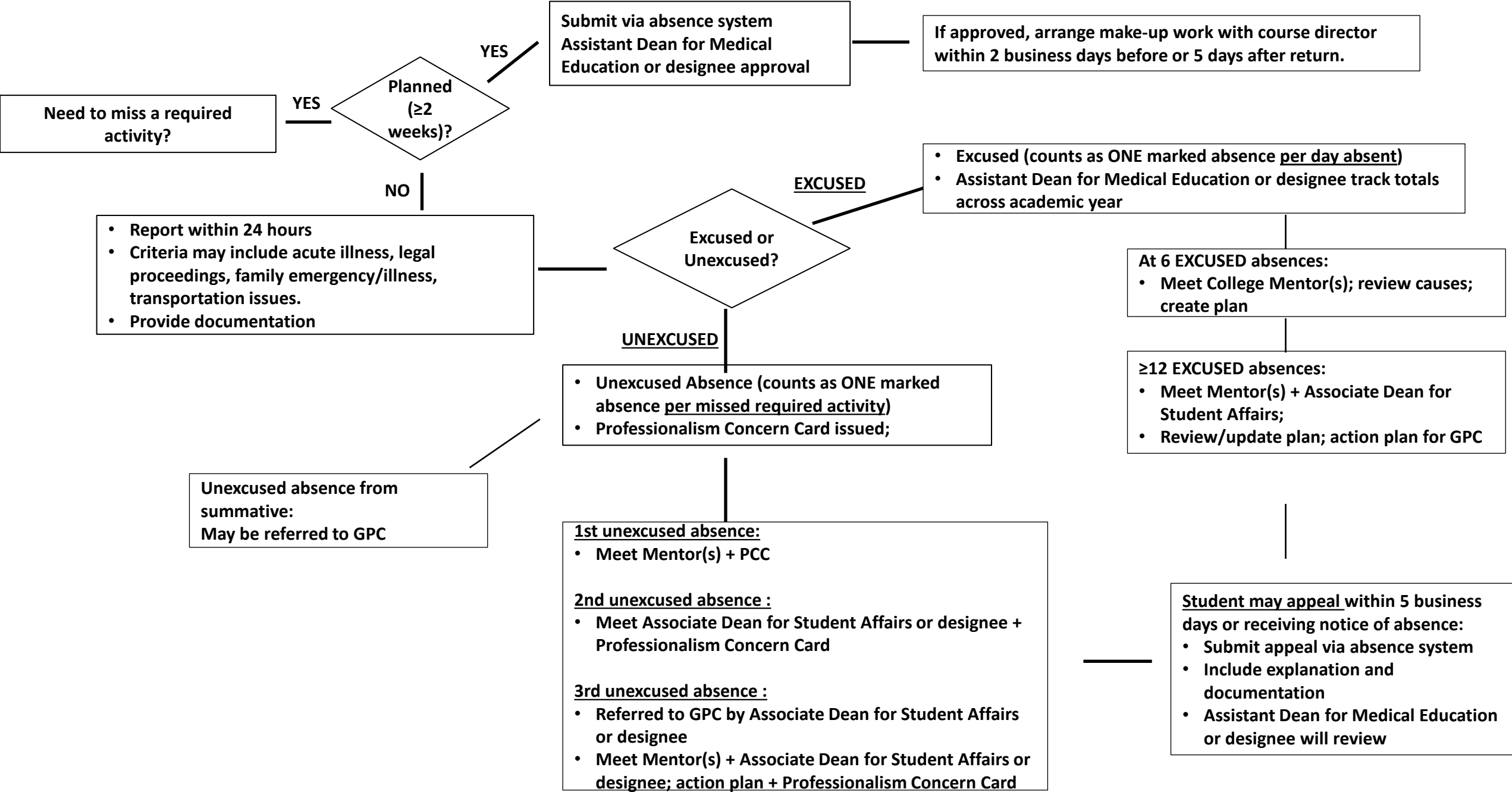
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# Tardy Flow Diagram



# Attendance (Absences) Flow Diagram





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Medical Education Program Policy

|                               |                                                          |                                   |                                                                                   |                            |                        |
|-------------------------------|----------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------|----------------------------|------------------------|
| <b>Policy Name:</b>           | Pre-clerkship phase attendance policy                    |                                   |                                                                                   |                            |                        |
| <b>Policy Domain:</b>         | Student attendance/curriculum engagement/professionalism | <b>Refers to LCME Element(s):</b> | 3.5, 9.9, 10.3                                                                    |                            |                        |
| <b>Approval Authority:</b>    | Curriculum and Educational Policy Committee (CEPC)       | <b>Adopted:</b>                   | 4/15/2019                                                                         | <b>Date Last Reviewed:</b> | July 2023 <sup>5</sup> |
| <b>Responsible Executive:</b> | Assistant Dean for Medical Education (Pre-Clerkship)     | <b>Date Last Revised:</b>         | October 2025 <sup>3</sup>                                                         |                            |                        |
| <b>Responsible Office:</b>    | PLFSOM Office of Medical Education                       | <b>Contact:</b>                   | Mirjana Babic, M.P.A.<br><a href="mailto:mbabic@ttuhsc.edu">mbabic@ttuhsc.edu</a> |                            |                        |

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1. **Policy Statement:** Medical student attendance, which includes both their presence and engagement, is a vital component of medical education. Student participation is required in specific pre-clerkship activities, and their engagement in all pre-clerkship activities is expected. Attendance (and its components, presence and engagement) are considered elements of medical student professionalism and their personal and professional development, as outlined in the PLFSOM Educational Program Goals and Objectives, specifically: Medical students' attendance, composed of both student presence and engagement, is a vital component of medical education. Their presence is expected at specific pre-clerkship activities, and their engagement in all pre-clerkship phase activities is paramount. Attendance (and its components, presence and engagement) are considered elements of medical student professionalism and elements of their personal and professional development, as outlined in the PLFSOM Educational Program Goals and Objectives, specifically: Medical students are expected to attend and participate in all assigned pre-clerkship phase activities. Attendance and participation are considered elements of medical student professionalism, and personal and professional development, as outlined in the PLFSOM Educational Program Goals and Objectives, specifically:
  - Objective PRO-5.6 – "Demonstrate honesty and integrity in all professional and academic interactions"
  - Objective PRO-5.7 – "Meet professional and academic commitments and obligations"
  - Goal 8 – "Demonstrate the qualities required to sustain lifelong personal and professional growth"

2. Both internal data and external peer-reviewed studies strongly indicate that student presence and engagement during activities correlate with academic success in medical school. As such, the school monitors medical student presence at specific sessions and expects sufficient medical student engagement in all pre-clerkship phase curricular activities. Expectations for medical student presence at a given academic activity will be visible and/or communicated clearly to students before each activity. Internal as well as published studies strongly indicate that attendance and participation correlate with academic success in medical school. As such, the school monitors and encourages medical student attendance and participation in all pre-clerkship phase curricular activities, and sets specific expectations for attendance and participation for all activities designated as "required" (including all graded

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activities).

**3.2. Reason for Policy:** ~~This policy defines the requirements or expectations for pre-clerkship phase student presence in support of the school's educational program goals and objectives and, and generally in support of student academic success. This policy defines the expectations for pre-clerkship phase student attendance and participation in support of the school's educational program goals and objectives and, more generally, in support of student academic success.~~

**4.3. Who Should Read this Policy:** All students, ~~all~~ members of the PLFSOM Committee on Student Grading and Promotion (GPC), ~~all~~ pre-clerkship phase course directors ~~and faculty~~, the PLFSOM associate and assistant deans for student affairs, the PLFSOM associate and assistant deans for medical education, all pre-clerkship course coordinators, and all Office of Student Affairs and Department of Medical Education staff ~~that interact with students in regards to attendance and/or conduct.~~

**5.4. Resources:** This policy is primarily applied and supported by the PLFSOM Office of Medical Education, Department of Medical Education, and Office of Student Affairs. This policy is administratively maintained (reviewed, revised, and disseminated) by the PLFSOM Curriculum and Educational Policy Committee (CEPC).

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**6.5. Definitions:**

- **Absence:** Non-attendance or arrival more than 10 minutes after the scheduled start time for an assigned activity. Absences are recorded at the course level by the required activity. However, excused absences (planned or unplanned) may involve entire days, including multiple required activities. Excused absences (planned or unplanned) involving one or more required activities in the same day will be counted as one absence under Section 6X. For unexcused absences, each required activity missed shall be accounted for as one absence under Section 6X. However, excused absences (planned or unplanned) may involve entire days, including multiple required activities, and those days shall be accounted for as one absence under Section 6X, regardless of the number of required activities missed. An excused absence requiring only part of a day, as determined by the assistant dean for medical education (pre-clerkship phase) or their designee, shall be accounted for as one absence under Section 6X, regardless of the number of required activities missed during the excused absence. For unexcused absences, each required activity missed shall be accounted for as one absence under Section 6X.
- **Assigned activity:** Any educational program administrative or curricular activity assigned to a student (as disseminated via the school's curriculum and learning management system softwares or in e-mails sent to the students via their official TTUHSC accounts)
- **Attendance:** Timely presence in and attention to an assigned activity (may be monitored, and may be recorded and assessed for required activities)
- **Critical summative assessment:** Critical summative assessments are graded activities involving performance standards that are obligatory to passing the overlying course or requirement. They are specified in the overlying course or requirement syllabus and disseminated via the school's curriculum and learning management systems or in e-mails sent to the students via their official TTUHSC accounts
- **Engagement:** Active participation in the learning or discussion of educational material (includes both in-person and virtual components of the curriculum)
- **Excused absence:** An excused absence is an absence (planned or unplanned) that meets the criteria outlined in Sections 6.VI and 6.VII and has been approved by the Assistant Dean for Medical Education (pre-clerkship phase) or their designee. Excused absences may involve entire days, including multiple required activities, or only part of a day, as determined by the approving authority. When approved, an excused absence is recorded as one absence under Section 6X, regardless of the number of required activities missed per day.
- **Graded activity:** Any graded activity that substantively contributes to the student's fulfillment of the overlying course objectives and to the student's final grade. All graded activities are considered required, but not all graded activities constitute critical summative assessments (see overlying course or requirement syllabi)
- **Planned absence:** An absence anticipated and pre-approved by a student due to special circumstances consistent with Section 6.VI below. Absences will be considered planned only if it is requested two or more weeks in advance.
- **Professionalism concern card:** Professionalism concern cards are issued to students for significant professionalism lapses, such as an unexcused absence, and serve as formal documentation to address and remediate the concern.

**Commented [FM1]:** I don't think this is consistent with the rest of the paragraph.

Consider  
"However, excused absences (planned or unplanned) may involve entire days, including multiple required activities. Excused absences (planned or unplanned) involving one or more required activities in the same day will be counted as one absence under Section 6X. For unexcused absences, each required activity missed shall be accounted for as one absence under Section 6X."

**Commented [HT2R1]:** OSA request "An unexcused absence should count as one absence per day, not per individual activity. Otherwise, under the new policy, a single unexcused day (e.g., missing Med Skills, SCI, or Spanish) would trigger a GPC referral, which is overly punitive."

**Commented [FM3R1]:** This will have to be discussed by the CEPC

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- **Required activity:** Any educational program administrative or curricular activity for which attendance is required (as disseminated via the school's curriculum and learning management systems or in e-mails sent to the students via their official TTUHSC accounts)
- ~~**Graded activity:** Any graded activity that substantively contributes to the student's fulfillment of the overlying course objectives and to the student's final grade. All graded activities are considered required, but not all graded activities constitute critical summative assessments (see overlying course or requirement syllabi)~~
- ~~**Critical summative assessment:** Critical summative assessments are graded activities involving performance standards that are obligatory to passing the overlying course or requirement. They are specified in the overlying course or requirement syllabus and disseminated via the school's curriculum and learning management systems or in e-mails sent to the students via their official TTUHSC accounts~~
- ~~**Engagement:** Active participation in the learning or discussion of educational material (includes both in-person and virtual components of the curriculum)~~
- ~~**Attendance:** Timely presence in and attention to an assigned activity (may be monitored, and may be recorded and assessed for required activities)~~
- ~~**Encouraged:** Highly suggested, as it is seen as an important component of medical education. Students will not receive penalties for activities that fall under this category~~
- ~~**Expected:** Required, as it is a vital component of medical education. Students may receive penalties for failing to meet certain expectations~~
- **Tardy attendance:** Late arrival to an assigned activity (defined as arriving within 10 minutes after the scheduled start time for an assigned activity). For some time-sensitive assigned activities (such as OSCEs, [Medical Skills](#), [summatives](#), [Team-Based Learning events](#) and [Anatomy/Microbiology labs](#)), tardy admittance to an assigned activity may may not be allowed, and under these circumstances the student will be counted as absent and an absence recorded (consult course or requirement syllabi for the definitive list of activities that fall under these circumstances)
- ~~**Absence:** Non-attendance or arrival more than 10 minutes after the scheduled start time for an assigned activity. Absences are recorded at the course level by the required activity. However, excused absences (planned or unplanned) may involve entire days, including multiple required activities, and those days shall be accounted for as one absence under Section 6.IX, regardless of the number of required activities missed. An excused absence requiring only part of a day, as determined by the assistant dean for medical education (pre-clerkship phase) or their designee, shall be accounted for as one absence under Section 6.IX, regardless of the number of required activities missed during the excused absence. For unexcused absences, each required activity missed shall be accounted for as one absence under Section 6.IX~~
- ~~**Planned absence:** An absence anticipated and pre-approved by a student due to special circumstances consistent with Section 6.VI below~~
- **Unexcused absence:** An unexcused absence is any absence that does not meet the criteria for approval under Sections 6.VI or 6.VII.  
This includes failure to request or obtain approval for a planned or unplanned absence, or failure to attend a required activity without valid justification.  
Each required activity missed without approval is recorded as one absence under Section 6.X. Unexcused absences constitute a professionalism lapse and may

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result in the issuance of a Professionalism Concern Card.

- **Unplanned absence:** An absence unanticipated by the student and for which pre-approval is not possible – consistent with Section 6.VII below

● ~~Unexcused absence: An absence inconsistent with the criteria for excused absence, planned or unplanned, per Sections 6.VI and 6.VII below~~

— ~~Excessive absences (regardless of cause): Student is absent from 6 or more of the required sessions.~~

▲ ~~Excessive unexcused absences: Student has 6 or more unexcused absences within a single semester or 12 or more unexcused absences within an academic year~~

**7.6. The Policy:**

**General expectation of attendance and participation:** Consistent on-time attendance and participation engagement demonstrate respect for the educational environment and are essential ways for



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~~the school to monitor student progress in multiple competencies~~ monitoring student progress.

Being on time and prepared to participate fully are essential to the effective work of learning teams. When it is necessary for students to be absent from a required activity, students must approach such absences with the same standard of professional responsibility required of practicing physicians. ~~All absences from pre-clerkship phase required activities, whether planned or unplanned. Students must report all absences from pre-clerkship required activities to the PLFSOM Department of Medical Education (see Sections 6.VI and 6.VII below).~~ are expected to be reported to the PLFSOM Department of Medical Education, and to be excused according to the criteria outlined below. An absence may be excused if it meets the criteria outlined below.

I. **Relation of absences to professionalism:** Unexcused absences from pre-clerkship phase required activities constitute a professionalism concern and are thus grounds for referral of the student to the GPC for review according to the criteria outlined below (see also the PLFSOM Policy on Grading, Promotion, and Academic Standing) – see also Section 6.VIII, below).

II. **Absences and academic responsibility:** Under no circumstances does an absence, or tardiness, relieve a student of meeting all assigned academic requirements. Regardless of the cause or status of an absence, students are responsible for the content, work, and academic performance standards associated with all missed activities. Students are also expected to meet any participation requirements and, for group/team-based activities, to equitably contribute to their group's learning (even in relation to missed activities). See section XII (Responsibility for make-up work).

~~III.~~ **General school and faculty responsibilities related to this policy:**

~~The school and its faculty~~ Pre-clerkship faculty and Department of Medical Education staff are accountable for:

- Notifying students of their assigned activities via the school's curriculum management systems or by the student's official TTUHSC e-mail account
- Monitoring attendance for all required activities
- Notifying students of attendance concerns
- Establishing clear expectations for students regarding the timely completion of graded activities, critical summative assessments, and the scheduling of make-up activities/assessments when indicated as outlined below
- Acting fairly and in good faith under this policy

~~IV.~~ **General student responsibilities related to this policy:**

Students are accountable for:

- Maintaining awareness of course policies related to attendance and participation. It is the student's professional responsibility to review the absence policy and specific attendance requirements for all assigned courses and activities.
- Accurately managing their schedules to ensure on-time preparation, attendance, and participation in assigned activities.
- Accurately confirming their attendance as and when required (misrepresentations of attendance, for oneself or others, is considered a professionalism concern for

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which a student may be referred to the GPC for academic review).

- Communicating professionally about absences according to the systems established and disseminated by the Department of Medical Education.
- All absences involving required activities (including all graded activities and all critical summative assessments) should be reported via the online absence management



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system (or alternative system, when indicated and disseminated by the Department of Medical Education) regardless of whether the student presumes the absence will be excused or not.

- Seeking the school's assistance ([College mentors, OSA, the Office of Accessibility Services](#)), ~~if~~ [if reoccurring](#) personal circumstances interfere with their on- time attendance and participation.
- Accepting that faculty and school decisions under this policy shall be based on the specific relevant circumstances. Because of this, decisions rendered in any specific situation shall not be considered as establishing generally applicable precedents.

**III-V. Planned absences:** A planned absence from a pre-clerkship phase required activity must be reported a minimum of two weeks in advance (unless deemed unavoidable by the assistant dean for medical education (pre-clerkship phase) [or their designee](#); ~~Non-~~ [Non-](#)compliance ~~shall-will~~ result in the absence being counted as unplanned). The student will notify the Department of Medical Education via the online absence management system (or alternative system, when indicated and disseminated by the Department of Medical Education). Planned absences must be pre- approved by the assistant dean for medical education (pre-clerkship phase) or their designee. Requests (sent to [plfabscence@ttuhsc.edu](mailto:plfabscence@ttuhsc.edu)) should be based on compelling circumstances such as:

- Routine/non-acute medical and dental appointments
- Discretionary legal proceedings/consultations or other appointments for necessary professional services
- Essential personal/family events (weddings, graduations, etc.)
- Religious obligation/observance
- Scheduled conference presentations/unique programs/school-requested tasks

Requests deemed insufficient or excessive shall be denied – subject only to appeal to the Assistant Dean for Medical Education (or the ~~theirdean's~~ [their designee](#)) within 5 business days of the student's notification of the denial. Appeals must be submitted in writing or via the student's TTUHSC e-mail account and copied to the assistant dean for medical education (pre-clerkship phase) [or their designee](#) ([plfabscence@ttuhsc.edu](mailto:plfabscence@ttuhsc.edu)). Student appeals of a denied absence request should include a detailed explanation of the request and of the basis for the appeal.

If a student's absence request conflicts with a required activity that cannot be otherwise made-up or completed, the absence may adversely affect the student's grade or other performance assessments in the activity and its overlying course or requirement.

**IV-VI. Unplanned absences:** Unplanned absences should be reported to the PLFSOM Department of Medical Education via the online absence management system (or alternative system, when indicated and disseminated by the) as soon as the circumstances reasonably allow (typically within 24 hours). In situations not involving critical summative assessments (as designated by the overlying course or requirement syllabus), the criteria for excused unplanned absences include:

- Acute illness (documentation of a directly related physician encounter is required for absences of three or more days)
- Participation in legal proceedings (with documentation)

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- Serious illness or death of a family member (documentation may be required for multiple absences or absences of three or more days)

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- Other personal transportation related events (with documentation) or family emergency (with documentation)

In situations involving critical summative assessments (as designated by the overlying course or requirement syllabus), the above criteria still apply, but documentation is required in all cases (specifically including documentation of a directly related physician visit on the day of or before the absence).

**VII. Total unplanned/planned absences regardless of cause:** For the reasons outlined in Section 6.I above, there is a general expectation of consistent attendance and engagement in all required and optional sessions. As such, students are required to learn and understand how to apply the information provided in optional and required sessions.

- If a student accrues six excused absences during an academic year, their attendance record will be reviewed by their College Mentor.
- Students will meet with the College Mentor to:
  - 1. Review this policy.
  - 2. Review the nature (types and pattern) of the student's absences.
  - 3. Discuss corrective measures, available assistance, and support services as appropriate.
  - 4. Create and submit a formal plan (written or electronic) signed off by the student and college mentor(s). Plans may include expected modifications to the student's behavior; intention to utilize medical, social, psychological, financial, or other support services; or anything else deemed reasonable by the college mentor(s).
- If a student accrues more than 12 excused absences during an academic year, their record will be reviewed by their College Mentor and the Associate Dean for Student Affairs (or designee).
- Students will meet with the College Mentor and Associate Dean for Student Affairs (or designee) to:
  - 1. Review this policy.
  - 2. Review the nature (types and pattern) of the student's absences.
  - 3. Discuss any related corrective measures, assistance, or support services the student may need to consider.
  - 4. Review the required Remediation Plan.
  - 5. Discuss an action plan for GPC.

Accruing 12 or more unexcused absences during an academic year is a professionalism concern that will be forwarded to the Grading and Promotions Committee for review of the student's fulfillment of educational program objectives and academic fitness for continued participation in the educational program.

- The Paul L. Foster School of Medicine recognizes the importance of physical and mental health, and any student requiring additional flexibility may request support accommodations through the Office of Accessibility Services at any time. Students are encouraged to discuss their concerns and any potential accommodations with the Office of Accessibility, college mentors and the Office of Student Affairs before reaching the threshold of excessive absences, so the situation can be managed proactively instead of reactively.

**Commented [HT4]:** This must be old paragraph. Unexcused absences are addressed below at 6 VIII.

**Commented [CJ5R4]:** Thank you, I removed it.

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**VIII. Unexcused absences:** All absences should be reported via the [online absence management](#) system (or alternative system, when indicated and disseminated by the Department of Medical Education) regardless of whether the student presumes the absence will be excused or not.

- As per Sections 1 and 6.I above, unexcused absences from pre-clerkship phase required activities constitute a professionalism concern and are thus grounds for referral of the student to the GPC according to the criteria outlined below (see also the PLFSOM Policy on Grading, Promotion, and Academic Standing).
- Referral of a student to the GPC based on unexcused absences shall be made by the Associate Dean for Student Affairs (or their designee).
- [An unexcused absence from a required activity will result in reduced or no credit for that activity, depending on the specific course policy and the student's performance on any associated make-up assignments \(if permitted\).](#)
- [Alternatively, students may lose points toward their final grade due to unexcused absences, as outlined in the individual course syllabi.](#)
- [A Professionalism Concern Card will be issued for each unexcused absence.](#)
- [First unexcused absence: The student will meet with their College Mentor\(s\) and receive a Professionalism Concern Card.](#)
- [Second unexcused absence: The student will be referred to the Office of Student Affairs, meet with the Associate Dean for Student Affairs \(or designee\), and receive a Professionalism Concern Card.](#)
- [Third unexcused absence: The student will be referred to the GPC by the Associate Dean for Student Affairs \(or designee\), meet with their College Mentor\(s\) and the Associate Dean for Student Affairs \(or designee\), and receive a Professionalism Concern Card. The student will also be required to create and submit a formal plan \(written or electronic\) signed off by the student and college mentor\(s\). Plans may include expected modifications to the student's behavior; intention to utilize medical, social, psychological, financial, or other support services; or anything else deemed reasonable by the college mentor\(s\).](#)
- [An unexcused absence from a critical summative assessment may result in referral to the GPC for a professionalism concern. Referral in this circumstance will be at the discretion of the Associate Dean for Student Affairs \(or designee\). Referral of a student to the GPC based on unexcused absences shall be made by the associate dean for student affairs \(or their designee\). Unexcused absence from a required activity may result in reduced or no credit for the activity depending on the overlying course or requirement policy and the student's performance on any associated make-up assignments, if allowed. Alternatively, students may lose points toward their final grade due to unexcused absences as outlined in the individual course syllabi. A single unexcused absence from a critical summative assessment may result in referral of a student to the GPC based on a professionalism concern. Referral of a student to the GPC based on an unexcused absence from a critical summative assessment shall be at the discretion of the associate dean for student affairs \(or their designee\).](#)

**Total absences regardless of cause:** For the reasons outlined in Section 6.I above, there is a general expectation of consistent attendance and [engagement in all required and optional sessions in assigned activities regardless of the potential cause\(s\) of any particular absence or combination of absences \(see definition of absence in Section 5 above\).](#) [As such, students are required to learn and understand how to apply the information provided in optional and](#)

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required sessions.

If a student is absent more than 6 days per semester (including excused absences), it will be reviewed by the College Mentor and Associate Dean for Student Affairs. Students will meet with the College Mentor and Associate Dean for Student Affairs (or designee) to:

- 1. Review this policy.
- 2. Review the nature (types and pattern) of the student's absences.;
- 3. Discuss any related corrective measures, assistance, or support services the student may need to consider.
- 4. Explore options for mitigating the adverse academic consequences of their absences, including creating an Individual Learning Plan.

Excessive absences could be a violation of the Student Code of Conduct and may be forwarded to the Grading and Promotions Committee for review of the student's fulfillment of educational program objectives and academic fitness for continued participation in the educational program.

The Paul L. Foster School of Medicine recognizes the importance of physical and mental health, and any student requiring additional flexibility may request support accommodations through the Office of Student Affairs at any time. Students are encouraged to discuss their concerns and any potential accommodations with the Office of Student Affairs before reaching the threshold of excessive absences, so the situation can be managed proactively instead of reactively. As such, any student with 5 or more absences during an academic year, regardless of cause, shall be required to meet in person with the associate dean of student affairs (or their designee) to: 1. Review this policy; 2. Review the nature (types and pattern) of the student's absences; 3. Discuss any related corrective measures, assistance, or support services the student may need to consider; and 4. Explore options for mitigating the adverse academic consequences of their absenteeism. In addition, any student with 10 or more absences during an academic year, regardless of cause, shall be referred by the associate dean for student affairs to the GPC for review of the student's fulfillment of educational program objectives and academic fitness for continued participation in the educational program.

IX. **Appeal or Dispute Process:** Students may appeal a decision regarding the classification of an absence as excused or unexcused by submitting a written request for review to [plfabscence@ttuhsc.edu](mailto:plfabscence@ttuhsc.edu) within five (5) business days of notification. The appeal should clearly describe the circumstances, include relevant documentation, and explain why the absence should be reconsidered. Appeals may include cases where absences were marked unexcused due to factors beyond the student's control (e.g., system errors, lost emails, or documentation inadvertently sent to a course director or coordinator instead of through the required absence management system). Appeals will be reviewed by the Assistant Dean for Medical Education (Pre-Clerkship Phase) or designee to ensure due process and fairness.

**VI.X. Missed graded activities and critical summative assessments:**

- **Missed graded activities and critical summative assessments due to planned absences:** In requesting approval for a planned absence under Section 6.VI above, it is the student's responsibility to review their assigned activities during the proposed absence, and to list in their request any graded activities and critical summative assessments they will miss (failure to declare a graded activity and/or critical summative assessment may result in no credit, and no make-up opportunity, for the activity/assessment). Requests for planned absences may be denied solely on the basis of their interference with the student's timely participation in assigned graded activities and/or critical summative assessments. For an approved planned absence involving

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missed graded activities and/or critical summative.

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assessments, ~~the student must contact the relevant course or requirement director to arrange a make-up~~ it is the student's responsibility to contact the relevant course or requirement director to arrange for a make-up activity or assessment. Make-up activities or assessments shall, whenever possible, be scheduled at the discretion of the course director within 2 business days immediately before or 5 work days immediately after the approved absence. As also noted under Section 6.VI above, some required activities, including some graded activities, cannot be made-up or completed as intended (usually due to the team-based or experiential nature of the activity); ~~and~~ Under these circumstances, the absence may adversely affect the student's grade or other performance assessments in the activity and its ~~overlying-respective~~ course or requirement.

- **Missed graded activities and critical summative assessments due to unplanned absences:** For an unplanned absence involving missed graded activities and/or critical summative assessments, it is the student's responsibility to contact the relevant course or requirement director as soon as possible, and no later than 24 hours after returning, to arrange for a make-up activity or assessment. Make-up activities or assessments shall, whenever possible, be scheduled at the discretion of the course director within 5 business days immediately after the student's return. As also noted under Section VI above, some required activities, including some graded activities, cannot be made-up or completed as intended (usually due to the team-based or experiential nature of the activity); ~~and~~ Under these circumstances, the absence may adversely affect the student's grade or other performance assessments in the activity and its ~~overlying-respective~~ course or requirement.
- **Missed graded activities and critical summative assessments due to unexcused absences:** Missed graded activities or critical summative assessments due to unexcused absence will result in no credit for the activities or assessments (the student is then subject to the remediation policies of the overlying course or requirement).

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XI. **Tardiness:** Repetitive tardiness demonstrates that a student has consistent difficulty arriving at class on time. For designated time-sensitive activities—such as OSCEs Medical Skills, Team-Based Learning activities, Summative exams and Anatomy or Microbiology labs—late entry may not be permitted, and students arriving late will be marked absent. A complete list of sessions with strict attendance policies can be found in the -corresponding course or requirement syllabi.

- a. If a student is tardy to 6 or more of required sessions they attended within the academic year, the student shall be required to meet with one (or both) of their college mentor(s). The student and college mentor(s) shall review the causes of the student's tardiness, determine if there is a pattern, collaborate to devise a solution to help address the student's tardiness, and create and submit a formal plan (written or electronic) signed off by the student and college mentor(s). Plans may include expected modifications to the student's behavior; intention to utilize medical, social, psychological, financial, or other support services; or anything else deemed reasonable by the college mentor(s).
- a-b. If a student is tardy to 126 or more of the required sessions within the academic year, they shall be required to meet with the Dean of Student Affairs (or their designee) for individual counseling and to review the plan created by the student and their college mentor(s). If the Dean of Student Affairs (or their designee) determines that the student has made a reasonable effort (at the discretion of the Dean or their designee) to address concerns by following their individualized plan, the student may need to update their current plan or create a new plan with the Dean or their designee. If the Dean of Student Affairs (or their designee) determines at this time that the student has not made a reasonable effort (at the discretion of the Dean or their designee) to address concerns by

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~~following their individualized plan. The student may will be referred to the GPC, as this constitutes concerns with professionalism and meeting academic program requirements.~~

c. ~~Referral of a student to the GPC based on unexcused absences/tardies shall be made by the Associate Dean for Student Affairs (or their designee).~~

d. ~~Tardiness involving a critical summative assessment may result in reduced time allowed for completion of the assessment (students may be denied compensatory time), exclusion from the exam (and associated loss of credit for the exam), and/or diversion to an alternative testing location/station.~~

~~Repetitive tardiness is disruptive and constitutes a professionalism concern that may be cited in student assessments and reported to the associate dean for student affairs as a potential basis for individual counseling, and for processing in the context of other academic concerns as may arise. A student who accumulates 5 episodes of tardiness involving required activities in any semester is required to meet with the associate dean for student affairs (or their designee) for individual counseling (consistent with Section 6.IX above). Persistent repetitive tardiness, despite individual counseling by the associate dean for student affairs (or their designee), may result in referral of a student to the GPC based on a professionalism concern, and this is required for any student accumulating 10 or more episodes of tardiness involving required activities in any semester. Referral of a student to the GPC based on repetitive tardiness shall be made by the associate dean for student affairs (or their designee). Tardiness involving a critical summative assessment may result in reduced time allowed for completion of the assessment (students may be denied compensatory time), exclusion from the exam (and associated loss of credit for the exam), and/or diversion to an alternative testing location/station.~~

VI. **Responsibility for make-up work:** To meet the objectives of any missed activity, students should review relevant learning materials, participate in any linked formative assessments, practice quizzes, or posted discussion questions, and consult with their classmates regarding the specific content covered in the activity. For missed required activities, regardless of cause, students should contact the course director to determine if make-up work is required. Course directors (or their designees) may issue alternative assignments for students to complete when they are absent from a required activity, regardless of whether the absence is

**Commented [FM6]:** Just checking if your need this here? I believe it was covered above.

**Commented [CJ7R6]:** Yes, should read tardies instead of unexcused

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XII. excused or unexcused. Make-up work may be required even in situations where the student will not receive credit for a missed required activity based on the overlying course or requirement policy. Students must complete required make-up work by the faculty-assigned deadline, without reminders from the activity/course staff or faculty.

XIII. **Responsibility for the additional costs related to absences and tardiness:** In particular situations, unexcused absence from, or tardy attendance of, a required activity may result in a student being responsible for the additional costs incurred in making-up the activity (for example, the unbudgeted cost of providing a previously unplanned standardized patient).

VII.XIV. **Evaluation and Continuous Improvement:** ~~This policy will be reviewed in odd-numbered years by the Curriculum and Educational Policy Committee (CEPC). Updates will be based on This policy will be reviewed every odd-numbered year by the Curriculum Committee and updated based on student academic outcomes (e.g., unit exam, CEYE, and Step 1 performance), student and faculty. This policy will be reviewed every three years in odd-numbered years by the Curriculum and Educational Policy Committee (CEPC). Updates will be based on satisfaction surveys, presence/engagement analytics, and student feedback and learning outcomes. Students and faculty will be invited to provide structured feedback at the end of each semester.~~

This policy does not apply to Leave of Absence situations. Please refer to HSCEP OP 77.05, "Student Leaves of Absence and Suspensions," for information regarding Leaves of Absence. This policy does not apply to Leave of Absence situations. Please refer to HSCEP OP 77.05, "Student Leaves of Absence and Suspensions," for more information

**Commented [FM8]:** Our policy on policies is every 3 years. I would keep this section simple and straightforward. Centrally, we don't ask for feedback on policies after each semester so would leave this out.

**Commented [CJ9R8]:** Agree with this.

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**Commented [HT10]:** Can this be added somewhere in this policy?

**Commented [HT11]:** Would it be possible to include this statement somewhere in the policy?

**Commented [CJ12R11]:** Yes, how about under "Policy statement" section?



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# DAYLE ALONSO, M.D.

Phone: (786) 447-8347  
Email: Daylealonso84@gmail.com

11166 Ebb Tide Drive  
El Paso, TX 79936

## MEDICAL EDUCATION

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|                                                                                                                                                 |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| <b>Psychiatry Residency</b><br><i>Texas Tech University Health Sciences Center   Transmountain Campus<br/>El Paso, TX.</i>                      | <b>07/2021-06/2025</b>  |
| <b>Doctor of Medicine</b><br><i>Technological Institute of Santo Domingo.<br/>Santo Domingo, Dominican Republic.<br/>Graduated with Honors.</i> | <b>08/2010-04 /2015</b> |
| <i>Medical Sciences University<br/>Ciego de Avila, Ciego de Avila, Cuba.<br/>Not Graduated – Interrupted</i>                                    | <b>09/2002-06/2008</b>  |

## WORK EXPERIENCE

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|                                                                                         |                   |
|-----------------------------------------------------------------------------------------|-------------------|
| Psychiatry Instructor   Texas Tech University Health Sciences<br>El Paso, TX            | 08/2025- Present  |
| Psychiatry Physician in Training   Texas Tech University Health Sciences<br>El Paso, TX | 07/2021-06/2025   |
| Medical Assistant   La Colonia Medical Center<br>Miami, Florida                         | 12/2018 – 05/2021 |
| Medical Assistant   Ritecare Medical Center (Urgent Care)<br>Hialeah, Florida           | 02/2018 – 12/2018 |
| Mental Health Technician   Citrus Health Network<br>Hialeah, Florida.                   | 01/2017 – 02/2018 |

## HONORS AND AWARDS

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|                                                                                                                                                                    |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>Resident Education Teaching Award</b><br>TTUHSC Department of Psychiatry. In gratitude for Teaching and Mentoring the<br>psychiatry Clerkship Medical Students. | <b>06/2022</b> |
| <b>Magna Cum Laude</b>                                                                                                                                             | <b>04/2015</b> |

## PROFESSIONAL ACCOMPLISHMENTS

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### **Academic Chief Psychiatry Resident**

**2024-2025**

- Assist educational committee with recruitment and scheduling presenters for didactics.
- Facilitate Research and scholarship activities for residents.
- Assist program director and clinic administration with coordinating residents and medical students rotating in psychiatry.
- Actively participate in planning wellness events and coordination for graduation.

### **Committee in Transmountain Grand Rounds (TIGER)- Representative**

**2024-2025**

Represented Psychiatry residents in monthly meetings to plan and implement mental health-related grand rounds.

### **Interviewer, Psychiatry Residency Admissions 2022-2023**

Evaluate candidates' goals, interests, and personalities that align with the program culture and interests, provide program information, and contribute to ranking decisions.

### **Interviewer, Psychiatry Residency Admissions 2023-2024**

Evaluate candidates' goals, interests and personality align with the program culture and interests, provide program information, and contribute to ranking decisions.

## PRESENTATIONS AND INVITED LECTURES

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### **Research Project: Quality Improvement in Emergency Detention Order in Primary Care.**

September 2023.

### **Community Presentation: "Suicide" EL Paso Electric Company**

May 2022

**Presentation:** Transmountain Hospital Grand Rounds "Emergency Detention Order in Primary Care" February 2024

**Presentation:** Second Binational Mental Health Conference. "Ciudad Juarez, Mexico." The neural underpinning of fear and worry: key drivers in anxiety disorders. August 22<sup>nd</sup>, 2024

### **Case presentations:**

"Psychosis secondary to Post herpetic encephalitis" Psychiatry Didactics. February-2022.

"Depression as an early manifestation of dementia" Psychiatry Didactics. June -2023.

### **Lectures:**

"Neurocognitive Disorders, Alzheimer, Vascular and Frontotemporal dementia" Psychiatry Didactics.

"Psychopathology Of Psychosis" Psychiatry Didactics

"Neurobiology and Psychopharmacology of Psychosis" Psychiatry Didactics

"Literature review- Medical Causes of Catatonia" Consultation Liaison Conference Series.

## PROFESSIONAL TRAINING AND CERTIFICATIONS

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ECFMG Certified

Healthcare Provider Advance and Basic Life Support (ACLS and BLS)

Psychopharmacology Master Program at Neuroscience Education Institute.

ECT certified by the International Society for ECT and Neurostimulation.

## PROFESSIONAL MEMBERSHIP

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American Psychiatric Association (APA)

American Neurology Association (ANA)

Texas Medical Association (TMA)

American Medical Association (AMA)

## COMMUNITY SERVICE

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**Compadres Therapy** | TTUHSC EP Days of Service 4/19/2024

- Painting outdoor furniture for the equine therapy stable located in New Mexico.

**Medical student** | Ciego de Avila, Cuba

- Home visits to screen for clinical Signs of Hemorrhagic Dengue - 07/2007- 12/2007
- Vaccinations Campaign for children 07/2007- 05-2008.

**Medical Student** | Municipio Peravia, Santo Domingo, Dominican Republic.

- Adolescent-targeted sexual education programs implemented within schools are designed to mitigate the risk of early pregnancies.

## LANGUAGES

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**English** – Advance

**Spanish**- Native

## REFERENCES

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**Peter Thompson, MD**

Psychiatry Department Chairman.

Texas Tech University Health Sciences Center 4800 Alberta, El Paso TX 79905.

Phone: 915-215-5850. Email: pm.thompson@ttuhsc.edu

**Liliana Monroy, M.D.**

Psychiatry Residency Training Associated Program Director. Texas Tech University Health Sciences Center | Transmountain Campus. El Paso TX 79911.

Phone: 915-215-8400. Email: [Liliana.Monroy-Tijerina@ttuhsc.edu](mailto:Liliana.Monroy-Tijerina@ttuhsc.edu)

**Kristine Glass, M.D.**

Psychiatry Department, Faculty. Texas Tech University Health Sciences Center 4800 Alberta, El Paso TX 79905.

Phone: 915-215 8400. Email: [Kristine.Glass@ttuhsc.edu](mailto:Kristine.Glass@ttuhsc.edu)

# I. LEE SWINNEY, JR.

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## EDUCATION

Creighton University Phoenix, Phoenix, AZ – Surgical Critical Care Fellowship, 2024-2025

Texas Tech University Health Sciences Center (TTUHSC) El Paso, El Paso, TX - General Surgery Residency, 2019-2024

Paul L. Foster School of Medicine (PLFSOM), El Paso, TX - Allopathic Medicine, 2015-2019, MD

Georgetown University, Washington, D.C. - Physiology and Biophysics, 2014-2015, MS

American University, Washington, D.C. - Post baccalaureate Premedical Program, 2011-2013

United States Naval War College, Newport, RI- National Security and Strategic Studies, 2010, MA

Texas A&M University, College Station, Texas - Maritime Systems Engineering, 1995-1999, BS

## HONOURS AND AWARDS

**Texas Surgical Society Raleigh Ross scholar** 2024

**TTUHSC El Paso 7th Annual Learning Symposium Best Oral Presentation** 2017

*Expanding the Impact of Sports Physical Drives in Underserved Bordertown Communities, Author, Oral Presentation*

**TTUHSC El Paso 7th Annual Learning Symposium Best Poster Presentation** 2017

*Providing Preventative Women's Healthcare in Underserved Border Population, Author, Poster Presentation*

**PLFSOM 100-hour club – El Paso, Tx** 2017

Awarded to PLFSOM students who have achieved at least 100 hours of community service hours

## PUBLICATIONS

**Journal of the American College of Surgeons** 11, Nov 2024 2024

*Prehospital Resuscitation with Calcium after Trauma: A Prospective Review*

**Obesity Surgery** 30, Oct 2019 2019

*Trends in Drain Utilization in Bariatric Surgery: An Analysis of the MBSAQIP Database 2015–2017*

**Journal of Healthcare for the Poor and Underserved** 30, May 2019 2019

*Retrospective Analysis of Population Demographic Characteristics, Medical Interventions, and Resource Use at a Medical Student-Run Clinic on the Texas-Mexico Border*

**Surgery for Obesity and Related Diseases** 14.11, Nov 2018 2018

*Where are sleeves performed? An analysis of inpatient versus outpatient databases in a large state*

**Journal of Student-Run Clinics** v. 4, n. 1, May 2018. 2018

*Providing Women's Cancer Screening and Education in an Underserved Border Population*

## PRESENTATIONS

**Latino Surgical Society Joint Meeting** 2025

*Crossing Lines: How The Expiration Of Title 42 Changed The Injury Landscape At The Us-Mexico Border.*

**2025 Southwestern Surgical Congress Annual Meeting Quick Shot presentation** 2025

*Crossing Lines: How The Expiration Of Title 42 Changed The Injury Landscape At The Us-Mexico Border.*

**2024 ACS Clinical Congress Quick Shot presentation** 2024

*Prehospital Resuscitation with Calcium after Trauma: A Prospective Review*

**2024 Annual Meeting – ACS Florida Chapter** 2024

*Complete Resection of a Large & Dangerously Positioned Retroperitoneal Liposarcoma: A Case Report, Author, Poster Presentation*

**Texas Surgeons Summit** 2021

*Incidence of Appendicitis During the COVID Pandemic*

**TTUHSC El Paso 7th Annual Learning Symposium** 2017

*Expanding the Impact of Sports Physical Drives in Underserved Bordertown Communities, Author, Oral Presentation*

**TTUHSC El Paso 7th Annual Learning Symposium** 2017

*Providing Preventative Women's Healthcare in Underserved Border Population, Author, Poster Presentation*

**TTUHSC El Paso 6th Cultural Competency Conference** 2017

*Expanding the Impact of Sports Physical Drives in Underserved Bordertown Communities, Author, Poster Presentation*

**TTUHSC El Paso 6th Cultural Competency Conference** 2017

*Providing Preventative Women's Healthcare in Underserved Border Population, Author, Poster Presentation*

**Society of Student Run Free Clinics Annual Conference – Anaheim, CA** 2017

*Expanding the Impact of Sports Physical Drives in Underserved Bordertown Communities, Author, Poster Presentation*  
**Society of Student Run Free Clinics Annual Conference – Anaheim, CA** 2017  
*Providing Preventative Women's Healthcare in Underserved Border Population, Author, Poster Presentation*

## RESEARCH EXPERIENCE

**Texas Tech University Health Sciences Center (TTUHSC) El Paso – El Paso, TX** 2016  
**The effects of cyclic mechanical stretch on interleukin-6 (IL-6) release in human proximal tubule (HK-2) cells**  
Bench research involving the cultivation of cell lines and performing mechanical stretch testing and harvesting cell lysates.  
**TTUHSC El Paso – El Paso, TX** 2016-2017  
**Chart review of Medical Student Run Clinic (MSRC) patients**  
Data collection and manuscript writing for publication of IRB approved study.

## VOLUNTEER EXPERIENCE

**Medical Student Run Clinic (MSRC) - 2016 - 2017**  
**Laboratory Services Director** 2016-2017  
Operated a CLIA waived medical laboratory. Performed phlebotomy and all laboratory tests needed for the patients. Additionally conducted the training and standardization of all new laboratory personnel.  
**Logistics and Supplies Director** 2016-2017  
Ensured the upkeep of the clinic building, ordering of supplies, and appropriate use of all supplies.  
**American Heart Association Basic Life Support Instructor** 2015-2019  
Part a cadre of instructors responsible for initial and recertification classes at TTUHSC El Paso. Certification courses involve both lecture and hands on practice and evaluation.  
**Arundel Volunteer Fire Department - Emergency Medical Technician and Firefighter** 2013-2015  
Licensed Maryland State Emergency Medical Technician who provided care to patients in an emergency setting. Responds to 911 dispatch calls to provide immediate life saving interventions and transport to appropriate medical facilities. Responded to 911 emergency dispatches to emergent fire environments providing fire suppression and salvage/recovery operations. In addition to fire response, worked as a part of a team to: assist victims of motor vehicle collisions, evaluate suspected and actual gas leaks, and measurement of carbon monoxide levels. These efforts achieve the goal of minimizing threats to life and property.

## WORK EXPERIENCE

**Texas Tech University Health Sciences Center El Paso – 2025 – Present**  
**Assistant Professor of Surgery** 2025-Present  
Surgical ICU, Trauma, Burn, and Acute Care Surgery Attending Physician  
Associate Critical Care director, serving on UMC Code Blue subcommittee and Patient Blood Management Committee  
**UNITED STATES NAVY — 1999-2014**  
**US Naval Academy - Science, Technology, Engineering, and Math (STEM) Instructor** 2013-2014  
Developed training of K-12 faculty from around the country in techniques of project-based learning (PBL). PBL is designed to make STEM subjects inviting and approachable to underserved youth populations. Additionally, developed new curriculum expanding the scope of subjects being presented, allowing for presentation of a greater variety of STEM disciplines.  
**Plans Officer (US Cyber Command)** 2010-2013  
Developed long range strategic planning on a diverse team of senior military staff professionals. Planning focused on developing partnerships with the United Kingdom, Canada, Australia, and New Zealand. Engaged with foreign dignitaries to ensure desired goals were met.  
**Professional Education (US Naval War College)** 2009-2010  
Completed ten-month Master of Arts program at the United States Naval War College earning a master's degree in National Security and Strategic Studies.  
**Assistant Director (US Naval Forces Central Command)** 2008-2009  
Managed and led a diverse group of 12 subordinates in current and future operations. Successfully developed and managed sensitive information programs. Led the development of eleven separate strategic plans. Performance as only deployed member of division ensured successful major command exercise.  
**Flight Instructor (Training Squadron 22)** 2005-2008  
Conducted the development and training of multinational and multiservice students as future Naval Aviators. Coordinated and scheduled daily events involving over 90 students, 50 instructors and 45 aircraft. Crew resource management instructor conducting and developed teamwork skills for entire squadron. As operations duty officer, was responsible for the safe execution of a multi-squadron flight and simulator schedule. As standardization pilot, responsible for training new instructors on the techniques and procedures of advanced flight training.

**Naval Aviator/Assistant Operations Officer (Electronic Attack Squadron 133)** **2004-2005**  
Planned and executed operations involving four combat aircraft and 200 personnel. Readiness of squadron was ensured through development training plans that maximized use of resources while minimizing time required. Combat aviator who planned and executed 100 combat missions in support of OPERATION ENDURING FREEDOM in Afghanistan.

**Naval Aviator/Maintenance Division Officer (Electronic Attack Squadron 133)** **2002-2004**  
Ensured resource availability by leading five work centers and 55 enlisted personnel in the maintenance of four aircraft.

**Student Naval Aviator** **1999-2002**  
Completed rigorous training program earning Naval Aviator designation and becoming carrier qualified pilot.

## **TEACHING EXPERIENCE**

**CPR instructor** **2016-2019**  
Instructed medical students in BLS

**Medical student trauma simulations** **2020-2024**  
Responsible for the administration, grading and feedback to 3<sup>rd</sup> medical students on their surgery rotation. Additionally responsible for administering trauma simulations with 4<sup>th</sup> year medical students during their bootcamp for upcoming intern year.

**Surgical Anatomy Elective** **2024**  
Prepared pre and post dissection knowledge assessments for 4<sup>th</sup> year medical students. Led them through Open splenectomy.

**ATLS Instructor** **2020-Present**  
Taught and evaluated students undergoing initial and recertification in Advanced Trauma Life Support

## **CERTIFICATIONS**

American Board of Surgery – Board Certified  
American Burn Association - ABLS  
American College of Surgeons - ATLS instructor  
American Medical Certification – ACLS  
American Medical Certification – BLS  
DaVinci Xi – Certification

# AY 2025-26 CEPC Overview

10/13/2025

Maureen Francis, MD, MS-HPed, MACP

# Calendar Overview

- Fall 2025
  - November
    - Annual Report Pre-clerkship Phase
    - Year 1 & 2/Pre-clerkship Committee report
      - Key initiatives
      - Progress report & CQI efforts
  - December
    - Annual report Clerkship Phase
    - Year 3 & 4/Clerkship Committee report
      - Key initiatives
      - Progress report & CQI wfforts

# Calendar Overview

- Spring
  - Clerkship phase review
    - January – review process and rubrics
    - February to May – Team presentations
    - June – wrap-up and action plans
  - January
    - Review new elective proposals
    - Evaluation Committee Report
    - Leadership Advisory Group report
    - Student CEPC representative report
  - April
    - Common clerkship policies and clerkship syllabus review
  - May
    - Pre-clerkship updates and syllabus review

# Ongoing

- Policy updates
- Reports regarding LCME
- Strategic planning
  - Closing our 2021-2026 plan
  - Working on 2027 to 2031 plan



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## Medical Education Program Policy

|                               |                                                    |                                   |                                                                                   |                            |              |
|-------------------------------|----------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------|----------------------------|--------------|
| <b>Policy Name:</b>           | <b>The Common Clerkship Policies</b>               |                                   |                                                                                   |                            |              |
| <b>Policy Domain:</b>         | Clerkship Administration                           | <b>Refers to LCME Element(s):</b> | 6.1, 6.2, 8.8                                                                     |                            |              |
| <b>Approval Authority:</b>    | Curriculum and Educational Policy Committee        | <b>Adopted:</b>                   | 7/11/2016                                                                         | <b>Date Last Reviewed:</b> | October 2025 |
| <b>Responsible Executive:</b> | Assist. Dean for Med. Ed. for Clinical Instruction | <b>Date Last Revised:</b>         | September 2022                                                                    |                            |              |
| <b>Responsible Office:</b>    | Office of Medical Education                        | <b>Contact:</b>                   | Mirjana Babic, M.P.A.<br><a href="mailto:mbabic@ttuhsc.edu">mbabic@ttuhsc.edu</a> |                            |              |

1. **Policy Statement:** The common administrative requirements related to successful participation in the required clinical clerkships by students in years 3 and 4 are published annually in a document titled "[Common Clerkship Policies](#)".
2. **Reason for Policy:** The intention of this policy is to clarify the administrative practices and expectations associated with successful participation in the required clinical clerkships by students in years 3 and 4.
3. **Who Should Read this Policy:**
  - a. All clerkship directors, co-directors and coordinators.
4. **Resources:** The assistant dean for medical education for clinical instruction and the year 3-4 coordinators.
5. **Definitions:**
  - a. "Common": shared by all members of a group (in this case, the clerkships).
6. **The Policy:** The common administrative requirements related to successful participation in the required clinical clerkships by students in years 3 and 4 are published annually in a document titled "Common Clerkship Policies". **Students are also responsible for compliance with requirements that are specific to the individual clerkships as outlined in their syllabi.** As long as the changes are non-substantive and relate primarily to the updating of trivial year-specific information (personnel changes, dates, locations, etc. --as reviewed and approved by the assistant dean for medical education for clinical instruction), the Common Clerkship Policies may be re-published for each academic year without review and approval of the CEPC. Any substantive changes are to be presented to the CEPC for review and approval prior to the start of the affected academic year.

*Policies are subject to revision. Refer to the Office of Medical Education website or contact the Office of Medical Education to ensure that you are working with the current version.*