

MINUTES OF THE CURRICULUM PLANNING COMMITTEE

January 7, 2009

PRESENT: Georgia Blackwood, Kate Bowers, Craig Chiefetz, Mary Ellen Cleary, Linda Costanzo, Steve Crossman, Bob Diegelmann, Alan Dow, Doug Franzen, Frank Fulco, Margaret Grimes, Richard Krieg, Sahar Lotfi-Emran, Virginia Pallante, Vibin Roy, Jeanne Schlesinger, Ike Wood

ABSENT: Darryn Appleton, John Bigbee, Cindi Cornelissen, Susan DiGiovanni, Mark Kovacs, Julia Messina, David Reines, Evan Reiter, Russ Seneca, Crystal Shrestha.

The meeting was called to order at 3:05 p.m. by Ike Wood, Committee Chair. Minutes of the December 18, 2008 meeting were approved. Ike Wood informed the committee that there was no need to review the ground rules or the valued outcomes as members were already aware of these items.

Ike Wood presented a review of the homework material:

- Latest additions to LCME Accreditation Standards
- Competency-Based Medical Education: A Defense Against the Four Horsemen of the Medical Education Apocalypse
- Recommendations for Clinical Skills Curricula for Undergraduate Medical Education

Salient points from the readings were as follows:

LCME Accreditation Standards

- The curriculum committee, working in conjunction with the chief academic officer, should review the stated objectives of individual courses and clerkships, as well as methods of pedagogy and student evaluations, to assure congruence with institutional educational objectives.
- Student should be trained in information management skills.
- The curriculum must introduce students to the basic principals of clinical and translational research, including how such research is conducted, evaluated, explained to patients, and applied to patient care.
- The faculty should specify learning objectives (knowledge, skills, and attitudes) that will, at a minimum, equip graduates to understand the basic principles and ethics of clinical and translational research, and how such research is conducted, evaluated, and applied to the care of patients. There are several ways in which programs can meet the requirements of this standard. They range from separate required coursework in the subject, to the establishment of appropriate learning objectives and instructional activities within existing, patient-focused courses or clerkships.
- As part of their formal training, students should learn the importance of demonstrating the attributes (attitudes, behaviors, professional identity) of a professional and understand the balance of privileges and obligations that the public and the profession expect of a medical doctor.

- The school and its faculty, staff, students, and residents should regularly assess the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct, and develop appropriate strategies to enhance the positive and mitigate the negative influences.
- Medical schools should make available sufficient opportunities for medical students to participate in service-learning activities, and should encourage and support student participation.
- The objectives of the educational program must be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician.
- It is expected that medical schools will provide an appropriate number and variety of research opportunities to accommodate those students desiring to participate.
- The educational program must include instructional opportunities for active learning and independent study to foster the skills necessary for lifelong learning.

Competency Based Education

- Teaching patient shortages
 - Patients are sicker and discharged quicker. Fewer patients are available to students.
 - Patients in the outpatient setting have less time for being teaching patients.
 - The demand for teaching patients has increased due to preclinical exposure to students and increasing class size.
 - Students are competing with interns and residents to see patients.
 - The educational demands on students may not fully integrate them into the clinical team.
- Teacher shortages
 - Impact of the 80-hour workweek makes residents less available for teaching.
 - Need to improve clinical efficiency reduces teaching time for students.
 - Teaching often lacks a direct link to revenue.
 - Faculty who primarily teach may have lower salaries.
- Conflicting systems
 - Students generally do not contribute to efficiency or quality in patient care, and it is not clear whether they contribute to safety problems.
 - Educational demands on students make it difficult for them to be integrated into the health care team.
 - Information systems used in hospitals and clinics are built on computer platforms and software that are incompatible with educational platforms and software.
 - HIPAA may interfere with students' needs about teaching patients.
 - Teaching in an academic medical center operated decidedly in a nonprofit mode, whereas the clinical operation competes in a for-profit corporate health system. Teaching is considered non-profit.
 - The larger culture does not value teaching in the same way it does other parts of its professional structure.

- Teaching a task has a different skill set than executing it, and it is very time-consuming if done well, which often goes unappreciated.
- To be a teacher in this culture demands people who love to teach or have no other options.
- Financial problems
 - Tuition is rising faster than inflation. This may be impacting students going into primary care and contributes to depression, burnout and feeling of excessive burden among residents.
 - Reduced healthcare spending will affect medical education directly through the physicians with whom students apprentice in various clerkships, and indirectly through the Dean's tax on clinical revenue.
 - As clinical revenues decline, the funds earmarked for medical education from the Dean's tax will most likely diminish.
 - Reduction in resident support from Medicare may leave more for residents to do and less time to teach.
 - Less research funding may mean that money will be diverted from education.
 - Increase in number of medical schools and size dilutes state funding.
 - Federal grants for medical education are declining.
 - As medical schools increase their class sizes, they are likely to encounter a higher proportion of students needing accommodations, which is likely to create more financial stress.

Ike Wood asked the committee members to keep these points in mind as we review the entire curriculum and as we focused on the clinical component.

The committee broke out into three subgroups with Craig Cheifetz forming his own group on the INOVA campus. Each subgroup brainstormed about potential structures for the clinical phase of the curriculum. The subgroups then presented a cursory overview to the larger group:

Inova Version-Clinical Years

Assumption is that years one and two will now be completed in 18 months and the clinical experiences will begin by March of the second year.

Core clerkships in block and testing format:

Med/surg then testing= 16 weeks

Ob/peds then testing= 12 weeks

Psych/neuro then testing=10 weeks

Ambulatory care IM and FP=12 weeks

Career assessment and career decision experience block= #3 4 week blocks

Once the above is completed an 18 month period begins where students must one of the following career tracks: Each track will have the required components of a research project, an AI experience, a selective, and a business related course in their area.

Expert clinician track in a chosen field (med/surg/peds/neuro/ortho/anesth/rad etc.)
 Clinical research track
 Extra degree track
 International health track
 Primary care track

- All tracks will begin with a 12 week return to basic sciences for their selected track which would be an adult learning model and not necessarily lecture based.
- Three of the last 6 months are a three month AI experience in their chosen field.

Group 1 Version-Clinical Years

Our main idea is that the “M3” year should consist of core *clinical* experiences that are universal across all fields of medicine, analogous to the “foundations” portion of the preclinical curriculum. The core knowledge/skills/attitudes (KSA) would be determined by the current rotation coordinators with input from all clinical faculty. We could also use the content of the shelf exams to help develop an appropriate list of topics to cover. As a result, we could shorten the “M3” portion of the curriculum to allow students more time/flexibility to explore potential future career choices.

We envisioned a set of rotations through the core areas of medicine: Internal Medicine, Surgery, Psych, OB/GYN, pediatrics, and neurology. Each rotation would include an orientation period, which would have hands-on practice with simulators to re-emphasize the core clinical skills learned during the pre-clinical years. Each rotation would also include built in didactic sessions/CPC’s to cover core material and also to review relevant basic science in biochemistry, genetics, physiology, and pathology. For example, each Friday afternoon from 12-3pm, students on Medicine would have didactic sessions. The first is on reading EKG’s; the 2nd on interpreting blood gasses, etc. Each rotation would also have a “checklist” of clinical experiences/patient types/pathology to be completed during the rotation. This could be tracked via an “e-portfolio” or passport system. The medical societies could also be used as a forum to discuss/present cases seen during the rotations and to share experiences. The faculty members in each society could also help monitor student progress to make sure they are completing the requirements. Since we have talked about having senior students help in the student clinic, and most rotations incorporate an outpatient component, we talked about having students complete a rotation in the student clinic as part of the 3rd year.

The length of the curriculum would be determined by the topics to cover, but we think could be covered in 8-9 months. (see example diagram at the end of this document). At the end of the M3 period, all students would be tested for competency across the set of core K/S/A. This would possibly include the shelf exams, but also other methods of assessment – hands on skills via simulators, OSCE’s, etc.

During the M4 year, students would have a small set of requirements to complete. This would include an AI, critical care exposure, an EM rotation (“advanced core clinical

skills”). Students would also be required to remediate any areas in which they were deficient from the M3 section. Students would be given time to interview for residency, of course! Student could be divided into “career specific” tracks – with other requirements based on the specialty to which the student is applying. That is, a student interested in surgery might do 1-2 more surgery months, while a future pediatrician might do another month of pediatrics. We could perform a “needs assessment” to help develop the tracks by surveying residency directors and asking them to identify areas they feel incoming medical students need improvement. These other courses could be either mandatory or voluntary. A teaching requirement could also be developed, specific to each track. For example, a student interested in ENT would help teach the head/neck portion of anatomy; a student interested in internal medicine could co-lead preclinical small groups in renal, cardiovascular, pulmonary, or endocrine pathophysiology. Research/capstone projects could also be a part of each career track.

CORE CLINICAL SKILLS

Internal Medicine – 8 weeks

General Surgery – 4 weeks general, 4 weeks “Selective” (subspecialty vs. more general)

Pediatrics – 4 weeks

OB/GYN – 2-4 weeks

Psychiatry – 2-4 weeks

Neurology – 2-4 weeks

Student Clinic – 4 weeks

(All time frames are estimates and depend on list of “core skills” to be developed in each area)

ASSESSMENT

ADVANCED CLINICAL SKILLS / CAREER TRACK

Internist Track	Surgery Track	Radiology	Pathology
AI*	AI*	AI*	AI*
Teaching*	Teaching*	Teaching*	Teaching*
Interviews*	Interviews*	Interviews*	Interviews*
EM*	EM*	EM*	EM*
MRICU*	STICU*	Critical Care*	Pathology*
—————	—————	—————	—————
Cardiology	Trauma Surgery	Gen. Radiology	Research
Pulmonary	Anesthesia		

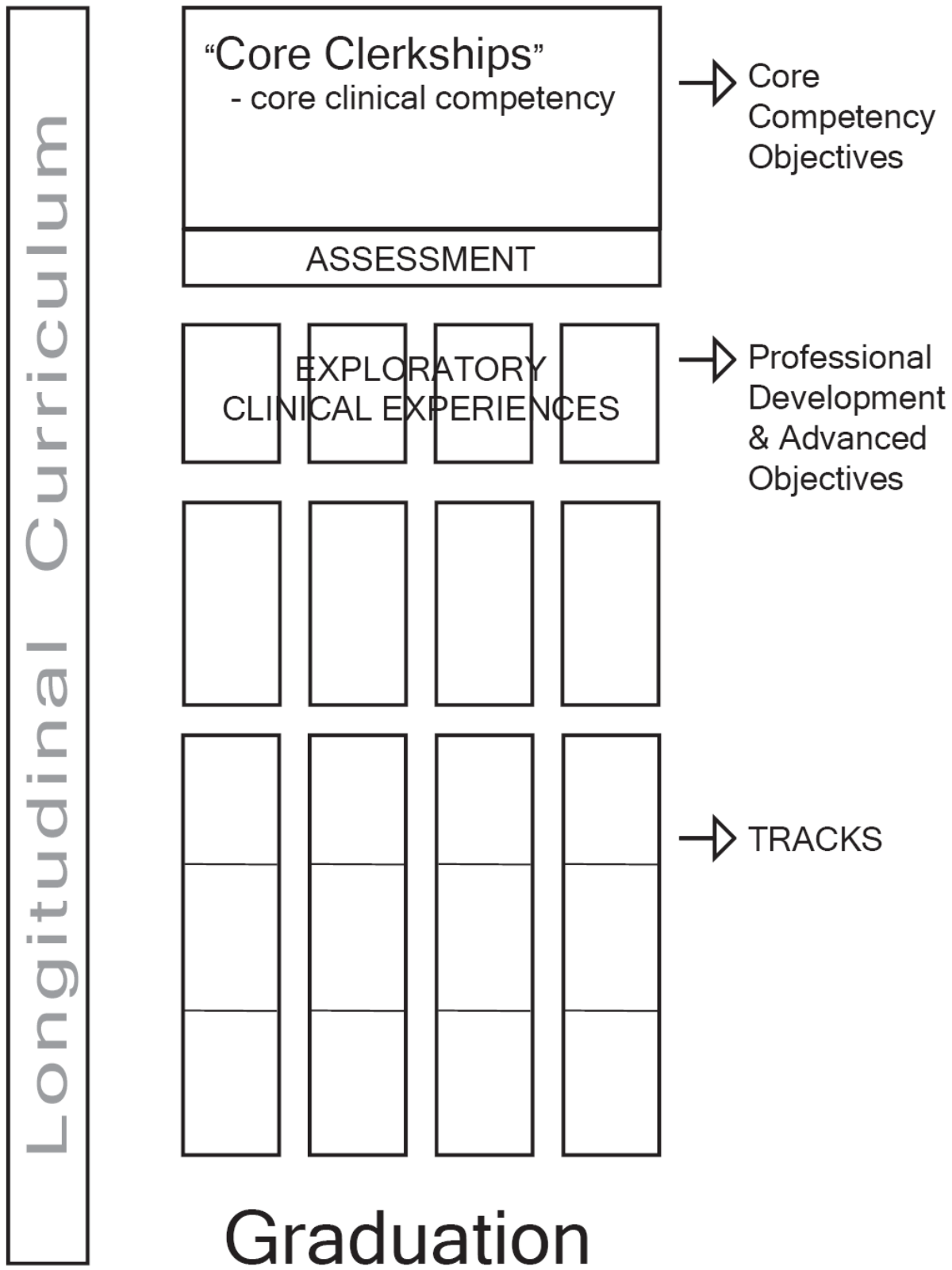
(These are offered as examples only. Items above the line would be required; items below the line would be optional but “strongly recommended” based on input from the residency directors’ needs assessment)

Group 2 Version-Clinical Years

Clinical Education Proposal

M2 March	Core Clinical Rotations	Inpatient Internal Medicine (4 weeks)	
		Outpatient Medicine -- IM or FM (4 weeks)	
		General Surgery (4 weeks)	
		OB/Gyn (4 weeks)	
		Pediatrics (4 weeks)	
	The Brain -- Integrated Psych/Neuro (6 weeks)		
M3 November	Comprehensive Core Clinical Skills Assessment -- Written Exam, OSCE, etc.		
	Remediation for weaker students		
M3 December	Select Interest Track, Meet Advisor, Begin Advanced Clinical Training		
	Advanced Clinical Training	Interest Track: primary care, procedural, etc	Key Block Components
		Mentoring	Early electives to explore fields of interest
		Capstone project selection and execution	Required inpatient Internal Medicine AI (4 weeks)
		Continuity experience with ongoing clinical skill assessment	Required surgical AI (4 weeks)
		Directed teaching experience	Required ambulatory experience (4 weeks)
		Scheduled vacation and board study time (up to 16 weeks)	
		Possible capstone project elective time (up to 4 weeks)	
		Other electives as selected with track mentor (up to 36 weeks of total elective time)	
Graduation			

Proposed Clinical Curriculum



Ike Wood suggested at the next meeting, the plans be represented in more detail. In the interim, it would be helpful if committee could review the plans for recurring themes, novel ideas, etc. so a consensus may be developed on the model which best fits the needs.

The meeting was adjourned at 4:45 p.m.

Respectfully submitted,
Ike Wood, M.D.
Committee Chair