VCU School of Medicine
Virginia Commonwealth University

EDUCATION STRATEGIC PLANNING GROUP RECOMMENDATIONS

On March 17, 2004 over 100 faculty, chairs, and students met for a day long retreat in the Medical Sciences Building. Many of those involved were experienced in the curriculum, but others were new to the process. Participants met in small groups in the morning and afternoon to discuss the following topics:

1. Protecting the SOM teaching mission in the face of increasing research/other teaching demands.
2. Protecting the SOM teaching mission in the face of increasing clinical demands.
3. Fostering professionalism, humanism, and cultural competency in our students.
4. Bridging the bench to bedside gap.
5. Incorporating a competency based curriculum into the M3 year that reflects SOM learning objectives.
6. Maximizing the educational content of the M4 year.
7. Incorporating new instructional technology into the education effort and how to best prepare our faculty.

Each group was charged with the following responsibilities:

1. List no more than five concrete measurable goals in their topic area.
2. Identify what resources would be required to meet those goals.
3. Identify strengths and weaknesses inherent in the goals.
4. Identify 10 faculty members who would serve on a committee tasked with developing a timeline and process for implementation of the goals.

For the past year the faculty leadership from the retreat have been meeting to refine the recommendations and develop plans for implementation. The group has been named the Education Strategic Planning Group. The original seven ideas were consolidated into five subcommittees. The following is a synopsis of the subcommittees' work and their recommendations.

M3 /M4 YEAR SUBCOMMITTEE

M3 YEAR DEVELOPMENT OF CLINICAL EDUCATIONAL INNOVATORS PROGRAM

The committee supports the development of a system for competency based learning and evaluation. The competencies should be compatible with the SOM objectives, FCM

course and the ACGME competencies. Each clerkship should develop its own competencies in a way that can be evaluated with measurable outcomes. Both formative and summative evaluations are necessary. The system should be Palm or web-based. Administration of this system would be done by the Clinical Educational Innovators (CEI) as part of a new Educational Program.

Faculty from the departments of each of the seven required clerkships (Internal Medicine, Surgery, Pediatrics, Obstetrics/Gynecology, Psychiatry, Neurology, and Family Medicine) would have the opportunity to apply to be a CEI. Applications would be considered by a committee consisting of the Senior Associate Dean for the Curriculum, the Associate Dean for Student Affairs, the Assistant Dean for Medical Education, the clerkship director for the applicant's department, the Associate Dean for Continuing Professional Development and Evaluation Studies, the Associate Dean for Faculty and Instructional Development, and a student representative, with final approval by the Dean. Candidates would be selected on the basis of demonstrated excellence in teaching, dedication to innovative clinical education, enthusiasm for serving as a role model and mentor, motivation to participate in faculty development sessions, and support of the applicant's department chair. The application process would take place during July, 2005, with interviews and selection of teaching faculty occurring in August, 2005.

CEIs would spend ½ day (4 hours) per week in small group teaching (Innovations sessions) with the M-3 students rotating through the clerkship in their department. It would be required that this teaching time be devoted solely to students, separate from any clinical responsibilities that might compete for the faculty members' time and attention. The faculty member would be compensated for his/her time. For all clerkships, the CEI:student ratio would be approximately 1:15, with opportunities for meeting with smaller subgroups of students. Since each student in Family Medicine is assigned to a different geographic site, the CEI for the Department of Family Medicine may have to schedule his/her teaching time during the first and last days of the rotation, with internet contact in between. Topics to be explored by teachers and students include:

1. The development and evaluation of competency-based clinical skills (including demonstration and practice of clinical procedures), that are compatible with the Foundations of Clinical Medicine Course, and the six ACGME competencies for graduate medical education
2. Patient-physician communication
3. Professionalism and ethical issues
4. Humanism and multi-culturalism
5. Critical review of the literature/evidence-based learning
6. The practical use of technology in clinical decision-making
7. Formative evaluations of students

The program would be administered by the Assistant Dean for Medical Education, the Senior Associate Dean, and the Curriculum Office. The CEIs would meet monthly as a group to:

1. Identify appropriate topics for Innovations sessions with students
2. Develop competency-based techniques to assess student abilities
3. Share educational innovations and materials
4. Review current literature on clinical teaching and evaluation methods
5. Disseminate successful methods to all SOM faculty
6. Explore sources for outside funding
7. Generate and develop ideas for publication in the medical education literature

At this time of transition for VCU SOM, when a new dean is being recruited with a substantial package to drive forward a program of basic science research, a visible commitment to the advancement of clinical teaching is of vital importance and will be welcomed by the SOM community. This group of skilled clinical educators could serve as the nucleus for further development of an Academy to support, reaffirm and further develop the educational mission at VCU SOM.

M3 YEAR SCHEDULE CHANGES

1. The M3 and M4 should be considered as a continuum.
2. Start the M3 clinical year one month earlier.
3. Spread out the required clerkships over 15 months, allowing for the potential of 3 months of electives.
4. On the Surgery clerkship students would be given expanded choices of subspecialties: Vascular surgery, ENT, Neurosurgery, Orthopedics, Plastic Surgery, Transplant surgery and Ophthalmology. There would be no requirement to place students on subspecialty rotations.

M4 YEAR

1. Establish an M4 Advisory Board whose members would be responsible for counseling students and approving elective schedules. This group would participate in faculty development sessions on career counseling. Membership would have representation from a range of clinical departments.*
2. Limit the number of AI's in any one department to two. Any student wishing to take more than two would have to seek advisor approval.*
3. Limit designated reading electives to one.*
4. Limit non-clinical months (research, independent study, reading, and board review) to four.*
5. Designate the Step 2 board review course as an elective (currently required). Students who did not pass Step 1 on the first taking, have two marginal grades during M1 and M2 and have any less than passing clerkship grade will be required to take the course.*
6. Require a one month emergent care selective to include ER, Anesthesia, MRICU, STICU, NICU, or the PICU.*

* approved by Curriculum Council January 2005

RESOURCES NEEDED

1. .10 FTE support for faculty advisors.
2. Funds to support faculty development.
3. Funds to support data collection, management, and analysis for evaluation.

PROFESSIONALISM, HUMANISM, CULTURAL COMPETENCY (PHCC) SUBCOMMITTEE

Longitudinal Curriculum Overview

1. At matriculation, the medical students would be divided into teams of 15 members
2. These teams will meet for every month for the M1 and M2 years. The teams might be regrouped in M2. For the M3 year teams will be assigned according to the regular M3 schedule groups and would meet at the end of each clerkship. M4 students would meet with their advisors twice a semester.
3. Each Team will be assigned a faculty mentor whose job will be to:
    a. Serve in an advisory capacity for all students on the team.
    b. Facilitate group process.
    c. Attend a faculty development retreat for group mentors each year.

M1 YEAR

1. Students would receive their professionalism cards from the School of Medicine Professionalism Committee chair at the White Coat Ceremony.
2. The M1 course directors would discuss as part of a yearly agenda professionalism issues related to student and faculty behavior. Examples of discussion topics would include lack of professionalism on the electronic bulletin board, which topics to cover in which courses, and how faculty should deal with unprofessional behavior by a student.
3. A lecture series for topics in PHCC would be developed. Potential topics could include "healing versus treating" and "The Compact with Tomorrow's Doctor."
4. There would be a ceremonial recitation and signing of "The Compact Between Teachers and Learners of Medicine."
5. Each student group would develop a community service project in the greater Richmond area based on a community needs assessment and the group's collective interest.
6. Each student group would meet monthly with their PHCC group leader. The initial meeting would include: defining the purpose of the community service project; identifying the elements of effective teamwork and the expected end product; describing how team members will be evaluated; and defining the role of the faculty mentor. Other meeting topics could include: analysis of group process; Myers-Briggs Type Indicator; promotion of health and self care; AAMC's Careers in Medicine Program; and a pre-matriculation reading assignment discussion, e.g., The Spirit Catches You and You Fall Down.

M2 YEAR

Student groups would continue to meet on a monthly basis but the group membership might be changed. Goals would be set for the M2 year. Topics for discussion may include expansion of topics covered during the M1 year. Other topics might include an analysis of how the team is working collaboratively and how decisions are made, what measurable goals have been set; what are the barriers and enhancers to collaborative work. As with the M1 groups, the meetings would allow a support network for determining the needs of individuals and the group as a whole, a deeper understanding of the formal and hidden curriculum and its impact on student behaviors, feelings and interactions.

M3 YEAR

1. There would be a ceremony at the beginning of the year acknowledging the increased responsibility and the importance of professional behavior in a humanistic and cultural competent manner.
2. Student groups will meet at the end of each clerkship or every two months. Topics will be centered on clinical issues and might include exploration of both positive and negative experiences and how they impact on the student's development as a physician. The cultural competency curriculum will be expanded. The concept of healing versus treating will be revisited. There will be an analysis of the development of benevolence or cynicism; discussion on how to foster altruistic humanistic care; how to avoid cynicism; countertransference issues to patients, supervisors, and staff; identification of situations that are potential triggers for cynical attitudes and behaviors. Other topics could include how students are taking care of themselves and each other, barriers to effective collaborative team functioning, and dealing with conflict on the team.

M4 YEAR

1. Students will be evaluated on professionalism on their electives as they are on the M3 clerkships.
2. Feedback from the mock Clinical Skills Assessment at EVMS will be reviewed for possible remediation.
3. M4 students will meet with their faculty mentor twice a semester to cover such topics as: exploration of career decisions; values clarification in the context of residency selection; clarification of the student's identity as a physician; review of the "Compact" pledges to see if objectives have been met and what have been the most influential factors.

FACULTY DEVELOPMENT

1. Formation of the Gold Humanism Society

    a. Presentation by members of the faculty who demonstrate the principles of humanism.
    b. Humanism award for the outstanding student, resident, and faculty and hospital staff.
2. AAMC Careers in Medicine exercises.
3. "Blitz" the faculty with information on humanism.
4. Faculty development on having a balance in life and dealing effectively with stress, and on being an effective mentor/advisor
5. Grand rounds within each clinical department on humanism, professionalism, and cultural competency.
6. Annual one day retreat for M1-M4 faculty mentors/advisors to:
    a. Review small group curriculum and resources
    b. Share successes and challenges
    c. Review role of mentor
    d. Encourage self-care

RESOURCES NEEDED

1. A faculty director of Student Humanism with 1.0 FTE support.
2. Recommend that the School of Medicine develop a Culturally and Linguistically Appropriate Services coordinator to develop a cultural competency curriculum and to ensure that students have adequate cultural competency skills, including knowledge in the use of interpreters.
3. The School of Medicine should recommend that the Vice President of Health Sciences coordinate cultural competency activities throughout the Medical Center so that resources will be available to all. This includes the development of a library.
4. In the SOM there should be a longitudinal curriculum to teach medical students, house staff, and faculty cultural competency and specific information regarding the cultural and ethnic groups most likely to be seen in medical practice in Richmond.
5. Longitudinal Courses should be available for different languages to support all students who want to work with those populations (e.g., Spanish, American Sign Language).
6. International students from all cultures should be able to obtain information on aspects of American culture.
7. Continuation of the Professionalism Committee with administrative financial support.
8. Faculty to serve as mentors to the student groups, 15 for M-1, 15 for M-2, 12 for M-3, and 12 for M-4.
9. Salary Support for faculty mentors.
10. Media related to humanism.
11. Evaluation of curriculum success by surveying students prior to beginning the new curriculum M-1 to M-4 and to continue yearly surveys to determine if the curriculum is achieving its purpose. Monitor the professionalism scores on the EVMS checklist provided with the M-2 FCM OSCE and the M-4 mock clinical

skills exam. Survey patients who have an ongoing relationship with the medical center routinely over a month's period of time. This may include Cystic Fibrosis, Asthma, Diabetes, or Hypertension clinic patients (to obtain a variety of ages). A particular class of medical students, residents, and faculty will be chosen. Patients, nursing, and other hospital staff will be surveyed before the start of the cultural competency curriculum, six months, one year, and two years after the institution of the curriculum. The cultural competency learners themselves will also be assessed for their level of cultural competency before, during, and after the course. Peers will also be surveyed for a 360-degree feedback.

12. Support efforts of the VCUHS in the development of resources to address CLAS issues.
13. To help promote PHCC resources that would be helpful could include Dr. Consuelo Navarro who teaches medical Spanish on the Monroe Park campus, the "Worlds Apart" video series for cultural competence education, and "What Language Does Your Patient Hurt In" by Suzanne Salimbene.
14. Funds to produce in-house cultural competency curriculum videos.

TECHNOLOGY SUBCOMMITTEE

1. Create a 'School of Medicine Information Technology Committee' with the following mission statement: **To advance higher education by promoting the efficient use of information technology in teaching and research.**
   The committee would:
   (a) Monitor and evaluate technology needs in teaching and research.
   (b) Organize and implement faculty training workshops and lectures.
   (c) Monitor changing needs in software requirements and communication compatibilities among University, Hospital and INOVA facilities.
2. Develop instruction and training in information technology and basic use of personal computers.
   (a) Implement an on-line assessment tool to identify individual faculty competencies in information technology.
   (b) Create a pro-active education program to deliver information technology training to faculty.
   (c) Establish a merit-based incentive program to encourage faculty information technology competency.
   (d) Identify core software programs for general faculty use and provide means by which these programs can be acquired at reduced cost.
3. Standardize information technology services and information.
   (a) Store School of Medicine and Hospital data on HIS or AT/AIT supported servers.
   (b) Evaluate technology personnel requirements on the MCV campus to ensure timely and continued monitoring of classroom hardware facilities.
   (c) Inform faculty of changes and updates to podium software and requirements.
   (d) Maintain a consistent level of desktop support to insure timely

installation of security software.
(e) Establish regular meetings among departmental information technology staff and with the School of Medicine Information Technology Committee.
4. Enhance video-conferencing and distance learning.
    (a) Provide faculty with training and incentives to produce media for the delivery of off-campus lectures.
    (b) Evaluate current phone line and/or internet options for delivery of lecture content to Inova Fairfax Hospital.
    (c) Create an additional, large-scale teleconferencing facility on VCU campus.
5. Maintain technology facilities and equipment.
    (a) Develop an emergency contingency plan for maintaining information technology and develop a list of contact personnel.
    (b) Establish a notification system to alert faculty of any planned building construction that might impact the delivery of information technology services.

RESOURCES NEEDED

1. Faculty development costs.
2. Core software programs for faculty.
3. Development of a desktop support team.
4. Development of a large-scale teleconferencing facility.
5. Funds to support data collection, management, and analysis for evaluation.

BENCH TO BEDSIDE SUBCOMMITTEE

1. Establish a journal club throughout the curriculum using evidence-based medicine as a foundation.
    a. M1/2 articles would provide clinical rationale for abstract basic science concepts.
    b. M3/4 articles would focus on EBM for common clinical practices.
    c. Class divided into groups of 15 based on FCM groups
    d. Meet monthly
    e. Course directors of concurrent courses would provide leadership/faculty
    f. Grades based on attendance (at least 75% for P); presentation of article necessary for HP/H grades.
2. Introduce a two week long course on Population Medicine between M2/M3 focusing on the design, implementation and interpretation of clinical trials.
3. Develop in-house or provide access to externally based interactive case-based self instruction modules.
4. Require all faculty who write more then 4 test items to participate in a formal faculty development workshop designed to improve item-writing skills.

RESOURCES NEEDED

1. Development of a new two week long course.
2. Case-based self instruction modules.
3. Faculty development workshop.
4. Funds to support data collection, management, and analysis for evaluation of impact on the curriculum.

PROTECTING THE SOM TEACHING MISSION IN THE FACE OF INCREASING CLINICAL AND RESEARCH DEMANDS SUBCOMMITTEE

While acknowledging that the different demands on basic science and clinical faculty, the clinical and research groups had similar themes in their recommendations for the SOM. These are summarized as follows:

1. Define the economic aspect of the problem with a comprehensive analysis of educational funding at VCU SOM in the contexts of national trends and VCU's clinical enterprise.
2. Encourage advanced planning for future teaching needs as a priority for administrators, particularly chairs.
3. Recognize and reward teaching effort. Create endowed professorships for teaching.
4. Develop measures for the productivity and quality of faculty teaching. Redefine teaching "excellence" as it pertains to Promotion and Tenure, and establish a minimum standard that would be uniformly applied.
5. Establish a formal SOM-based teaching institute that would offer opportunities for faculty development in teaching, and include formal mentoring, instruction, and advising for all new junior faculty by seasoned faculty.
6. Develop more efficient and effective models for basic science and clinical teaching maximizing the use of technology.
7. Organize clinical teaching around core competencies.
8. Encourage the institution to improve revenue streams to free up faculty for teaching and the development of teaching skills and materials.
9. Contract collateral faculty (full or part time) to handle some of the professional school teaching.

RESOURCES NEEDED

1. Establishment of a SOM Teaching Institute.
2. Creation of endowed professorships for teaching.
3. Contractual relationships with collateral faculty.
4. Funds to support data collection, management, and analysis for evaluation of impact on faculty.

SUMMARY

1. Develop a program of Clinical Educational Innovators to interact with students across the four years. Each CEI would work with a group of 15 students and facilitate discussion across a range of topics appropriate for the students' level of training.
2. Add flexibility to the M3 schedule.
3. Add structure to the M4 schedule and establish a new emergent care selective.
4. Foster professionalism, humanism, and cultural competency throughout the medical center.
5. Establish a community service project for M1 and M2 students.
6. Promote faculty development and standardization of information technology.
7. Develop a large-scale teleconferencing facility.
8. Establish a journal club throughout the curriculum focusing on EBM.
9. Emphasize education by developing measures for the productivity and quality of teaching, analyzing educational funding, and creating endowed professorships for teaching.
10. Establish a teaching institute in the SOM.