
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER

SCHOOL OF MEDICINE

Office of Curriculum

Year 3-4 Curriculum Summit

June 17 2005

Final Report

Prepared by:
Office of Curriculum
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Years 3-4 Curriculum Summit Report
June 17, 2005
Summary of Key Ideas -- Dr. Bickley

Group 6:

- This report is the most innovative and the most detailed. Suggest we start with this as a template and add in other ideas as below.
- Features gradation of clinical learning from standardized patient to real patients in ambulatory setting to in-patient clerkships; excellent suggestions for including patient perspective and for capstone; detailed suggestions re schedule.

Group 1:

- Passing exams seems to drive curricular decisions
- Need to develop listening skills early
- Teaching communities with some support in group for PM continuity clinic

Group 2:

- Skills labs: use telemedicine to teach core material across campuses
- Research-required case report
- Earlier introduction of clinical competencies
- 6 clerkships; 1PM per week for longitudinal ambulatory clinic experience-extends through Year 4 (3 hrs for patients; 1 hour for didactics or field/hospice/home care experience)
- Year 4: one month Residency prep; skills lab; capstone research experience; merit badges for competencies

Group 3:

- Emphasize H and P; differential diagnosis
- Need horizontal integration-teach topics in interdisciplinary fashion

Group 4:

- Establish core objectives for the whole year with consensus across specialties
- Pilot change on one campus first
- Students set their own objectives- yearly and daily!
- Combine continuity clinic with tutorials and ambulatory experience

Group 5:

- Reduce/eliminate residents as teachers; senior faculty need to be more involved with teaching, working with basic scientists
- Minicourses with merit badges such as ACLS
- Year 3-4 continuity clinics: "It is important to distinguish the need for continuity of the student-patient interaction rather than episodic contacts in a clinic that is continuous"
- Department- based long term clinics integrating subspecialties and long-term care
- AM-in-patient; PM Longitudinal clinic Mon-Tues—pair MSIII and MSIV; Dept based ambulatory clinic Wed-Thurs Friday
- Year 3: 6 rotations with option for clerkship blends
- Year 4: July-Dec-electives, away rotations; Jan-Apr required clerkships and capstone: Master Teachers close the loop

Group 1

Leader: Fred McCurdy, MD MBA
Ron Owens, MD, Amarillo
Steve Urban, MD, Amarillo
Christopher Powers, MD, El Paso

Gilbert Handal, MD, El Paso
Randy Schiffer, MD, Lubbock
Elmus Beale, PhD, Lubbock
Tamara Lane, MeD, Lubbock

Group 1 Morning Presentation Patient-Centered

What is patient-centered ?

- May mean many things
- Undefined for the moment

Longitudinal

- Community-based experience
- Community-based practitioners
- Assigned families

Dealing with patients without jargon

Seeing individual patient differences

Master teacher

Learner-Centered

Individualized student-based curriculum

Master teacher

3rd year ambulatory/4th year inpatient

Learning communities

Communication skills: interview ; writing

Evidence-based

Encourage life-long learning skills

Need Copernican Revolution

More focus on what's good for the student

Competency-based assessment

Feedback (360 degrees)

Group 1 Summary

Morning Session: The group facilitator began the morning session with establishing ground rules for how the discussion would proceed. He then posed two questions from the plenary: "If you were to redesign the third year curriculum, how would the redesign reflect an environment that was learner centered and patient centered". The group took each of these posed situations separately.

One of the first questions posed by one member of the group was "What does patient centered mean?" The group attempted to give descriptors, but at the end of the morning, this question was still not adequately answered to the satisfaction of the entire group – there was not group consensus on this point

The following points were delineated by the group:

Learner Centered	Patient Centered
Master Teachers are critical to making any of this work	Longitudinal –Patient over time
Medical school as a “liberal arts education” – broad exposure to a wide variety of topics to be explored in depth at the graduate level	All patient experiences
Ethics	Assigned to families – continuity clinics was offered as a learning model
Tailored learning experiences	OB example (e.g., student follows pregnant woman and after delivery follows both the mother and the infant)
Individualized student-based curriculum – radical departure from the current curriculum where all students study the same things at the same pace; this concept allows the student to study at his/her own pace based upon student needs rather than faculty needs	Community experience – exposure to community-based practice (e.g., continuity of care, caring for patients with chronic illness, caring for patients who are not chronically ill but have periodic visits to the doctor – example of well child care given)
Considerations for a more learner focus	Dealing with the person without jargon
Career choice – high variable and individual	Interview – how to interview effectively
Passing exams – something that everyone has to do, but this seems to “drive” curricular decisions	Examination (physical examination) – students (and faculty presumably) have lost the art/skill of the physical examination
3 rd Year ambulatory	Early exposure to patients
4 th Year inpatient	Develop listening skills early
Learning Communities	Bring in psycho-social aspects
Early Clinical Experience	Individual differences – different learning styles in particular
Master Teachers	Fitting plans to the patients’ circumstances
Communication skills must be emphasized	Use of master teachers was constantly emphasized throughout the AM

Other things needing emphasis

Evidence-based medicine

Research

Life-long learning skills

New assessment methods must be developed; will require much background work by experienced educators versed in assessment methods

Competency-based primarily

Feedback needs to be strongly encouraged and demanded of the faculty

Learning environment: More focus on what is good for the student; less focus on what is good for the faculty

Afternoon Session: The afternoon discussion was based on the eight themes that appeared to emerge from the AM reports of all the groups listed in the table below under the heading “Themes”. The deliberations of this group in the afternoon were much more difficult. There were members who seemed open to broad change. Others were either unwilling to allow for much change or were only willing to concede small changes with the remainder of the third year remaining largely unchanged except for equalizing the departmentally-based clerkships. Limited notes are available due to the nature of the discussion and are listed under “Special Student Clinic”.

Themes	Special Student Clinics
Longitudinal	Each discipline establishes objectives
Master Teacher	Controls over experience – Who controls the experience?
Faculty:Student relationship	How to think – problem solving
Developmental sequencing	Burden of illness
Interdisciplinary student conferences	• Depression
Year-long objectives	• hypertension
Eliminate redundancies	• etc
Common problems	
Integration of science in all experiences	

All of this resulted in the final report given to the larger group:

- Combined blocks (to be determined) utilizing teaching communities and interdisciplinary continuity clinics staffed with a faculty team along with interdisciplinary student conferences

Versus

- Accepting the clinical rotations block team report without change

Versus

A hybrid approach

- Blocks of instruction determined by the departments in the morning
- Continuity clinic in the afternoon

The group was unable to form a consensus on the exact nature of the change in the third year. There was no meaningful discussion of the 4th year.

Group 2

Leader: Rush Pierce, MD, Amarillo
 Gene Luckstead, MD, Amarillo
 Marita Sheehan, MD, Amarillo
 JoAnn Larsen, EdD, Lubbock

Pedro Serrato, MD, El Paso
 Mike Ragain, MD, Lubbock
 Harry Weitlauf, MD, Lubbock

Group 2 Morning Presentation

Major Issues

Student Continuity Clinic/ Patient panels for students

Pay teachers to teach/faculty development

Skills labs

Central (non-Departmental) coordination of curriculum; combined Departmental experience

Teach core material (including basic concepts of pathophysiology) in bigger groups using telemedicine technology (NOT HEALTH-LINK)

Other Issues

System based practice

Research - required case report

Introduction of clinical competency earlier

Delay career decision

Faculty teaching students directly

Group 2 Summary

The schedule for the third and fourth year proposed by this group retains the traditional six block clerkships in the third year. Each clerkship would be eight weeks long and psychiatry and neurology would be combined. Thus the six block clerkships would be family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry-neurology, and surgery. In addition to the block clerkships in the third year, each student would be released from their block rotation one afternoon per week for a longitudinal ambulatory clinic experience. This clinic would have a selected panel of patients for the student, would be staffed by dedicated faculty (in family medicine, internal medicine, and pediatrics), and would not involve residents.

The ambulatory clinic component would extend into the fourth year, so that an individual student would have a longitudinal clinic one afternoon a week for the entire third and fourth year. To accommodate all of the students, the clinic would be staffed four or five afternoons a week, but each student would attend only one afternoon each week. The faculty dedicated to this clinic would spend four or five afternoons on their time on this teaching activity. The longitudinal nature of the clinic would allow for mentoring of students by the faculty. Each afternoon would be structured so that three hours was spent seeing patients in the clinic, and one hour would be spent in didactic sessions related to ambulatory topics, or field trips to long-term care facilities, hospice, home health care agencies or other locations as determined by the faculty.

The fourth year would continue the longitudinal ambulatory clinic one afternoon per week. In addition, one month block rotations would be required in "Residency preparation" (a sub-internship), "skills lab" (to develop competence in procedures) and a "capstone research experience". Each student would be required to complete certain defined competencies before graduation, and some students would elect remedial activities to complete a "merit badge" system of completed competencies. In addition, fourth year students would select "electives" determined by their interests and advice from faculty advisors.

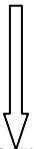
Group 3

Leader: Pete Davis, MD, El Paso
Steve Berk, MD, Amarillo
Gwynne Little, PhD, Lubbock
Antonio Jesurun, MD, El Paso

Terry McMahon, MD, Lubbock
Robert Bennett, MD, Odessa
Bo Brobst, Lubbock
James Van Hook, MD, Amarillo

Group 3 Morning Presentation

Pt Centered



Learner Centered

Product

Well trained to proceed to next step (liberal medical education)
Integrated learning making for a well rounded physician
Prepare to pass board and select specialty
Assure good clinical skill, PE, Hx, and DDX

Horizontal integration

Departments meet to discuss ways to teach specific topics

Reformers need to work with residency program directors

Dictating early decision making

Away electives

Research requirement

High pressure for above reasons

Group 3 Summary not provided

Group 4

Leader: Kathy Horn, MD, El Paso

Ron Hodges, MD, Amarillo

Rodney Young, MD, Amarillo

Richard Lampe, MD, Lubbock

Jeremy Deer, Lubbock

Barbara Pence, PhD, Lubbock

Kathleen Stanley, MD, Lubbock

Dannen Mannschreck, MD, Odessa

Michael Bourgeois, MD, Lubbock

Group 4 Morning Presentation

Learner Centered/ Student Centered

Pertinent to what they will be doing

Student clinics where education is priority

Separate resident from student learner

Include residents as teachers/educators

Faculty interaction!!! Amarillo Surgery

Self directed learning objectives

Competency based with evaluation

Independence and building confidence

Group 4 Summary

We had a lot of trouble getting away from the department centered model.

Dr. Mannschreck felt we should be more radical – per Clin Rotations Bloc Team Report Jan 2005

All agreed that a longitudinal component was important but seemed to want to “stick it on”

although the experience of one member when this was tried in his school was it was undervalued.

Talked about a longitudinal half day per student with the rest of the week dedicated to a dept based experience – inpatient & outpatient

Have trouble visualizing how a student could see a patient in primary setting and then follow to subspecialty like in the Cambridge model. Some of our thoughts were written at the bottom of our presentation sheet that was left on the wall in Lubbock.

We did not get to 4th year at all. Did agree Master Teachers were a good idea.

Liked idea of establishing objectives over the whole 3rd year – consensus building across

specialties. Some agreement for centrally run curriculum instead of dept but not a lot of in-depth discussion about this.

Future

Not too drastic! Student and faculty (some exceptions D.M.)
Pilot programs all campuses versus one campus
Continuity with tutorials
Longitudinal/ambulatory with overlap

Group 5

Leader: Gary Sutkin, MD, Lubbock
Dennis Dove, MD, Amarillo
Patty Crocker, MD, El Paso
Darryl Williams, MD, El Paso

Kitty McMahon, PhD. Lubbock
Jay Park, MD, Odessa
Manuel De La Rosa, MD, El Paso
Jan Pumphrey, Amarillo

Group 5 Morning Presentation

Long-term continuity, ambulatory experiences
Yr 3-4, chronic condition clinics, patient continuity
Combination of dept- & integrated-based

Group 5 Summary

Professor-student conferences

- No residents, student present case (in at least part of the curriculum there should be direct teaching activities of students by faculty)
- Professors = Master Clinical Teachers (all departments; these individuals should have major teaching responsibilities but not exclusive teaching responsibilities)
- Professors = basic scientists should be integrated into the curriculum in various settings including rounds, presentations, student advisement.
- Minicourses (ACLS, "Merit badge") These clinical courses can be used to incorporate other material such as cultural competence, ethics, etc

Long-term continuity, ambulatory experiences

- Yr 3-4, chronic condition clinics, patient continuity It is important to distinguish the need for continuity of the student-patient interaction rather than episodic contacts in a clinic that is continuous
- Combination of dept- & integrated-based The student should have a long-term integrated experience, but each department could use similar clinics to teach subspecialties or to demonstrate how long-term care is provided in that discipline

Learning Objectives, discipline-generated, reviewed by all to integrate(delete duplications of shared/common) – yearly objectives

Curriculum Planning

- Learning Objectives – Universal
- Strategy – Universal
- Details – Determined by each Campus

Afternoon Session Template

S	M	T	W	TH	F	S
AM	In-Patient					
PM	Longitudinal Clinic		Dept Based Ambulatory Clinic		Student Conference	X

YR 3

6 rotations (with an option for clerkship blends)

Each rotation is 8 weeks, including a combined Neuropsychiatry rotation

Optional 2 week subspecialty elective over vacation weeks

YR4

July – Dec: Electives, Away Rotations, and Sub-I

Jan-Apr: required clerkships and Capstone

Master Clinical Teachers close the loop

Longitudinal Clinic

Through third and fourth years

2X ½ d/wk clinic

½ d/wk conference

Possibly at an outlying clinic

Staffed by Master Clinical Teacher without resident involvement

Pair MS3 & MS4 together

Student responsible for coverage when he out of town (interviewing, for example)

Department-Based Ambulatory Clinic

2 X ½ d/wk clinic

Staffed by Master Clinical Teacher without resident involvement

Group 6

Leader: Chris Aronoff, MD, Lubbock
Frank Hromas, MD, Amarillo
Manuel Schydlower, MD, El Paso
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Robert Kimbrough, MD, Lubbock
Simon Williams, PhD, Lubbock
Kristin Stutz, Amarillo
Diane Schwartz, Amarillo

CONSTRUCTS

A. YEARS 3 and 4 – Kimbrough

Initially: ambulatory with standardized patients

Small group (5-7) led by a basic science and a clinical faculty; throughout the year

Evaluated by both the SP, the basic science faculty and the clinical faculty

Eventually between all three evaluator types, student is deemed prepared to see “real patients”
(this will occur at different rates)

Subsequent:

Real patients: deliberate assignment of students to patients in the ambulatory setting

Separate Student Clinic, NOT integrated within a particular department

Every AM or every PM, go to the continuity clinic

Other half-day, go to the specialty clinic; follow your patient when you refer them to a specialist
or for a procedure

OR M/W/Fri continuity clinic vs. Tues/Thurs. continuity clinic

Finally: Hospitalized patient experiences as PART of their ongoing ambulatory experiences

B. YEARS 3 and 4 – Williams

Continuation of early clinical experiences into the 3rd and 4th years

C. YEARS 3 and 4 – Schydlower/Kimbrough

Combination of clerkship blocs to 4 months with continuity within a bloc

Family/Surgery/Ortho

Internal Medicine/Psychiatry
Ob-Gyn/Pediatrics

OTHER CONSIDERATIONS TO INCLUDE WITHIN CONSTRUCTS

******Direct faculty physician supervision of students**

Deliberate teaching re: radiology; pathology as part of these experiences

Continuation of student portfolios

Process of their experiences throughout the medical school years

Bring in humanism elements

Web-based learning for patient experiences that are NOT available OR an S.P. experience

Capstone Experience

What should it consist of?

Group case presentation re: what have you learned from one particular patient – research project

VS. individual paper

Humanism: cultural; professionalism; ethics

Basic science concept

Clinical medicine

Current issues

Additional Skills

Review of basic skills that graduates need as interns

PALS, BLS, ACLS, ATLS

Medical jurisprudence

Medical Student Grand Rounds – weekly – disease entity known at beginning

Common complaints, not diseases

Patient perspective on their illness

Ethical issues

Multidisciplinary – MDs/PhDs

M&M conferences within departments

Top 10 most common disease entities OVERALL

Top 20 most common disease entities per subject area

Group 6 Summary

Important themes to include in the curriculum redesign:

Faculty as primary teachers

Interdisciplinary conferences including basic science professors and clinical professors.

1. Real patients to be included (This meets the patient centered goal)
2. Include patient's perspective on the disease
3. Cover basic science and clinical science
4. These conferences would center on the common medical diseases (TOP 20 diagnoses, or TOP 5-10 for each specialty)
5. Professional/Ethical issues can be covered

Include relevant radiology and pathology as part of daily teaching

Group educational sessions to teach PALS, BLS, ACLS, ATLS, Medical Jurisprudence

Capstone Experience

1. Individualized for the student
2. Should bring together the following elements of Medicine
 - i. Basic science
 - ii. Clinical medicine
 - iii. Humanistic elements
 - iv. Ethics
 - v. Place in the context of the society as a whole
3. Continuation of student portfolios

4. Gradual development of skills with corresponding accepting greater patient care responsibilities

CURRICULUM IDEA

The 3rd and fourth year would be combined. Students would begin the year in small groups (4-8) lead by a master clinical teacher. The students would first work with standardized patients representing the most common medical diseases seen in each specialty. Before graduating on to seeing real patients, students would need to successfully pass this part of their curriculum. Students would be evaluated by both the master clinical teacher and the standardized patient before moving on. This process may occur at different rates for each student; however, a deadline for remediation would need to be defined.

Students would then move into real continuity clinics staffed by a master clinical teacher. After approximately 9 months of a predominantly outpatient education, 6 month of inpatient medicine would occur.

There were several ideas on how the 9-12 months of out patient medicine would be constructed. These are listed below. Despite these differences it would be expected that the student follow their patients when they are admitted to the hospital and would participate in a surgery their patient might have.

REAL PATIENTS CLINIC

Students would be assigned either:

- 1) 5 days per week for two hour sessions – assigned to see 3 patients/two hours OR
- 2) 2 half days per week for four hour sessions

The students would be precepted by Master Teachers

Real patients could be assigned once the student has been evaluated/assessed to be ready by the standardized patient clinic OR could be integrated slowly into the standardized patient clinic concept.

	MON	TUES	WED	THURS	FRI
AM (2 hrs)	Didactics	Didactics	Didactics	Didactics	Didactics
AM (2 hrs)	Specialty Clinics; hospital medicine	Specialty Clinics; hospital medicine	Specialty Clinics; hospital medicine	Specialty clinics; hospital medicine	Specialty clinics; hospital medicine
PM (4 hours)	ER Preceptor: Students could be assigned to the ER to pick up patients to follow in their clinic	Ob/Gyn or Surgery preceptor: make attempt to schedule ob/gyn or surgical problems	Family or Internal Medicine preceptor – chronic disease management	Neuro-Psychiatry preceptor: make attempt to schedule neuro-psych problems	Pediatric preceptor: make attempt to schedule well child checkups; acute pediatric illnesses

- In the model above the student would have his/her clinic every afternoon; however the preceptor could vary by specialty. Patients would be scheduled based on problems into the clinic with the appropriate preceptor. Any other subspecialty appointments a patient might need would be scheduled during the am when the student could attend that appointment with the patient. Alternatively the student could go to various subspecialty clinics to experience those areas of medicine not covered in their continuity clinic.
- Didactics as part of the half-day

Problem-based; case-based
 Pathology-physiology
 Clinical recognition/management (bio-psycho-social model)
 Radiology round

- Could also have the concept of a team of faculty preceptors consisting of Internal Med/Pediatrics, Family Medicine/ER, Ob/Gyn-Surgery OR have a Family Medicine/Internal Medicine/Pediatrics preceptor assigned to be “on-call” for the faculty who precept a variety of problems

The other option considered would be to run a continuity clinic throughout the year while continuing the standard blocks or preferably combined 4 month blocks with 2 specialties integrating their curricula. (Block 1 FM/Surgery/Ortho; Block 2 IM/Psyc; Block 3 OB/PEDS)

	MON	TUES	WED	THURS	FRI
AM	Block rotation	Block rotation	Block rotation	Block rotation	Block rotation
PM	Student Clinic	Student Clinic	Block rotation	Block rotation	Block rotation

Students could be scheduled into an ongoing Student Ambulatory Clinic which would be precepted by master teachers THEN go back to their routine activities in their block rotation

Need to have ongoing small group experiences to process their learning of other aspects, e.g. professionalism, ethics, etc.

SCHEDULING OF AMBULATORY EXPERIENCES

Ongoing with predominantly ambulatory for the first 12 months of the Clinical Years and increase time in the hospital in the next 6 months of the curriculum.

HOSPITAL ROTATIONS – 6 MONTHS:

1 month Pediatrics floor – 2 weeks each PICU/NICU

1 month Medicine floor – 2 weeks each MICU/CCU

1 month Surgery floor – 4 weeks SICU

Students would still have continuity ambulatory clinics in the afternoons either daily OR 2 half-days per week