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
Gilbert Handal, MD, El Paso
Ron Owens, MD, Amarillo
Randy Schiffer, MD, Lubbock
Steve Urban, MD, Amarillo
Elmus Beale, PhD, Lubbock
Christopher Powers, MD, El Paso
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:

<table>
<thead>
<tr>
<th>Learner Centered</th>
<th>Patient Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master Teachers are critical to making any of this work</td>
<td>Longitudinal – Patient over time</td>
</tr>
<tr>
<td>Medical school as a “liberal arts education” – broad exposure to a wide variety of topics to be explored in depth at the graduate level</td>
<td>All patient experiences</td>
</tr>
<tr>
<td>Ethics</td>
<td>Assigned to families – continuity clinics was offered as a learning model</td>
</tr>
<tr>
<td>Tailored learning experiences</td>
<td>OB example (e.g., student follows pregnant woman and after delivery follows both the mother and the infant)</td>
</tr>
<tr>
<td>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</td>
<td>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)</td>
</tr>
<tr>
<td>Considerations for a more learner focus</td>
<td>Dealing with the person without jargon</td>
</tr>
<tr>
<td>Career choice – high variable and individual</td>
<td>Interview – how to interview effectively</td>
</tr>
<tr>
<td>Passing exams – something that everyone has to do, but this seems to “drive” curricular decisions</td>
<td>Examination (physical examination) – students (and faculty presumably) have lost the art/skill of the physical examination</td>
</tr>
<tr>
<td>3rd Year ambulatory</td>
<td>Early exposure to patients</td>
</tr>
<tr>
<td>4th Year inpatient</td>
<td>Develop listening skills early</td>
</tr>
<tr>
<td>Learning Communities</td>
<td>Bring in psycho-social aspects</td>
</tr>
<tr>
<td>Early Clinical Experience</td>
<td>Individual differences – different learning styles in particular</td>
</tr>
<tr>
<td>Master Teachers</td>
<td>Fitting plans to the patients’ circumstances</td>
</tr>
<tr>
<td>Communication skills must be emphasized</td>
<td>Use of master teachers was constantly emphasized throughout the AM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other things needing emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based medicine</td>
</tr>
<tr>
<td>Research</td>
</tr>
<tr>
<td>Life-long learning skills</td>
</tr>
<tr>
<td>New assessment methods must be developed; will require much background work by experienced educators versed in assessment methods</td>
</tr>
<tr>
<td>Competency-based primarily</td>
</tr>
<tr>
<td>Feedback needs to be strongly encouraged and demanded of the faculty</td>
</tr>
<tr>
<td>Learning environment: More focus on what is good for the student; less focus on what is good for the faculty</td>
</tr>
</tbody>
</table>

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”.

3

11/1/2005
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 blacks (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  
Pedro Serrato, MD, El Paso  
Gene Luckstead, MD, Amarillo  
Mike Ragain, MD, Lubbock  
Marita Sheehan, MD, Amarillo  
Harry Weitlauf, MD, Lubbock  
JoAnn Larsen, EdD, 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

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>In-Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM</td>
<td>Longitudinal Clinic</td>
<td>Dept Based Ambulatory Clinic</td>
<td>Student Conference</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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 1/2 d/wk clinic
  1/2 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 1/2 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
Fiona Prabhu, MD, Lubbock
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 outpatient 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.

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

- In the model above the student would have his/her clinic every afternoon; hover 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 curriculi. (Block 1 FM/Surgery/Ortho; Block 2 IM/Psyc; Block 3 OB/PEDS)

<table>
<thead>
<tr>
<th></th>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Block rotation</td>
<td>Block rotation</td>
<td>Block rotation</td>
<td>Block rotation</td>
<td>Block rotation</td>
</tr>
<tr>
<td>PM</td>
<td>Student Clinic</td>
<td>Student Clinic</td>
<td>Block rotation</td>
<td>Block rotation</td>
<td>Block rotation</td>
</tr>
</tbody>
</table>

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