patients’ ethnic, cultural, and racial backgrounds, since most clerkships are taken in rural sites in NH and VT. The second concern is somewhat related, and that is exposure to an inadequate number of patients who have medical problems usually more closely related to “urban medicine”—HIV, complications of substance abuse, sickle cell disease and other diseases more commonly seen in African American patients, trauma related to stabbings and gunshot wounds, etc. The third concern relates to the difficulty that students have experienced making career decisions early in Year 4, when they have not had the chance to take any electives in Year 3 (without delaying a major clerkship into Year 4). During 2008, after more than 3 years of planning, we have taken specific steps to address all three of these concerns, which are beginning to work very well.

Another major concern, not as well perceived by the students, is the increasing difficulty the School has in recruiting physicians to contribute their time to teach our students. There is increasing financial pressure both in the community, and within DHMC, for physicians to overcome decreasing compensation rates from payors with increased efforts at maximizing productivity per hour, and increasing total hours in the clinic. This makes it harder to recruit community physicians to provide their time as voluntary faculty without compensation, and for DHC physicians to volunteer for various types of teaching roles.

WHERE WOULD YOU LIKE YOUR PROGRAM TO BE IN 5-7 YEARS

8. **What changes and improvements would you most like to design into your program?** Our current program leading to the MD degree is very good to excellent; we would like to see it become truly outstanding in every dimension, and to be ranked in the top 10% (13) programs nationally in terms of graduating outstanding physicians who are highly qualified in all of our major competency domains. We would like to make the following changes and improvements to in our MD program over the next 1-7 years. I will divide these up into three areas: those improvement projects already underway, those that are more simple and easy to accomplish, and those that would likely be more difficult or complex to accomplish.

**Important improvements already substantially underway:**

**Curricular needs:**

1) Continue to grow our new affiliation with CPMC, in order to be able to expose every single student to at least one required clerkship at a major urban teaching hospital with great variety and diversity of patient diagnoses and conditions, as well as patient cultural and ethnic backgrounds.

2) Facilitate student career decisions by continuing to improve advising and career choice activities in Years 1 and 2 through the Societies, and in Years 3 and 4 by implementing our new Year 3 structure that will permit each student to take one or two electives during Year 3, without the need to delay a major clerkship into Year 4. Maximizing degrees of freedom for students in the summer and fall of Year 4 is also an important part of this initiative.

3) Improve our ability to more precisely define our various educational competencies and levels of accomplishment, and document each student’s reaching a required appropriate level of mastery, as we see new LCME requirements and new AAMC and Carnegie Foundation reports moving forcefully in this direction.
4) Continue to build more various types of simulation activities (e.g. standardized patients, partial task models, group and team simulations, OSCEs, etc) into our courses, especially OD, clerkships, and ICE. Such simulations will allow us to promote student learning, allow more practice of difficult skills, encourage teamwork, and improve objective assessment of student mastery of specific tasks. We need to take maximal advantage of the beautiful new Simulation Center that just opened in November 2008.

**Infrastructure needs:**

5) Continue to refine ways to grow our class size from around 68 graduates per year in the past (with Brown-Dartmouth students moving away), to around 73 graduates per year now, to around 83 graduates per year by 2012 while still maintaining our excellence in teaching, small group conference learning, and strong student-faculty mentoring.

**Cultural needs:**

6) Continue to expand the capabilities of DMEDS to help us understand how to optimize the learning experiences offered by all clerkships, as well as to document comparability of sites, and ability of every student to meet learning/experience targets. Most importantly, use DMEDS to encourage a culture in which students take far greater responsibility for “taking charge” of their own learning experiences, and their own pace for making progress for meeting specific learning objectives in a competency-based curriculum.

**Less complex changes not already substantially underway:**

**Curricular needs:**

7) Adapt our admission requirements to suit our own curricular needs (e.g. many students are not fully ready for our own introduction to biochemistry course), but also to conform to new pre-med recommendations that will likely be developed in the next 1-2 years by the AAMC and HHMI.

8) Modify our curriculum so that it can adapt to new MCAT (currently under review by the AAMC) and USMLE (currently under review by the NBME) requirements.

9) Continue to improve Year 1 to include a richer role for societies, better coordination between courses, more clinical correlations for basic science lectures (perhaps with at least one such session each week), and with a new orientation that would include an introduction to the major issues facing medicine today.

**Infrastructure needs:**

10) Find more ways to expose our students to IPE—interdisciplinary professional education, through learning activities with students from other disciplines such as nursing, pharmacy, etc.

**Cultural needs:**

11) Develop more ways to help students remain positive, upbeat, optimistic, collegial, team-oriented, and respectful during medical school, which can sometimes (and unintentionally) produce feelings of negativity, cynicism, depression, loneliness, competitiveness, and disrespect of patients. In other
words, we need to work on our culture! Much of this work, we hope, will come through the Societies, but other initiatives will likely be needed. Greater team learning in Year 1, with more cooperative learning, would also help the culture of cooperation, and minimize the culture of competition.

**More complex or difficult changes not already substantially underway:**

**Curricular needs:**

12) Provide greater exposure to four important themes through the curriculum: public health issues, how the healthcare system works, ways to improve healthcare delivery at all levels, and issues related to social justice in medical care. Several of these initiatives may involve taking better advantage of expertise already on campus in TDI faculty.

**Infrastructure needs:**

13) Find ways to measure the contributions to the medical school from individual faculty, sections, and whole departments, so we can eventually move to a better system for “funds transfer” from the school to those individuals/sections/departments whenever their contributions to the school exceed basic minimal expectations. Related to this goal is the need to further define the baseline of support each faculty member owes to the medical school in return for the privilege of his/her faculty appointment.

14) Increase number of accessible and schedulable conference rooms at both campuses to allow more degrees of freedom in our scheduling of the various conferences.

**Cultural needs:**

15) Refine or redefine our school’s mission to continue supporting students’ entry any field of medicine, while also helping to encourage students to enter the fields that face a looming, massive doctor shortage—primary care disciplines and geriatric medicine. And, equally important, expose all of our students destined to enter other disciplines to these fields so they will be comfortable dealing with those aspects of their patients’ care. All of our graduates, regardless of intended specialty, will need to be more adept in the future dealing with primary care and geriatric problems as the population ages, and as the number of primary care physicians continues to decrease.

16) Find ways to help rekindle enthusiasm for teaching our students among physicians who are community-based, DH-based, and VA-based, and to make them feel that DMS is really “their own medical school”. We need to help our faculty feel more involved, more fulfilled, and more committed to “their own medical school.” We need to find ways to help each faculty member realize the benefits that a faculty appointment confer, in addition to the fun of teaching medical students.

17) Find a way to build some type of longitudinal clinical experience for each student, following a patient, group of patients, or even simulated patients over their four years at DMS.

18) Continue to find the optimal balance between close student-faculty contact, faculty mentoring, small group conferences, and face-to-face learning experiences, and taking advantage of the most powerful “transforming technology” that can supplement and enhance the educational experience. Such technologies include not only computers and PDAs, but also Blackboard sites, smart phones,
simulated reality experiences, Avatars, medical gaming, CLIPP cases, Cyber cases, telemedicine, virtual reality, etc.