



GEISEL SCHOOL OF MEDICINE
AT DARTMOUTH

MEDICAL EDUCATION COMMITTEE MEETING

TUESDAY, JUNE 18, 2013

4:00 – 5:30 PM

DHMC – AUDITORIUM A

MINUTES

1. Call to Order - Richard Simons, MD

The meeting was called to order at 4:00 PM with the following present:

Voting Members: Benjamin Colby, Scottie Eliassen, Victor Laurion, Dean Madden, Harold Manning, David Nierenberg, Greg Ogrinc, Virginia Reed, Christiaan Rees

Non-Voting Members: Ann Davis, Leslie Fall, Diane Grollman, Cynthia Hahn, Michele Jaeger, Virginia Lyons, Geoff Noble, Brian Reid, Glenda Shoop, Richard Simons, Cynthia Stewart

Guests: Adam Weinstein, Jen Friend, Tim Lahey, Roshini Pinto-Powell, Craig Donnelly, Brenda Sirovich, Nan Cochran

2. Approval of the May meeting minutes

A motion was made and seconded to approve the minutes of the May meeting as written. A vote was taken and the motion passed unanimously.

3. Announcements - Richard Simons, MD

June 25, 2013 from noon – 3:30 PM in room 201 of the Life Sciences Center, the Office of Medical Education is hosting a presentation and workshops with Dr. David Elkowitz from The Hofstra School of Medicine regarding Case Based Learning. The idea is to acquaint faculty with case based learning. Attendance is encouraged. So far 35 – 40 people have RSVP'd

September 20, 2013 - Phyllis Guze, MD from the University of California Riverside will be presenting Medical Education Grand Rounds. Dr. Guze will be here for a couple of days. Her presentation title is: "Medical Education, the Best is Yet to Come"

4. On Doctoring Pilot – Nancy Cochran, MD, Roshini Pinto-Powell, MD & Terri Eastman

Dr. Cochran presented the following:

Proposed On Doctoring Pilot for 2013-2014

Both students and surgical faculty have suggested that On Doctoring enable students to have increased access to surgical sites for their preceptor experience. In response to this feedback, we propose to expand the number and diversity of clinical preceptor experiences for a small pilot group of first and second year students beginning in fall, 2013.

This pilot will allow us to assess the benefits, challenges and complexity of having students work in two clinical sites simultaneously in phase I of the redesigned curriculum, beginning in 2015.

Objectives of the On Doctoring Pilot: participating students will:

1. Gain early exposure to primary and surgical, ob-gyn or sub-specialty care in inter-professional team settings
2. Develop longitudinal relationships with at least two clinical mentors in the pre-clerkship years
3. Develop longitudinal relationships with patients in primary care and surgical or subspecialty settings

Scope - 10 first and second year students who volunteer to participate will be selected via lottery.

- Curriculum and small group experiences unchanged
- Preceptor experience will expand from twice a month to three times/month
- Students will work in a primary site 2 weeks/month and in a secondary site once/month
- Secondary sites will include surgery, ob-gyn, surgical and medical sub-specialty clinics
- Clinical write-ups will largely be based on clinical experiences in the student's primary clinical site
- OCER will assist with faculty and site development

Questions:

Dr. Cochran clarified that the limit is a total of 10.

Dr. Nierenberg asked about the effects that this will have on students' schedules. Dr. Cochran responded by indicating that she didn't believe this will present a problem, but by starting small this can be further researched.

Dr. Nierenberg brought up a question that came up in regards to the new curriculum where there will be 3 preceptor visits per month, with an option of a 4th. This means that the number of preceptors should almost be doubled. Dr. Cochran reported that they have will be strongly encouraging preceptors to take on two students as this is the pattern with many medical schools.

Dr. Madden asked if this pilot represents a model that will be carried forward into the new curriculum redesign, or will it need to change with the new curriculum.

Dr. Davis noted that this pilot program is strongly supported by students

A motion was made and seconded to support this pilot program for the coming year. A vote was taken and the motion passed unanimously.

5. Curriculum Redesign

Dr. Simons noted who the currently appointed course directors are and that he has had meetings with most of the co-directors. Course director meetings will be held regularly to avoid redundancies. Dr. Lahey and other members of the working groups will plan to update the MEC regularly throughout the redesign process.

Dr. Tim Lahey presented a PowerPoint presentation in response to questions asked by the MEC. (See the attachment for full details of the PowerPoint slides).

Dr. Lahey provided clarification on how the need for only additional 1-2 FTEs to support the new curriculum was calculated. Details regarding this calculation can be found on slide #6 of Dr. Lahey's presentation. After much discussion, Dr. Madden expressed lingering concern and skepticism that 1-2 additional FTEs will provide the support needed.

In response to concerns expressed by Dr. Madden, Dr. Lahey clarified that the MEC has one vote today, but will also have many more going forward as the redesign evolves.

Dr. Nierenberg suggested taking one of the three PBL sessions per week and make it a small group conference or a large group conference for the content experts.

Dr. Adam Weinstein presented the clerkship portion of Dr. Lahey's PowerPoint presentation. In response to Dr. Nierenberg's question about the capacity of clerkships Dr. Weinstein indicated that the 2012-2013 class size was the largest ever and will need to communicate that clerkships will need to take students during months that have an overlap. Dr. Simons noted that this doesn't take into account the potential for additional clerkship slots with the developing affiliation with Mayo clinic. Clerkship directors have seen the table and are comfortable with these numbers and the variation in the number of students. Will schedule it so that it's spread out, but not any more than it is now. Dr. Weinstein indicated that electives make up the overlap to make sure the total is always 85. Elective time will remain throughout the blocks. Students noted that the start day of the week affects the usefulness of the clerkship. Students will be through most clerkships in April making more opportunity for sub-I's. Dates have not been set yet.

Michele Jaeger, noted that MD/PhD's may be cycling back in earlier than they currently are and may not have finished the Phd portion. Clerkships currently end in June which gives Dr. Harper time to get those in and then retrieve sub-I's and electives. In order to meet the earlier date, a lot of cooperation will be needed in order to meet this more strict transition time for grades.

Dr. Weinstein gave an example of when students could do sub-I's. Less desirable time to do sub-I's in September. Under the current system, 1/3 of students are taking sub-I's. Student is choosing the order, so they can set it to suit them. Student will have much more control over their sequence.

Dr. Nierenberg noted that while he's supportive of this, he has run into problems with clerkship capacity in the past. His suggestion is to keep looking at the schedule and reviewing it to make sure it will work. He also noted concern that the lottery as it is suggested will not work; the last 3 or 4 blocks may require assigning things to make it work. The schedule is only as strong as the weakest link and that is impossible to identify right now.

Dr. Madden questioned whether there is something that the 8 week internal medicine that allows us to do that we will be losing if it is shortened. Dr. Simons noted that the current medicine clerkship is outdated. Most medicine clerkships in the 1990's started to incorporate ambulatory in the medicine clerkship. Now medicine clerkships have an approximate mix of inpatient and ambulatory components with some as short as 6 weeks and as long as 12weeks, but an 8 week clerkship with half ambulatory and half inpatient is standard. Dr. Simons referred to Molly Cook's book where she indicates that a strictly inpatient medicine clerkship does a disservice because it is not reflective of what internal really is. Instead of losing anything, we will be getting something better having a medicine experience that reflects what the practice of what internal medicine is really like.

Dr. Simons opened the floor to other questions about the curriculum proposal that have not already been addressed.

Dr. Madden asked if Masters program electives that are taken by all medical students will be approved by the MEC as they can displace or be combined with other electives. Currently do not dictate what kind of elective students take. Students have to satisfy requirements of MD and then there's elective time for MBA.

Dr. Simons asked if this committee was ready to consider a motion on the curriculum redesign proposal. A vote can be taken now and then this committee would need to approve subsequent courses and would have to vote a third time on the entire package. **Dr. Madden made a motion to authorize the Dean's office and the Curriculum Redesign team to develop courses and to do the feasibility assessment and bring it back for final approval by the MEC of the entire developed package before it enters the implementation phase. The motion was seconded.** Further discussion: Dr. Simons indicated that we need to bring the whole package back to the MEC about a year in advance of launching this curriculum. Dr. Madden felt that it will be well supported as long as this is an open process and all course reviews have been reviewed and the third vote can act as an emergency brake should it be necessary. Dr. Simons noted that as proposals come to the committee, the MEC can propose modifications. **A vote was taken and the motion passed with no opposition.**

Adjourned at 6:07 PM

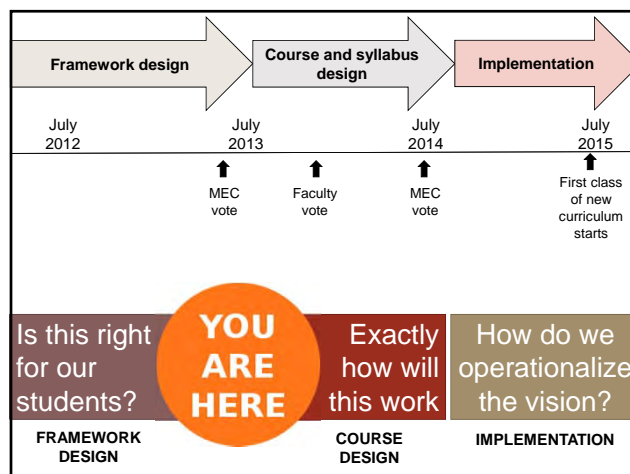
Future Meeting Dates:

- July 16, 2013 – Auditorium A
- August 20, 2013 – Auditorium A
- September 17, 2013 – Auditorium D



Geisel Curriculum Redesign Medical Education Committee

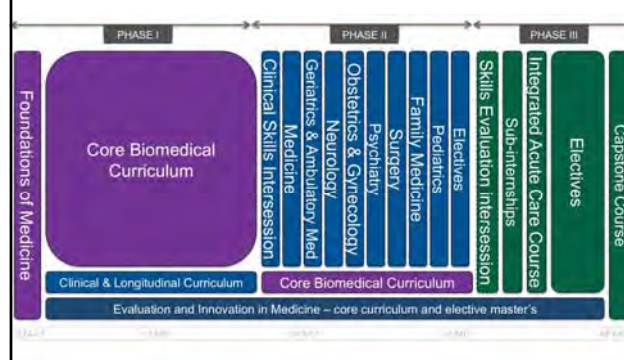
18 June 2013



Form Follows Function

Key aspects of redesign proposal	Specifics of proposed approach
Emphasis on active learning and critical thinking	Case-based and student-driven learning in Core Biomedical Curriculum
Better cross-departmental integration of foundational sciences	Cross-departmental courses of Core Biomedical Curriculum
Increased longitudinal clinical care experiences	Clinical & Longitudinal Curriculum
Intensified training in healthcare evaluation and delivery sciences	Core curriculum in Evaluation & Innovation in Medicine
Opportunities for individualized learning	Increased elective time during Y2-Y3, elective master's program in Evaluation & Innovation in Medicine
Improved integration of foundational sciences into clinical rotations	Foundational science learning built into Phase II clerkships and also Integrated Acute Care Course in Phase III
Enhanced attention to professional identity formation	Theme in Ethics & Humanities, and Theme in Practice Resilience

Curriculum Framework





**Can Our Faculty Teach All of Those
Small Group Sessions?**

We Have the Teaching Bandwidth

Proposed new course	Faculty Contact Hours in Existing Relevant Courses of Current Curriculum	Faculty Contact Hours in Proposed New Curriculum	Additional Faculty Contact Hours	Weeks in Course in Proposed New Curriculum	Additional Faculty Contact Hours/Week in Courses of the Core Biomedical Curriculum
Cellular & Molecular Basis of Disease	214	539	325	7	46
Infection, Inflammation, Immunity & Hematology	532	924	392	12	33
Homeostasis	978	1155	178	15	12
Command & Control	852	1155	303	15	20
Holding it together	360	385	25	5	5
Nourishing the Body	397	770	373	10	37
Where We Begin	228	385	157	5	31
Total	3561	5313	1753	69	AVERAGE 26 hrs/wk

The Dean has committed to support a small cadre of small group facilitators to offset the added faculty contact time (1-2 FTE) needed in the proposed model.

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AT DARTMOUTH

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**Is it a good idea – and feasible – to
have the clerkships last longer than
one year?**

Phase II

Clinical Immersion

A Bit Complicated?

OB/GYN	active	Surgery	Medicine	Pediatrics	elective	Psychiatry	Family
OB/GYN	active	Surgery	Pediatrics	Psychiatry	Family	elective	Medicine
Pediatrics	Medicine	active	Family	OB/GYN	Psychiatry	elective	Surgery
Pediatrics	Medicine	active	Psychiatry	Family	OB/GYN	elective	Surgery
Pediatrics	Medicine	active	Psychiatry	Family	OB/GYN	elective	Surgery
Pediatrics	Surgery	active	Family	Medicine	elective	OB/GYN	Psychiatry
Pediatrics	Surgery	active	Family	Medicine	elective	OB/GYN	Psychiatry
Pediatrics	Surgery	active	OB/GYN	Medicine	elective	Psychiatry	Family
Pediatrics	Surgery	active	Psychiatry	Medicine	elective	Family	OB/GYN
Pediatrics	Surgery	active	Psychiatry	Medicine	elective	Family	OB/GYN
OB/GYN	Family	elective	Surgery	Pediatrics	Medicine	active	Psychiatry
OB/GYN	Family	elective	Surgery	Pediatrics	Medicine	active	Psychiatry
Psychiatry	OB/GYN	elective	Surgery	Pediatrics	Medicine	active	Family
Psychiatry	OB/GYN	elective	Surgery	Pediatrics	Medicine	active	Family
Family	Psychiatry	elective	Surgery	Pediatrics	Medicine	active	OB/GYN
Family	Psychiatry	elective	Surgery	Pediatrics	Medicine	active	OB/GYN
OB/GYN	Family	elective	Surgery	Psychiatry	active	Medicine	Pediatrics
OB/GYN	Family	elective	Surgery	Psychiatry	active	Medicine	Pediatrics
Psychiatry	OB/GYN	elective	Medicine	Family	active	Surgery	Pediatrics
Psychiatry	OB/GYN	elective	Medicine	Family	active	Surgery	Pediatrics
Family	Psychiatry	elective	Medicine	OB/GYN	active	Surgery	Pediatrics
Surgery	elective	Family	Psychiatry	Medicine	Pediatrics	active	OB/GYN
Surgery	elective	Family	Psychiatry	Medicine	Pediatrics	active	OB/GYN
Surgery	elective	OB/GYN	Family	Pediatrics	Medicine	active	Psychiatry
Surgery	elective	Psychiatry	OB/GYN	Family	Pediatrics	active	Medicine
Medicine	elective	OB/GYN	Family	Pediatrics	Surgery	active	Psychiatry
Medicine	elective	OB/GYN	Family	Pediatrics	Surgery	active	Psychiatry
Medicine	elective	Psychiatry	OB/GYN	Pediatrics	Surgery	active	Family
Medicine	elective	Psychiatry	OB/GYN	Pediatrics	Surgery	active	Family
Pediatrics	Surgery	active	Medicine	OB/GYN	Family	Psychiatry	elective
Pediatrics	Surgery	active	Medicine	OB/GYN	Family	Psychiatry	elective

Aligned Schedule

Medicine	Pediatrics	Fam Med 6; Elec 2	Elec 2	Ob/Gyn 6	Surgery	Neuro	Elec 4		Elec 4	Elec 4
Surgery	Medicine	Fam Med 6; Elec 2	Elec 4	Neuro		Pediatrics	Elec 2	Ob/Gyn 6	Psych 6	Elec 2
Elec 4	Elec 4	Medicine	Ob/Gyn 6; Elec 2	Elec 4	Neuro	Psych 6	Elec 2	Surgery		Fam Med 6; Elec 2
Elec 4	Neuro	Surgery	Pediatrics	Elec 2	Ob/Gyn 6	Fam Med 6; Elec 2	Elec 2	Psych 6		Medicine
Psych 6	Elec 2	Surgery	Pediatrics	Elec 2	Fam Med	Medicine	Elec 2	Ob/Gyn 6	Neuro	Elec 4

Aligned Schedule

- Immersion Group—Consensus on aligned schedule
- Students have breaks all at same time
 - facilitates better connectiveness
 - important meetings and participation with one another and the medical school and local community, etc...
- To accomplish: Blocks to all be 8 weeks long. Every 8 weeks is a break between blocks
 - Surgery, Pediatrics, Medicine: 8 weeks long, natural break at end
 - Neurology: 4 weeks paired with another 4 week rotation (e.g. 4 week elective)—every 8 weeks there's a break
 - Ob/Gyn, Psych, FM: 6 weeks paired with 2 week elective or other experience—every 8 weeks there's a break

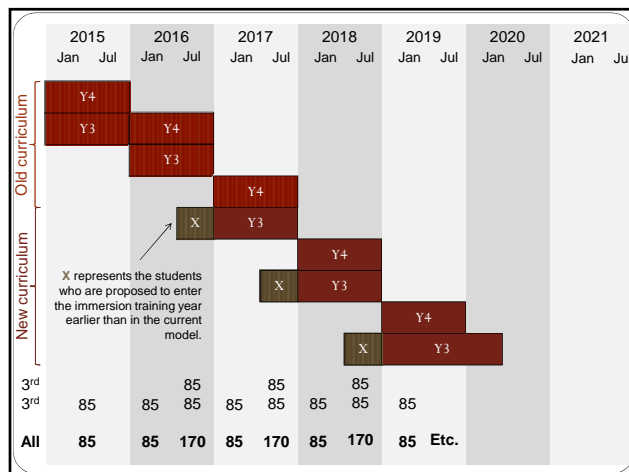
Medicine	Pediatrics	Fam Med 6; Elec 2	Elec 2	Ob/Gyn 6	Surgery	Neuro	Elec 4		Elec 4	Elec 4
Surgery	Medicine	Fam Med 6; Elec 2	Elec 4	Neuro		Pediatrics	Elec 2	Ob/Gyn 6	Psych 6	Elec 2
Elec 4	Elec 4	Medicine	Ob/Gyn 6; Elec 2	Elec 4	Neuro	Psych 6	Elec 2	Surgery		Fam Med 6; Elec 2
Elec 4	Neuro	Surgery	Pediatrics	Elec 2	Ob/Gyn 6	Fam Med 6; Elec 2	Elec 2	Psych 6		Medicine
Psych 6	Elec 2	Surgery	Pediatrics	Elec 2	Fam Med	Medicine	Elec 2	Ob/Gyn 6	Neuro	Elec 4

Aligned Schedule

Medicine	Pediatrics	Fam Med 6; Elec 2	Elec 2	Ob/Gyn 6	Surgery	Neuro	Elec 4		Elec 4	Elec 4
Surgery	Medicine	Fam Med 6; Elec 2	Elec 4	Neuro		Pediatrics	Elec 2	Ob/Gyn 6	Psych 6	Elec 2
Elec 4	Elec 4	Medicine	Ob/Gyn 6; Elec 2	Elec 4	Neuro	Psych 6	Elec 2	Surgery		Fam Med 6; Elec 2
Elec 4	Neuro	Surgery	Pediatrics	Elec 2	Ob/Gyn 6	Fam Med 6; Elec 2	Elec 2	Psych 6		Medicine
Psych 6	Elec 2	Surgery	Pediatrics	Elec 2	Fam Med	Medicine	Elec 2	Ob/Gyn 6	Neuro	Elec 4

16 Month Phase II

- 16 months? I thought we were talking 14 months?
 - Hold that thought for a sec...
- Either way: For certain periods of time there will be two years of medical students on the clerkships at one time



16 month Phase II—why?

- Currently, Neurology and Geriatrics and Ambulatory Medicine are in the 4th year of medical school.
 - Students have already chosen their field of residency by this time, but without experience in these important fields to guide their decisions.
- Many schools have moved away from separate inpatient and outpatient clerkships in Medicine
 - accordingly, the Medicine shelf exam includes both inpatient and outpatient content
 - inpatient medicine, and geriatrics and ambulatory medicine, will be linked together as one contiguous experience, building off each other, much as we already do for inpatient and ambulatory pediatrics in the Pediatrics clerkship
 - This will make the inpatient medicine shorter
 - in line with rotation duration at other schools
 - offset by enhanced longitudinal experiences in years 1-2, and new experiences in Phase III's Integrated Acute Care Course

16 month Phase II—why?

- Ability to give students more time for exploration and individualization
 - Current Geisel third year (July-June) includes 6 weeks of elective time.
 - With 16 months (May-August) it includes 18 weeks of elective time, in 2-4 week chunks, and even 8 week chunks
 - Gives students the opportunity to:
 - choose introductory clinical electives early on in the phase
 - more advanced electives, including sub-internships, later on in the final 4 to 6 months of the phase.
 - Critically, all clerkships will still be completed by the end of August, in time for grades to be included in their MSPE (Dean's) letter in their residency applications.

16 Month Phase II

- For certain periods there will be two years of medical students on the clerkships at one time.
 - confirmed that the proposed approach is feasible
 - it will not require any clerkship to take on more students at a time than their current capacity can handle.
- Specific factors which make this possible include
 - ~20% reduction in the number of students on each clerkship during the non-overlap periods through the incorporation of new clerkships (Neurology, Geriatrics and Ambulatory Medicine) into the phase
 - preferential emphasis of elective time during periods of overlap
 - subtle changes in the alignment of clerkships (will discuss in a bit)
- On to the Math...

The Math

- 85 students per class...
- This means
 - each clerkship has to have 85 students per PHASE II time-period (16 months)
 - each "block" has to have 85 students accounted for

Pediatrics

- Has Capacity of 18-20 students/block

Band-Width	May/ June	July/ Aug	Sept/ Oct	Nov/ Dec	Jan/ Feb	Mar/ Apr	May/ June	July/ Aug	Total/ Year
	10	10	14	14	14	14	8	6	90
Overlap	18	16							

Surgery

- Has Capacity of 20 students/block

Band-Width	May/ June	July/ Aug	Sept/ Oct	Nov/ Dec	Jan/ Feb	Mar/ Apr	May/ June	July/ Aug	Total/ Year
	10	16	14	14	14	14	10	4	96
Overlap	20	20							

- By having capacity for more than necessary, this creates flexibility
- We'll do all clerkships this way...

Medicine

- Capacity of 20 students/block

Band-Width	May/June	July/Aug	Sept/Oct	Nov/Dec	Jan/Feb	Mar/Apr	May/June	July/Aug	Total/Year
	10	16	14	14	14	14	10	4	96
Overlap	20	20							

Ob/Gyn

- Capacity of 16 students/block

Band-Width	May/June	July/Aug	Sept/Oct	Nov/Dec	Jan/Feb	Mar/Apr	May/June	July/Aug	Total/Year
	8	12	14	14	16	14	8	4	90
Overlap	16	16							

Psych

- Capacity of 14-16 students/block

Band-Width	May/June	July/Aug	Sept/Oct	Nov/Dec	Jan/Feb	Mar/Apr	May/June	July/Aug	Total/Year
	8	12	14	14	14	14	8	4	88
Overlap	16	16							

Family Medicine

- Capacity of 16 students/block

Band-Width	May/June	July/Aug	Sept/Oct	Nov/Dec	Jan/Feb	Mar/Apr	May/June	July/Aug	Total/Year
	10	12	14	14	16	14	6	4	90
Overlap	16	16							

Neuro

- Capacity of 10 students/block—the following 2 blocks/box

Band- Width	May/ June	July/ Aug	Sept/ Oct	Nov/ Dec	Jan/ Feb	Mar/ Apr	May/ June	July/ Aug	Total/ Year
	10	12	14	14	16	14	10	8	98
Overlap	20	20							

Complex Math...

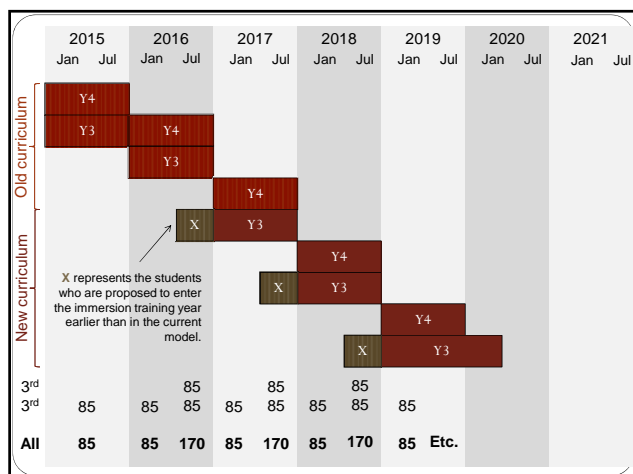
Bandwidth	May	June	July	Aug	Sept	Oct	Nov	Dec	Holiday	Jan	Feb	Mar	Apr	break	May	June	July	Aug	Total p
	2-1		2-2		2-3	2-4				2-5	2-6				2-7	2-8			
Peds	10		10		14	14		14		14	14				8	6			90
Surg	10		16		14	14		14		14	14				10	4			96
Med	10		16		14	14		14		14	14				10	4			96
OB-GYN/Elec (2wks)	8		10		16	14		16		14	14				8	6			92
Psych/Elec (2wks)	8		10		16	14		14		14	14				8	6			90
Fam Med/Elec (2wks)	10		11		14	14		16		14	14				6	5			90
Neuro/Elec	10		12		12	12		12		12	12				10	8			88
Elec/Neuro			20		20														
Elec	19														25	50			94
Total per Block	85		85		100	96		100		96					85	89			
Total per Overlap Block		170			174														

Exact Fit

Bandwidth	May	June	July	Aug	Sept	Oct	Nov	Dec	Holiday	Jan	Feb	Mar	Apr	break	May	June	July	Aug	Total p
	2-1		2-2		2-3	2-4				2-5	2-6				2-7	2-8			
Peds	10		14		11	12		12		12	12				8	6			85
Surg	10		14		12	11		11		11	11				10	6			85
Med	10		15		12	11		11		11	11				10	5			85
OB-GYN/Elec (2wks)	8		10		13	13		14		13	13				8	6			85
Psych/Elec (2wks)	8		10		13	13		14		13	13				8	6			85
Fam Med/Elec (2wks)	9		10		13	13		13		13	13				8	6			85
Neuro/Elec	10		12		11	12		10		12	12				10	8			85
Elec/Neuro			20		20														
8 week Elec	20														23	42			85
Total per Block	85		85		85	85		85		85	85				85	85			
Total per Overlap Block		170			170														

What about the first year of the redesign?

- 3rd year students in the current curriculum will be completing their 3rd year in May and June
- Concurrently, 3rd year students in the new curriculum will be starting their 3rd year in May and June



What about the first year of the redesign?

- 15 “grids” have electives for the first 2 weeks of May
- 18 “grids” have electives for the last 6 weeks of the year (end of May/June)
- If we ensure these grids are selected, then we have 15 students in electives over that time...

First Year...

Bandwidth	May	June	July	Aug	Sept	Oct	Nov	Dec	Holiday	Jan	Feb	Mar	Apr	break	May	June	July	Aug	Total p
Peds	21	22	23	24	25	26	27	28											85
Surg	8	18	14	20	11	12				12	12				10	6			85
Med	10	20	15	20	12	11				11	11				10	5			85
OB-GYN/Elec (2wks)	8	20	10	20	13	13				14	13				8	6			85
Psych/Elec (2wks)	6	16	10	16	13	13				14	13				10	6			85
Fam Med/Elec (2wks)	9	17	10	16	13	13				13	13				8	6			85
Neuro/Elec	8	20	12	20	11	12				10	12				12	8			85
8 week Elec	28	43													15	42			85
Total per Block	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	
Total per Overlap Block		170	170	170	170	170	170	170	170	170	170	170	170	170	170	170	170	170	

What about the first year of the redesign?

- 15 “grids” have electives for the first 2 weeks of May
- 18 “grids” have electives for the last 6 weeks of the year (end of May/June)
- If we ensure these grids are selected, then we have 15 students in electives over that time...
 - So we will need to have a handful more students open up the year with electives in this first year
 - Still plenty of schedule options to promote the intended flexibility and individualization
 - Importantly, capacity is ok

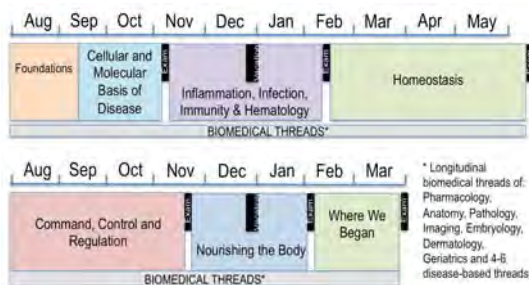


What else should we discuss?



Thank You!

Integrated Cross-Departmental Courses



Can Our Faculty Teach All of Those Small Group Sessions?

Yes, If the Dean Can Afford 1-2 FTE

Proposed new course	Faculty Contact Hours In Existing Relevant Courses of Current Curriculum	Faculty Contact Hours in Proposed New Curriculum	Additional Faculty Contact Hours	Weeks in Course in Proposed New Curriculum	Additional Faculty Contact Hours/Week in Courses of the Core Biomedical Curriculum
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How Much Will Clinical Faculty Supported for Teaching Be Paid?

Up to NIH cap + supplements

- **Support for major teaching contributions**
 - Course/clerkship directors, longitudinal preceptors, etc.
- **Salary at current rate up to NIH cap**
- **Discretionary supplements by chairs**
- **Etc: DH salary structure under review & historical idiosyncrasies of teaching \$**

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How will experts and generalists collaborate in the new curriculum?

Many Teaching Roles for Faculty



Course designer

Small group facilitator

Lecturer

Lab preceptor

Lead surgeon

Ward attending

Clinic preceptor

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Collaboration in the New Curriculum

EXISTING

Large group sessions

Largely led by experts

Small group sessions

Facilitated by experts and generalists

Course directors will determine who should teach what, just as they do now

REDESIGN

Interactive large group sessions

Largely led by experts

Small group sessions

Facilitated by experts and generalists

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Experts & Generalists All Have Roles

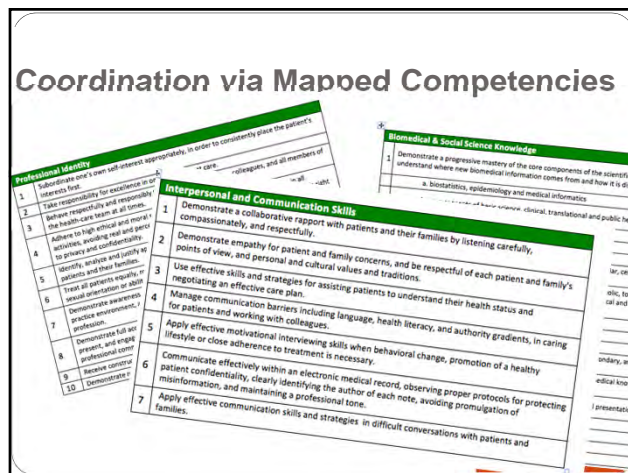
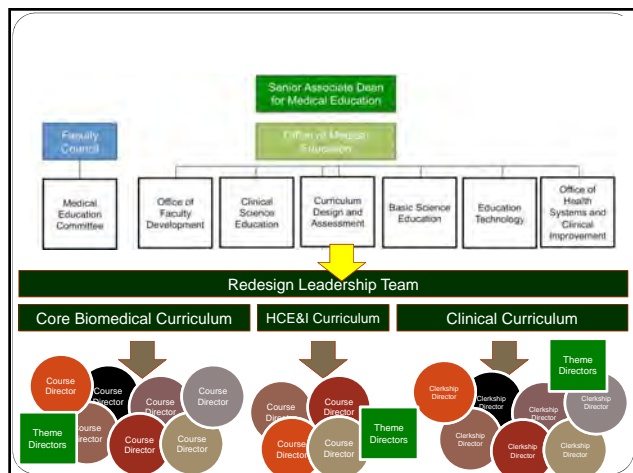
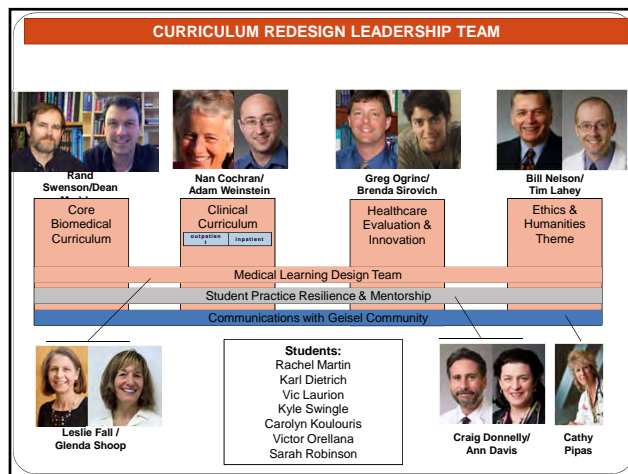
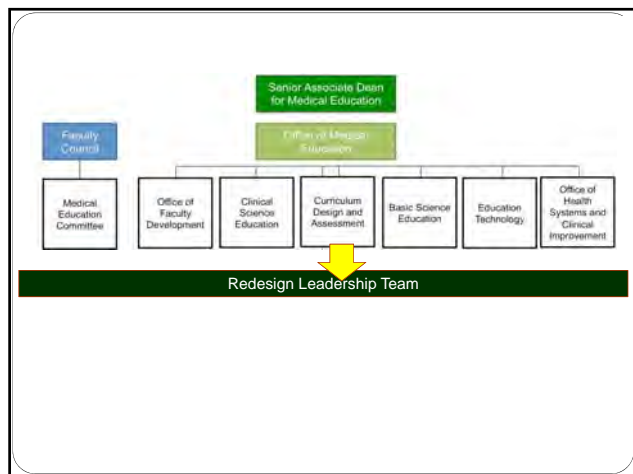
- Course directors select who teaches, just as in current curriculum
- Mixture of session types and a mixture of experts and generalists teaching
- Small group teaching by both generalists and experts
- Target: competency for MD, not expert competency
- "Sage on the stage" does not ensure student learning – balance is what is needed

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How Will the Curriculum Be Coordinated?



Course Directors for New Curriculum

Foundations of Medicine: Rosh Pinto-Powell, M.D.

Cellular and Molecular Basis of Disease:
Surachi Supattapone, M.D., PhD and TBA

Infection, Inflammation, Immunology:
Tim Lahey, M.D. and Paula Sundstrom, PhD

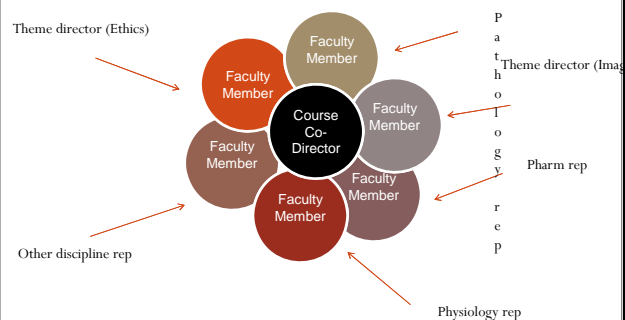
Homeostasis: Hal Manning, M.D. and Gene Nattie, M.D., PhD

Command and Control: Rand Swenson, M.D., PhD and Rich Comi, M.D.

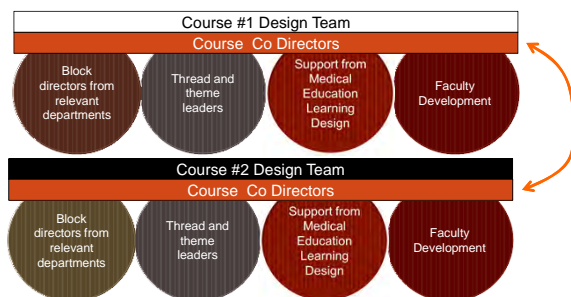
Nourishing the Body: Charlie Barlowe, PhD and Steve Bensen, M.D.

Where We Began: TBA

Course Committees



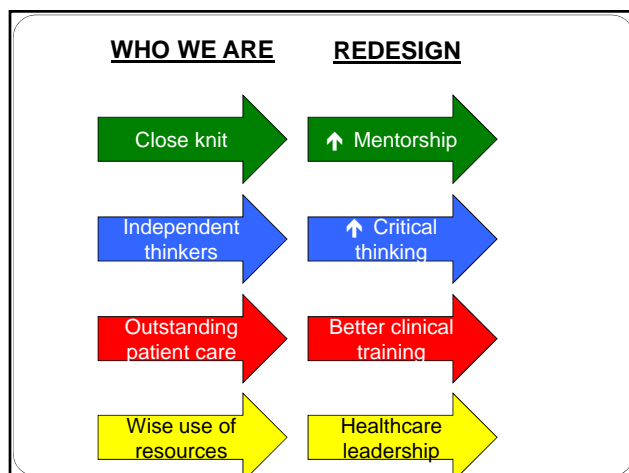
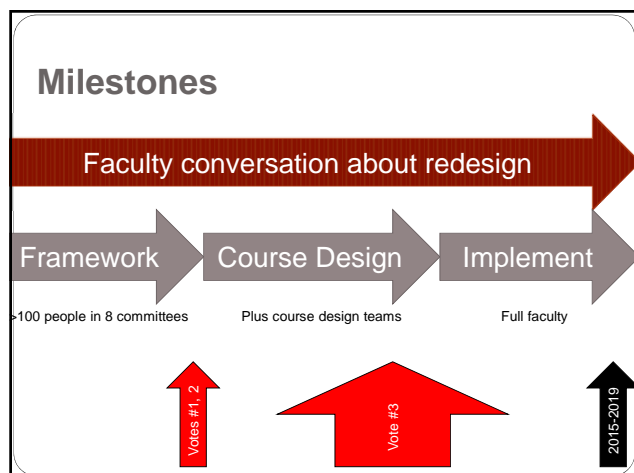
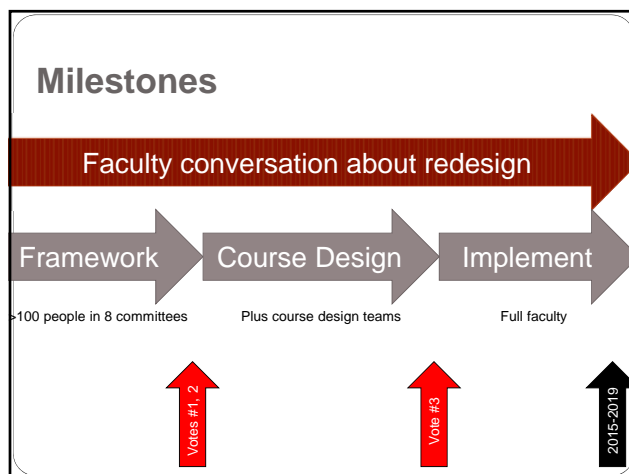
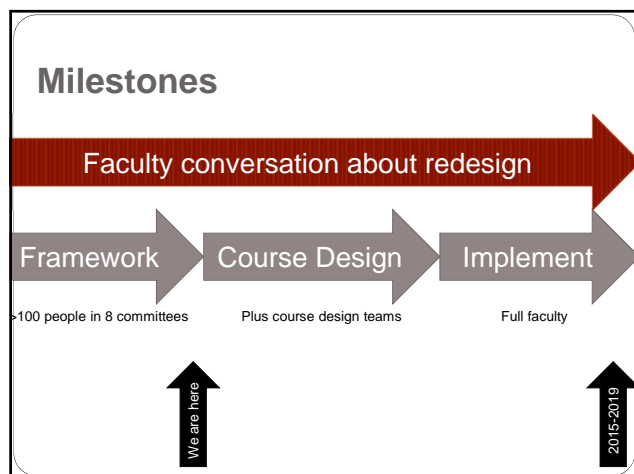
Integration and Coordination Between Courses of Core Biomedical Curriculum



Role of Medical Education Committee

- Approve all new courses
- Pay attention to integration both horizontally and vertically, "central control and coordination"
- Course and curriculum phase evaluation
- Assure compliance with LCME standards

***working closely with SAD Medical Education**



Curriculum Redesign Objectives

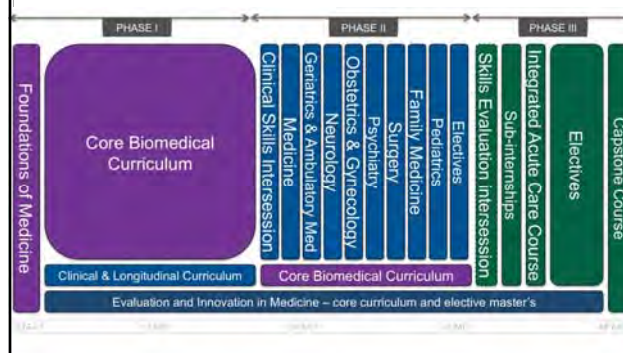


1. To promote active learning and critical thinking
2. To enhance integration of clinical & basic sciences
3. To engage students in outstanding longitudinal clinical training
4. To provide novel training to be scholars and leaders in healthcare evaluation and innovation
5. To improve incorporation of ethics, humanities, professionalism, mentorship, and practice resilience into the curriculum

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Curriculum Framework



Block	Topics
Cellular and Molecular Basis of Disease	Cell biology, genetics, oncogenesis
Inflammation, Infection, Immunity & Hematology Homeostasis	Immunology, inflammation, microbiology, virology, infectious diseases, hematology
Command, Control & Regulation	Cardiovascular, respiratory, fluids, electrolytes, and kidney/urinary system
Nourishing the Body	Endocrinology, brain & behavior, musculoskeletal & connective tissue
Where We Began	Integrated metabolism, gastrointestinal system
	Reproduction and development

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This is a conversation

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How will experts and generalists collaborate in the new curriculum?

Many Teaching Roles for Faculty



Course designer

Small group facilitator

Lecturer

Lab preceptor

Lead surgeon

Ward attending

Clinic preceptor

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Collaboration in the New Curriculum

EXISTING

Large group sessions led largely by experts

Small group sessions led by experts and generalists

Added faculty contact time
~26 hrs/week on average

REDESIGN

Interactive large group sessions led largely by experts

Small group sessions led by experts and generalists

Generalist medical educators who collaborate with existing faculty

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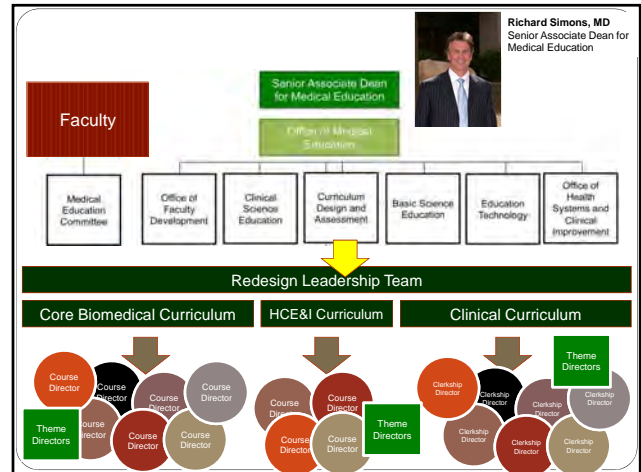
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This is a conversation

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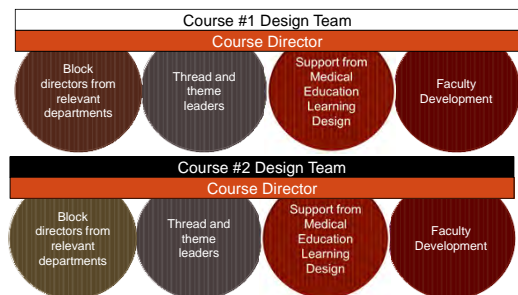
How Will Integration Be Coordinated Across Parts of the Curriculum?

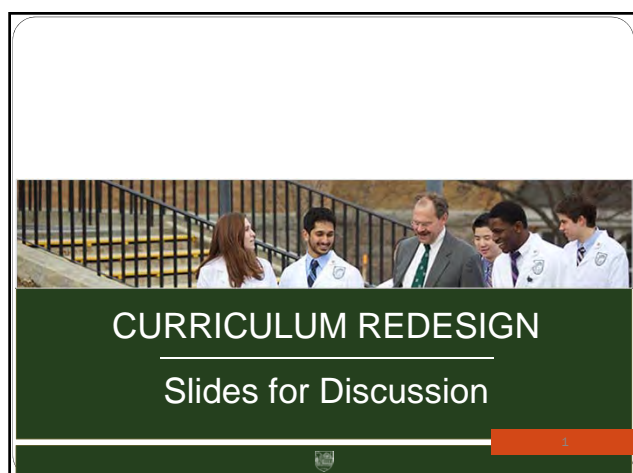
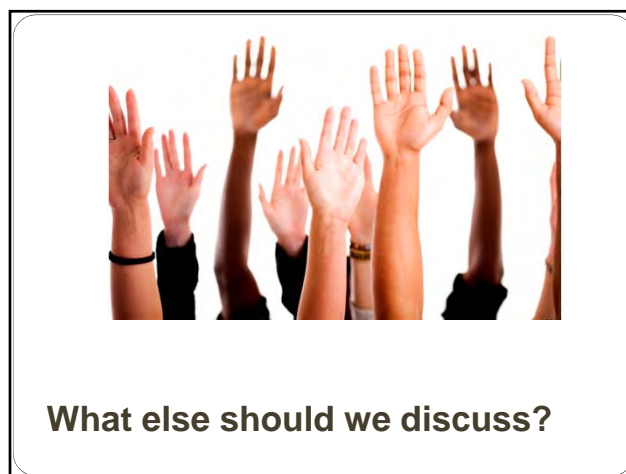
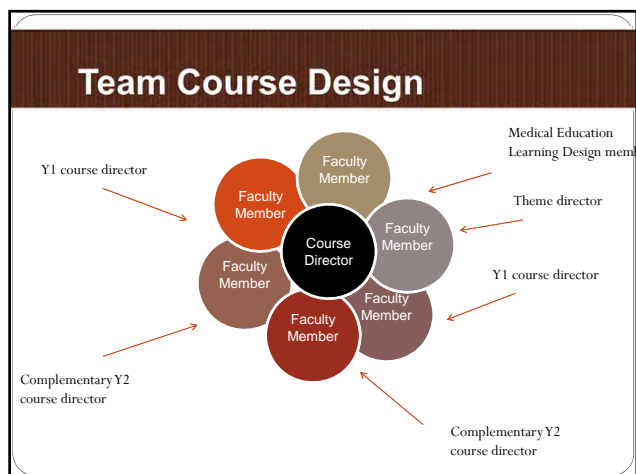


Coordination via Mapped Competencies

Professional Identity	Interpersonal and Communication Skills	Biomedical & Social Science Knowledge
1. Demonstrate a professional identity and responsibility for excellence in our services.	1. Demonstrate a collaborative rapport with patients and their families by listening carefully, compassionately, and respectfully.	1. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
2. Take responsibility for excellence in our services.	2. Demonstrate empathy for patient and family concerns, and be respectful of each patient and family's points of view, and personal and cultural values and traditions.	2. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
3. Behave respectfully and responsibly in the health care team at all times.	3. Use effective skills and strategies for assisting patients to understand their health status and for negotiating an effective care plan.	3. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
4. Adhere to high ethical and moral principles, avoiding malpractice and patient safety issues, and confidentiality to protect and enhance patient safety.	4. Manage communication barriers including language, health literacy, and authority gradients, in caring for patients and working with colleagues.	4. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
5. Identify, analyze and synthesize patient and family concerns.	5. Apply effective motivational interviewing skills when behavioral change, promotion of a healthy lifestyle or close adherence to treatment is necessary.	5. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
6. Treat all patients equitably, regardless of race, ethnicity, gender, sexual orientation, or social status.	6. Communicate effectively within an electronic medical record, observing proper protocols for protecting patient confidentiality, clearly identifying the author of each note, avoiding promulgation of misinformation, and maintaining a professional tone.	6. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
7. Demonstrate awareness of practice environment, profession, and patient safety.	7. Apply effective communication skills and strategies in difficult conversations with patients and families.	7. Demonstrate a progressive mastery of the core components of the scientific method, understand where new biomedical information comes from and how it is disseminated.
8. Demonstrate full and open communication with professional colleagues.		
9. Receive constructive feedback and demonstrate a commitment to continuous improvement.		
10. Demonstrate a commitment to continuous improvement.		

Integration and Coordination Within Courses of Core Biomedical Curriculum





But: How Many, Exactly?

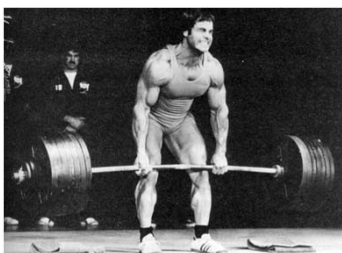
- This depends on course design
- Course design is up to course directors
- Faculty FTE assignments discussed with and approved by chairs
- We'll provide faculty FTE allocation for an average course shortly

A photograph showing a close-up of architectural drawings on a table, with drafting tools like a compass and a ruler visible.

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Implications for Teaching Workload

- More centrally-supported small group facilitators
 - Involvement is voluntary, vetted, and discussed with leadership
- Diverse faculty involvement continues
- Smaller impact on departments in general



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Financial Implications of Redesign

- Some teaching is expected
- More support for deeper commitments
- One example: small group facilitators with substantial FTE
- **It's in the budget**



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Many Teaching Roles for Faculty



Course designer



Small group facilitator



Lecturer



Lab preceptor



Lead surgeon



Ward attending



Clinic preceptor

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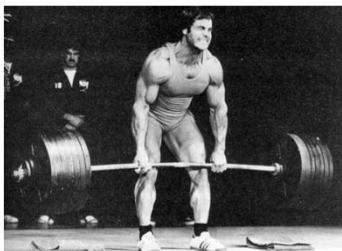


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Implications for Teaching Workload

- ↑ small group facilitators
- Continued diverse faculty involvement
- ↓ departmental impact in general



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Financial Implications of Redesign

- Some teaching is expected
- Added support for deeper commitments (course and clerkship directors)
- Faculty involvement is voluntary, vetted, and FTE negotiated with department chairs
- **It's in the budget**

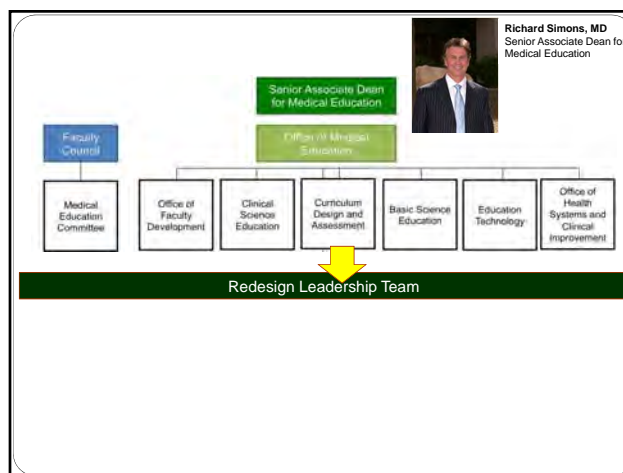


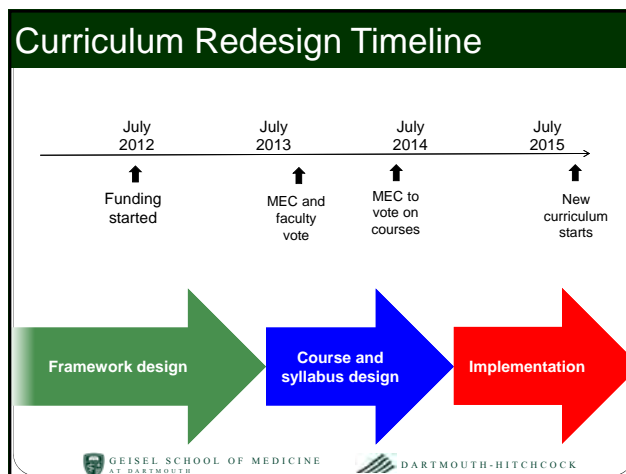
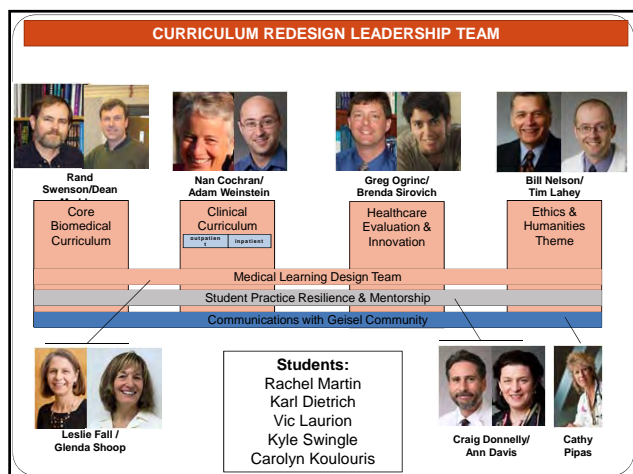
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What else should we discuss?





Questions for Geisel Leadership

We distributed the proposed redesign model to the Geisel community on March 1, and are now holding Town Halls, focus groups and departmental meetings.

What about the model can we clarify for you so that our message is clear and persuasive?

Questions for Geisel Leadership

The Medical Education Committee and full faculty will vote on this high level framework model in 2013, and then the Medical Education Committee will vote on the more detailed implementation plan in 2014.

What additional features of the model should we clarify or modify *now* to increase chances of a successful faculty vote in 2013?

Questions for Geisel Leadership

Geisel is committed to supporting outstanding teaching. The proposed curriculum model will require continued investments in faculty teaching time, faculty teaching development, and the infrastructure for teaching.

Do you foresee major resource obstacles to the successful implementation of the proposed curriculum model?

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Questions for Geisel Leadership

Creation and implementation of the curriculum redesign is a complicated institutional change during a time of increasing RVU and NIH payline pressures.

Are there political obstacles we should address more aggressively to ensure success of the curriculum redesign?

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General Schedule of a Week, Year 1-2	Mon	Tue	Wed	Thu	Fri
	Small group case-based session for Y1 students	Lab or other similar integrative session	Small group case-based session for Y1 students	Lab or other interactive teaching time	Small group case-based session for Y1 students
	Large group session aligned with small group	Clinical Longitudinal Curriculum (CLO) – longitudinal clinic and mentored small group discussion	Large group session aligned with small group	Review and discussion of challenging cases	Healthcare evaluation and innovation
	Review, mentorship/ advising, and study time		Review, mentorship/ advising, and study time	Review, mentorship/ advising, and study time	Review, mentorship/ advising, and study time

Phase I: Foundations of Medicine

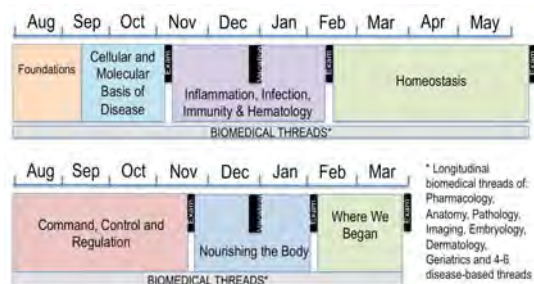
- **Introduction to “The Geisel Way”**
 - Case-based learning
 - Introduction to mentorship team
- **Multidisciplinary intro to physician role & medicine**
 - Core biomedical curriculum, physical exam/communications, ethics/professionalism, practice resilience, healthcare evaluation & innovation
- **Baseline evaluations, start of personal learning portfolio**
- **6 weeks, 16-20 hrs/wk+ review time**

Phase I: Core Biomedical Curriculum

- 18 months, 12-14 hrs/week
- 6 integrated cross-departmental blocks, each 4-8 weeks
- Led by *teams* of clinicians and investigators
- Systematic approach to clinical thinking
- Integrated lab sessions
- Multimodality evaluation at end of blocks



Integrated Cross-Departmental Courses



Block	Topics
Cellular and Molecular Basis of Disease	Cell biology, genetics, oncogenesis
Inflammation, Infection, Immunity & Hematology	Immunology, inflammation, microbiology, virology, infectious diseases, hematology
Homeostasis	Cardiovascular, respiratory, fluids, electrolytes, and kidney/urinary system
Command, Control & Regulation	Endocrinology, brain & behavior, musculoskeletal & connective tissue
Nourishing the Body	Integrated metabolism, gastrointestinal system
Where We Began	Reproduction and development

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Longitudinal Themes & Threads

THREADS ACROSS CORE BIOMEDICAL CURRICULUM

Human Structure: histology, anatomy, biomedical Imaging

Pharmacology

The spectrum of life

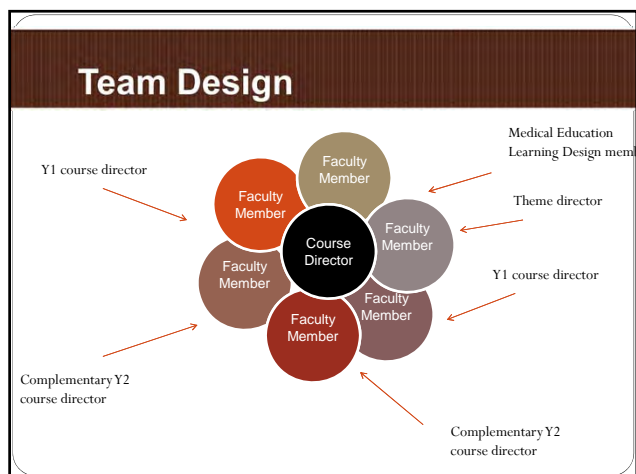
THEMES ACROSS ENTIRE CURRICULUM

Ethics, humanities and professionalism

Practice Resilience

Content woven into entire curriculum using same active learning approaches as mentioned before

Cross-cutting topics led by knowledgeable faculty who collaborate closely with block leaders



Many Teaching Roles for Faculty

Course designer

Small group facilitator

Lecturer

Lab preceptor

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Core Biomedical Curriculum

Phases I & II: Clinical Longitudinal Curriculum

- 18 months
- Location
 - Clinic + small group of 8/faculty member
- Timing
 - 3x/month primary care practice
 - Elective 1x/month other clinic
- Topics:
 - Communication, exam, clinical reasoning
 - Service learning/QI
 - Aligned with Core Biomedical Curr
- Mentorship / advising



Alignment with Core Biomedical Curriculum



Topics covered in Clinical Longitudinal Curriculum will be devised in coordination with CBC course directors.

For example: heart exam during Homeostasis.

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Clinical & Longitudinal Curriculum



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Evaluation & Innovation in Medicine

- 4 years, core and elective content
- All students receive core content embedded in the week. Master's students take extra courses during summer and elective time.
- Institutional strength in health outcomes and systems change
- Scholarly projects & publications
- Flexible student specialization e.g. healthcare delivery science, leadership, global health, healthcare innovation...

Evaluation and Innovation in Medicine All Students	Leadership			
	Healthcare Systems: Design & Improvement			
	Measurement, Analysis & Critical Appraisal			
	Medicine in Context			
Evaluation and Innovation in Medicine Master's	Electives x 4			
	Scholarly Project leading to publication / quality improvement			
		4 credits, ~ 80 hrs per credit over 4 years		
		6 credits, ~ 40 hrs per credit over 4 years		
	Required hours	Hours in existing 4-year Geisel curriculum	Hours in proposed 4-year curriculum	Elective hours in proposed 4-year curriculum
Core track for all students	320	135	185 (~0.75/week)	0
Elective master's program	360	0	0	360



Healthcare
Evaluation &
Innovation

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Phase II Clinical Immersion

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Phase II: Clinical Immersion Training

- Starting ~2017; development is at an earlier stage
- Standard clerkships in 14 month span
 - Medicine & GAM, surgery, pediatrics, ob/gyn, psychiatry, family medicine, & neurology + elective time
- Early exposure to multiple specialties and elective time
- Longitudinal clinical didactics in each clerkship
- Advanced case-based sessions in foundational biomedical sciences taught by clinician/scientist teams

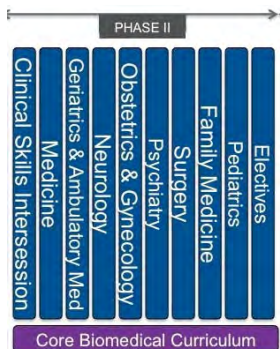
Clinical Skills Intersession

- 2-3 weeks
- Led by acute care and procedural specialties
- Pre-immersion preparation for basic clinical skills:
 - BLS
 - Phlebotomy
 - Peripheral IV's
 - Etc.



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Curriculum Framework



The Core Biomedical Curriculum Does Not End at the Third Year



Immersion rotations will include clinically-relevant sessions in foundational sciences integrated into clinical experiences by teams of clinicians and basic scientists.

Exact approach will be appropriate to each immersion rotation.



Clinical Immersion
Training

Phase III Differentiation & Exploration

Phase III: Differentiation

- Starting ~2018; development is at an earlier stage
- Required sub-internships
- New Integrated Acute Care Course
 - Collaborative integration into these didactics of clinically-relevant pathophysiology
- Several months of elective time
- Capstone Course



Skills Evaluation Intercession

- 2-3 weeks, starting 2017-2018, spring before Y4
- Later phase of development; we anticipate evolution of this short session so it builds on and complements clerkships, CLC, etc. in necessary way
- Guiding principles are: (1) overarching theme; (2) must align with institutionally required student travel (ERAS, etc); (3) must align with redesign principles
- Example under consideration: Observed Structured Clinical Exam (OSCE) + advanced communication/professionalism training, peer-to-peer training

Phase III: Capstone Course

- ~2 months starting in 2020
- Content of current capstone courses (CPT, HSP, AMS) as impacted by changes in curriculum of prior years
- Major facets
 - Completion and presentation of scholarly project (HSP)
 - Clinical skills for internship (CPT, ACLS, AMS)
 - Review of key pathophysiology (CPT, AMS)
 - Professionalism, ethics and humanism (AMS)
 - Class cohesiveness (CPT, HSP, AMS)
 - Elective experiences (AMS, HSP)



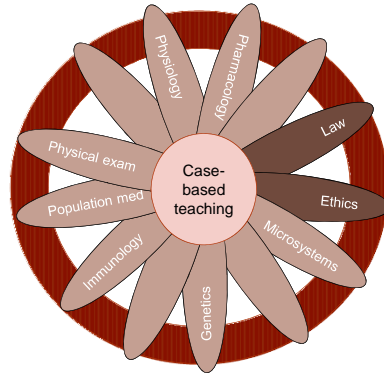
Clinical Immersion
Training

Why Ethics, Humanities & Practice Resilience?

- Support for
 - Patient empathy & professional behaviors
 - Personal well-being
- Adaptive work behaviors
- Avoidance of burnout
- Ethics and mentorship are required



Integration of Ethics, Humanities, Practice Resilience



Strategic Integration at Key Transitions in Student Development

- Foundations of Medicine
- Clinical and Longitudinal Curriculum
- Clinical Skills Intercession
- Capstone Course



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Ethics & humanities ~ 200 hrs total
Practice resilience ~ 34 hrs total

Frequently Asked Questions

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I don't see my department on that diagram. How will I teach in the new curriculum?

Multiple Faculty Teaching Roles

- Core biomedical curriculum
- Team design of cases
- Small group facilitators
- Large group framing session discussants
- End-of-block competency evaluation
- Phase II & III
- Clinical mentors
- Facilitators for small group, clinically-relevant discussions of foundational sciences linked to clinical experiences

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Multiple Faculty Teaching Roles

- Clinical & Longitudinal Curriculum
- Small group facilitators
- Clinic preceptors (primary care and monthly other)
- Healthcare evaluation & innovation
- Team-based design of cases
- Large and small group sessions
- Mentors for student scholarly work
- Threads & Themes
- Case-based design and framing sessions

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Is This Innovative Enough?

Innovation



- The learning context will be revolutionized
 - Small group > large group sessions
 - Active, experiential learning
 - Longitudinal outpatient training
- Innovative core and master's in healthcare evaluation and innovation
- Full integration of core biomedical curriculum in Y3-Y4



Do We Have Enough Space for All Those Small Group Sessions?

Rooms for Small Group Sessions

- Remsen renovation underway
- 8 rooms suitable for small group sessions e.g. 10-15 students each concurrently
- North Campus Academic Center includes several new rooms
- Space availability actively being evaluated and will be important piece of 2014-5 planning



This is neat – but different. How will I stay involved in teaching?



The faculty is really busy. Will there be support for teaching?

Support for Teaching

- Teaching is a joy, and an expectation.
- Contributions beyond baseline expectation* are funded additionally.
- The Office of Faculty Development is here to support you.

* Clerkship/course directors, longitudinal clinic and small group preceptors, other major contributors



How Will We Evaluate If The Redesign Is a Success?

Evaluation for Success

- Existing metrics
 - % time in active learning
 - Student performance on boards
 - Student satisfaction and burnout indices
 - Faculty resource utilization
 - Internship placement
- Novel metrics

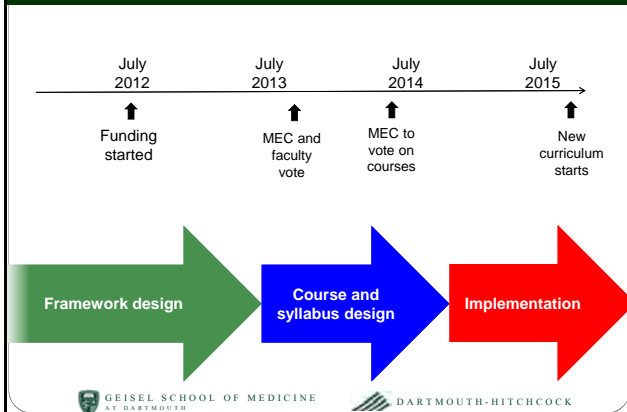


The next step is a grassroots effort



Connecting hearts & minds  to transform people's lives

Curriculum Redesign Timeline



Curriculum Redesign

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