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 12 weeks, 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

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

- Framework design
- Course and syllabus design
- Implementation

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<td>Faculty vote</td>
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<tr>
<td>July 2014</td>
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Is this right for our students? Exactly how will this work How do we operationalize the vision?
Can Our Faculty Teach All of Those Small Group Sessions?

We Have the Teaching Bandwidth

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<tr>
<th>Faculty Contract Hours in Current Curriculum</th>
<th>Faculty Contract Hours in Proposed New Curriculum</th>
<th>Added Faculty Contract Hours</th>
<th>Waste in Current Curriculum vs. Proposed New Curriculum</th>
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<tr>
<td>Faculty Contract Hours in Current Curriculum</td>
<td>Faculty Contract Hours in Proposed New Curriculum</td>
<td>Added Faculty Contract Hours</td>
<td>Waste in Current Curriculum vs. Proposed New Curriculum</td>
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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.

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

Phase II

Clinical Immersion
Clinical Immersion

- Builds on successful aspects of the present curriculum but with key changes.
- The clinical immersion proposal will include a ~16 month span.
- Clerkships now included in the ~16 month span:
  - Surgery
  - Pediatrics
  - Inpatient Medicine
  - Geriatrics and Ambulatory Medicine
  - Family Medicine
  - Obstetrics/Gynecology
  - Psychiatry
  - Neurology
  - Elective time
- Much as in the current curriculum, students will join department-specific healthcare teams in clinics and/or on the wards in the collaborative provision of direct clinical care.

Integrated Core Biomedical Curriculum

- Clerkships will deliberately incorporate clinically-relevant sessions in foundational sciences taught by collaborating clinicians and scientists.
- This program will have centralized oversight at Geisel and DHMC where the availability of scientist collaborators make this curriculum feasible.
- Case-based exercises, similar to, but more sophisticated than those students experience in Phase I of the curriculum.
- We will also use innovative online modalities to augment the existing in-person training experiences.

Clinical Skills Intersession

- Will aim to prepare students for life as full-time clinicians.
- Skills acquired in this ~2 week active learning intersession will include:
  - Advanced communications
  - Advanced physical examination skills
  - Phlebotomy and intravenous line placement
  - Basic life support
  - Advanced clinical reasoning
  - Evidence-based medicine
  - Using/getting the most out of the medical record
  - Amongst others.
- Thus, in the redesigned curriculum.
- Geisel students will continue to benefit from immersion in outpatient and inpatient departmental clinical practices.
- These experiences will be better integrated with foundational sciences and longitudinal outpatient training.
- Begin with effective training in basic clinical skills.

Block Schedule Alignment

- Currently – an unaligned schedule.
- Students not stopping/starting at same time.
- Dissatisfaction with half the class never being together at the same time for 6 to 12 month stretches . .
To accomplish: Blocks to all be 8 weeks long. Every 8 weeks is a break

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
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.

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Surgery

- Has capacity of 20 students/block.

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- By having capacity for more than necessary, this creates flexibility.
- We’ll do all clerkships this way…
### Medicine
- Capacity of 20 students/block

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### Ob/Gyn
- Capacity of 16 students/block

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### Psych
- Capacity of 14-16 students/block

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### Family Medicine
- Capacity of 16 students/block

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Neuro

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

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Overlap 20 20

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### Complex Math...

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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…
What else should we discuss?

Integrated Cross-Departmental Courses

Aug  Sep  Oct  Nov  Dec  Jan  Feb  Mar  Apr  May

Foundation
Cellular and Molecular Basis of Disease

Inflammation, Infection, Immunity & Inflammation

Homeostasis

Aug  Sep  Oct  Nov  Dec  Jan  Feb  Mar

Command, Control and Regulation

Nourishing the Body

Thank You!

Can Our Faculty Teach All of Those Small Group Sessions?
### Yes, If the Dean Can Afford 1-2 FTE

<table>
<thead>
<tr>
<th>Course</th>
<th>Faculty Aver Weekly Hrs (incl 1 hr prep)</th>
<th>Faculty Aver Weekly Hrs (presumed new curriculum)</th>
<th>Additional Faculty Contact Hours</th>
<th>Weeks in Excess of PHS 40 Hrs</th>
<th>Average FTE Hrs/Week</th>
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</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>274</td>
<td>105</td>
<td>207</td>
<td>7</td>
<td>12</td>
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<tr>
<td>Internal Medicine</td>
<td>275</td>
<td>135</td>
<td>170</td>
<td>15</td>
<td>12</td>
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<tr>
<td>Dermatology</td>
<td>362</td>
<td>196</td>
<td>302</td>
<td>15</td>
<td>25</td>
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<tr>
<td>Oncology</td>
<td>287</td>
<td>77</td>
<td>91</td>
<td>10</td>
<td>35</td>
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<tr>
<td>Gastroenterology</td>
<td>278</td>
<td>38</td>
<td>169</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>1081</td>
<td>291</td>
<td>1793</td>
<td>69</td>
<td>26</td>
</tr>
</tbody>
</table>

### How Much Will Clinical Faculty Supported for Teaching Be Paid?

- 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 $
Many Teaching Roles for Faculty

Course designer  Small group facilitator  Lecturer
Lab preceptor  Lead surgeon  Ward attending  Clinic preceptor

Collaboration in the New Curriculum

EXISTING
Large group sessions  Largely led by experts
Small group sessions  Facilitated by experts and generalists

REDESIGN
Interactive large group sessions  Largely led by experts
Small group sessions  Facilitated by experts and generalists

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

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 Benson, M.D.

Where We Began: TBA

Integration and Coordination Between Courses of Core Biomedical Curriculum

Course #1 Design Team
- Course Co-Directors
- Support from Medical Education Learning Design
- Faculty Development
- Block directors from relevant departments
- Thread and theme leaders

Course #2 Design Team
- Course Co-Directors
- Support from Medical Education Learning Design
- Faculty Development
- Block directors from relevant departments
- Thread and theme leaders

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
Milestones

Faculty conversation about redesign

Framework → Course Design → Implement

>100 people in 8 committees
Plus course design teams
Full faculty

Milestones

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Votes #1, 2

Milestones

Faculty conversation about redesign

Framework → Course Design → Implement

>100 people in 8 committees
Plus course design teams
Full faculty

Votes #1, 2

WHO WE ARE

Close knit
Independent thinkers
Outstanding patient care
Wise use of resources

REDESIGN

Mentorship
Critical thinking
Better clinical training
Healthcare leadership
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

Curriculum Framework

<table>
<thead>
<tr>
<th>Block</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Reproduction and development</td>
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</table>

This is a conversation
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

Collaboration in the New Curriculum

**EXISTING**
- Large group sessions led largely by experts
- Small group sessions led by experts and generalists

**REDESIGN**
- Added faculty contact time
  - ~26 hrs/week on average
- Generalist medical educators who collaborate with existing faculty
- Interactive large group sessions led largely by experts
- Small group sessions led by experts and generalists

This is a conversation
How Will Integration Be Coordinated Across Parts of the Curriculum?

### Coordination via Mapped Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Skills</td>
<td>1. Demonstrate a fundamental understanding of the roles of communication in health and health care; 2. Demonstrate the ability to communicate effectively with patients, families, and colleagues; 3. Demonstrate the ability to work collaboratively as a member of a health care team.</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>1. Demonstrate an understanding of the principles of patient safety and the role of the health care professional in maintaining patient safety; 2. Demonstrate the ability to implement patient safety strategies.</td>
</tr>
<tr>
<td>Medical Ethics</td>
<td>1. Demonstrate an understanding of the ethical and legal principles that govern the practice of medicine; 2. Demonstrate the ability to apply ethical principles in decision making.</td>
</tr>
<tr>
<td>Medical Science</td>
<td>1. Demonstrate an understanding of the basic principles of medical science; 2. Demonstrate the ability to apply medical science principles in clinical decision making.</td>
</tr>
</tbody>
</table>

### Integration and Coordination Within Courses of Core Biomedical Curriculum

#### Course #1 Design Team
- Course Director
- Black directors from relevant departments
- Support from Medical Education Learning Design
- Faculty Development

#### Course #2 Design Team
- Course Director
- Black directors from relevant departments
- Support from Medical Education Learning Design
- Faculty Development
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

CURRICULUM REDESIGN

Slides for Discussion

What else should we discuss?
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

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

Many Teaching Roles for Faculty

- Course designer
- Small group facilitator
- Lecturer
- Lead surgeon
- Ward attending
- Clinic preceptor

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
Implications for Teaching Workload

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

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

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?

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?

General Schedule of a Week, Year 1-2

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review, mentorship/ advising, and study time</td>
<td>Lab or other similar integrative session</td>
<td>Small group case-based session for Y1 students</td>
<td>Lab or other interactive teaching time</td>
<td>Small group case-based session for Y1 students</td>
</tr>
<tr>
<td>Large group session aligned with small group</td>
<td>Large group session, aligned with small group</td>
<td>Review and discussion of challenging cases</td>
<td>Healthcare evaluation and innovation</td>
<td></td>
</tr>
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</table>

- **Clinical Longitudinal Curriculum (CLC)** - Inpatient care and mentorship, small group discussion

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

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Longitudinal Themes & Threads

- Human Structure: histology, anatomy, biomedical imaging
- Pharmacology
- The spectrum of life
- 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
- Lab preceptor
- Lecturer

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.

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...
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.
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.

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 Intersession

- 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

Ethics & humanities ~ 200 hrs total
Practice resilience ~ 34 hrs total
Frequently Asked Questions

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

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
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

Curriculum Redesign Timeline

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Funding</td>
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Curriculum Redesign

Ideas, questions, concerns?