Minutes: Meeting of April 13, 1998

Present:
Drs. Carol Berkowitz, Bruce Chernof, Kenneth Dorshkind, Thomas Drake, Ronald Edelstein, Dohn Glitz, Theodore Hall, Lewis Hamilton, Carol Hodgson, Baxter Larmon, Neil Parker, Alan Robinson, Stuart Slavin (Co-Chair), Michael Stemerman, Margaret Stuber, Ronald Tompkins, John Tormey (Co-Chair), Richard Usatine and LuAnn Wilkerson.
Students: Alea Eusebio (MS2), Andrew Watson (MS2) and Andrew Weiss (MS3).
Guests: Joyce Fried, Louise Howard, Evie Kumpart, Gezelle Miller and Dr. Linda Baum.

There were no corrections made to the Minutes from the March 9th meeting and the Minutes were approved.

Review of last meeting and announcements, Dr. Tormey

It was proposed at the last meeting that students no longer be required to possess microscopes. The feasibility of dropping this requirement issue is being actively discussed by the Dean's Office, MEC leadership, and the Chairs of the Pathology and Microscopic Anatomy. Students are not currently required to use their own scopes in Year II, where they have been replaced by multi-headed teaching microscopes and web-based materials. A decision should be reached soon.

Educational computing overview, continued, Dr. Parker and Evie Kumpart

The minimum computer requirements for the Class of 2002 include the following: microprocessor speed of 166-180 MHz, hard drive size of 1 GB, and a Zip drive. It was decided not to require laptops because medical students require higher quality computer screens to view microscopic images, and facilities such as outlets in lecture halls are not available to accommodate every student.

An informal task force of UCLA and Drew members is currently at work to identify core competencies students need and to plan where and when they should be taught. A faculty survey was administered in fall 1997 to identify the computer skills that should be covered in the curriculum. Faculty indicated that e-mail, word processing, library searching and web access are key elements for student competency. The AAMC has published a list of core competencies for both students and faculty. The group note that some skills are necessary from day one and others can be learned when needed during medical school. Students will be taking computer-based tests in the future and will need to know how to prepare and deliver presentations. Computer competencies are probably best interwoven into the curriculum, rather than taught in a separate course.

A foundations program consisting of a review of requirements, demonstrations of systems and expectations and elective courses is being planned for the Class of 2002. Also, elective courses will be offered during the year for students who want to improve
their computer skills. Course chairs should assure that competencies need to be built into coursework and tested.

Suggestions offered during the discussion included:

1. Make instructional videotapes available to students to prevent repetition of same courses to same students.
2. Have a self-assessment course at the very beginning of each course.
3. Courses should be structured to include allotted time to learn computer skills, with built-in self-assessment. A case based course should require some computer-based activities.
4. Each first year course could take responsibility for teaching and testing one or more computer competency (ies).
5. After one more meeting, the task force should meet with the First Year Curriculum Group to share its recommendations.
6. Critical assessment of searches on the web of should be added to the list of competencies.

Medical Colleges Task Force, Interim Report, Dr. Slavin

History. The Medical Education Retreat began the curriculum restructuring process in October 1996 and helped to identify deficiencies in the curriculum. The Curriculum Structure Task Force was established to develop a broad outline for an improved curriculum structure. The findings were presented to the MEC and the Task Force was encouraged to move forward to develop greater detail for implementing this plan.

Toward this end, three new Task Forces were established, and they have been meeting since December of 1997. Phase 1 is responsible for looking into the pre-clinical years, Phase 2 is rethinking the core clerkships, and Phase 3 Task Force is designing the medical colleges and structure of the 4th year.

Strengths. The first task of the Medical Colleges Task Force was to look at the current fourth year curriculum. Strengths of the current curriculum are that it is flexible, enjoyable and relaxing; subinternships are thought to be very valuable, and students have opportunities for clinical experience, direct patient care and research.

Weaknesses. The weaknesses include:

1. Lack of direction or focus. With the positive flexibility, it seems that some students are not taking great advantage of the educational opportunities in the fourth year. There is also a sense that there is a lack of intellectual rigor.
2. Variable quality of mentoring. Some students have very good relationships with their mentors while others have relatively non-existent relationships.
3. Curricular omissions. In the AAMC survey, students indicated that there are content areas that seem to be neglected or undertaught (such as nutrition and pain management) and could be addressed in the fourth year.
4. Variable quality in elective courses and rotations. Some are excellent, others are less strong. Sometimes, electives might be chosen as an easy rotation rather than for the opportunity to learn.

5. Fourth year fizzle. The year fizzes out, and some students finish as early as February and drift through the last several months after the Match. Students end the year without any sense of cohesiveness.

6. Disconnection from the medical school. There is also a disconnection from school and peers during the final year.

**Colleges.** There was a strong consensus that the fourth year could be improved. There are various weaknesses and problems and the college concept, as a package, could address all of them.

A complete definition of a college has not been devised. The concept, however, is that it is a group of students and faculty who share common interests, working together to improve their educational experience in the fourth year. The colleges would be focussed on fourth year, but would also influence the first three years. Although colleges could be intellectual homes for students in the fourth year, they could reach outside their particular colleges for elective work under the guidance of their college mentors.

The colleges are not designed to be pre-internships. The goal is to address the weaknesses of the curriculum (lack of structure, etc.) while enhancing the strengths (flexibility, etc.) and create a more valuable experience that would lead to a better mentoring environment. The college experience would broaden students’ experience and provide a framework as they move forward into their internships. This concept should not be viewed as pre-professional training, but as a graduate school model.

Students would be required to declare a college at the start of the fourth year. However, the colleges would provide activities throughout the first three years of medical school, particularly during elective and summer time, which would help students prepare for college/career selection. The colleges would oversee existing electives, develop new electives, and implement faculty development for mentors.

Colleges would be multidisciplinary rather than discipline-based. The suggested colleges are:

- Primary Care
- Structural Biology (Students and faculty interested in surgery, radiology, pathology, and anesthesiology could participate.)
- Intensivist (anesthesiology, critical care, and emergency medicine interests).
- Research/Academic/Subspecialties: There was some difficulty in deciding the name of this college. The focus would be research, but it is hoped that research would take place in all of the colleges.
- Liberal Arts/Uncertain: There has been increasing support for this college.
Colleges would vary in size, resources and management. Their faculties would come not only from CHS but also from the affiliated hospitals.

**College Activities.** These would include mentorship, required courses (both college and clinical core rotations), selectives and electives, continuity experience, longitudinal seminar series, and scholarly work.

*Mentorship.* Rather than a central mentoring program overseen by the Dean’s Office, each college would be responsible for recruiting and training quality mentors. There would be both discipline-based mentoring (e.g., family medicine, internal medicine, and pediatrics) as well as multidisciplinary mentoring (e.g., medical education, public health, women’s health, geriatrics, international medicine, primary care research and health services research). Students could be matched with faculty with certain interests. Because the college would oversee this activity, a better quality assurance could be provided through faculty development and mentor seminars.

*Required courses.* The college core would consist of two two-week learning "retreats" – one at the start of fourth year and one after Match day. Activities of these core experiences would include seminars, small group sessions, workshops, and time to meet with mentors. The cores would also provide opportunities for students in each college to address important content areas in their own field, and also opportunities for the entire class to be convened on universal content areas. The time to be spent in college activities vs. school-wide activities has not been determined. Potential topics for college cores are law and medicine, nutrition, alternative medicine, quality in medicine, cost effective medical practice, pain management, physical exam skills and skills for residency (procedural skills, ACLS, ATLS, teaching, leadership skills, teamwork). Examples of Primary Care College core topics include geriatrics, long-term care, rehabilitation medicine, physical therapy, health education and nutrition.

In addition to college cores, there would be required clinical rotations similar to the currently required 300-level and 400-level courses. A four-week inpatient subinternship and a four-week urgent care or emergency medicine rotation might be required of students in the Primary Care College. Such clinical rotations need not be limited to the specialties of one college, and students would be able to explore specialties outside of their college. The colleges would decide on the specific requirements. The goal is not to narrow students’ pursuits, but to broaden them.

*Selectives/Electives.* Selectives would provide opportunities to choose three or four different rotations from a list of menus in each college. It was suggested that three-week rotations rather than four-week rotations would ensure exposure to more experiences and still be of satisfactory duration. Selectives in the Primary Care College might include adolescent medicine, allergy and immunology, dermatology, free clinic/underserved, geriatrics, infectious disease, orthopedics, sports medicine, and research.

*Continuity experience, Longitudinal seminar series, and Scholarly work.* A half-day per week continuity experience would give students the opportunity to pursue the clinical
experience of their choice or to work on a scholarly project. Students could choose to work on the project with peers and/or mentors. The longitudinal seminar series (including such topic areas as medical education, literature in medicine, international health, women’s health, public health, primary care and health services research) would allow students with common interests to come together once a month. This activity is modeled after Doctoring 4. Students would not be expected to attend every time. Each college would sponsor different seminar series, but students could choose seminars from any college. This activity addresses the issue of disconnection to the medical school and colleagues as well as content. Finally students would have to complete an acceptable scholarly product.

**Recommendations.** The Task Force recommends that the core clerkships end by mid-July at the latest. It further recommends adding four weeks to the fourth year continuum. UCLA students have fewer weeks of clinical training than at vast majority of medical schools.

If the core clerkships start in early July of the third year, students could complete them earlier than they currently do, even with addition of the extra four weeks. Currently, vacation time is used for travel and relaxation. The additional four weeks should not create an overly stressful environment. One student, who did not start the clinical years early, finished all course work in late February with only vacation time remaining.

**Implementation.** Implementation would be phased in first with mentoring. Then the seminar series, required clinical courses and selectives would be developed. The last activity to be implemented would be the college core/didactics. The overall implementation would occur over two years.

**Feedback.** The college concept has been presented to a group of recent graduates, about 15 fourth year students and to the Surgery Education Committee. There were concerns that the concept was too complex. However, the problems that need to be addressed are so multifaceted that a simple single solution would be inadequate. The college concept is a package deal that would address various issues and make an impact on the fourth year. Offering several colleges would broaden perspectives, but not serve as pre-professional tracks. The greatest concern from the fourth year students was that the concept would reduce flexibility. Although there would be a small reduction of flexibility, a significant amount of elective time (12-14 weeks) would remain available. Another concern was that students would have to make yet another choice that would increase anxiety. However, the Liberal Arts or Undecided College was designed to help address this issue. Finally, the activities of colleges would be educationally valuable, even to students who do not go into a field related to their particular college. This would be a significant improvement over the current system.

There are a number of problems in the current curricular structure. Part of the problem is that the school has tried to solve problems incrementally without respect for the total program. The college concept provides a structure under which solutions begin to interlock. The Task Force would like to maintain the flexibility of the fourth year, and
keep it enjoyable and relaxing after the rigors of the first three years and preparatory to entering residency.

**Recommendations from the MEC.** Dr. Alan Robinson suggested that the college names are getting in the way of moving forward with this concept. He suggested limiting the number of colleges and naming them with historical names (e.g., Osler College) to induce flexibility and overlap. A narrative of each college should be provided. He is excited about such a concept because he anticipates the planning of the new medical school facilities to follow a similar model. Colleges could also be structured by the selection of mentors.

**Next steps.** The Task Force should develop a strategy to build faculty buy-in early in the process through informed, knowledgeable partners in the planning stages.

It was decided to present the college concept to one or two more groups and then present it to the FEC at its June meeting, seeking approval from both the MEC and the FEC to move into the development and implementation stages with college teams.

The meeting was adjourned at 6:25 p.m.