Minutes of the Faculty Senate of the University of Colorado School of Medicine

April 10, 2012

I. Welcome: The meeting was called to order by President Ron Gill, Ph.D at 4:33 PM. Dr. Gill asked any guests and/or members of the media to introduce themselves. Dr. Bill Arend of the Department of Medicine introduced himself as a visitor and a member of the Retired Faculty Members Association. Dr. TJ Payne introduced himself as a new representative from the Department of Orthopedics.

II. Approval of the Minutes: The minutes of the March 13, 2012 meeting were approved without comments or corrections.

III. Dean’s Comments:
   a. Dean Krugman stated that there a few things to report regarding current searches and affiliate institutions:
      • The Dean of the School of Public Health has been selected and is David Goff, MD, PhD, currently Professor and Chair of Epidemiology and Prevention at Wake Forest University School of Medicine.
      • The search for a Dean of the School of Nursing is proceeding, three airport interviews have been conducted.
      • Two of three candidates for Director of the Bioethics Center have had interviews.
      • Dean Krugman said that he would be leaving the Faculty Senate meeting early to attend the first meeting of the University of Colorado Health System; this includes Poudre and the University of Colorado Hospital.
      • Regarding Memorial Hospital in Colorado Springs, Bruce Schroffel is there one day per week. Assuming that the negotiations with the city go through there will be an election in August where citizens will vote. If this is not approved it would stop our planning, including for the branch campus.
      • The committee has met to evaluate the six responses to the school’s RFP to the consultant group to help us with our strategic planning process. The state procurement process will notify the winner, then over the next nine months we will plan for the future. The Dean stated that he is hopeful that this will be a very broad conversation about the future with respect to the clinical, research, education, and community service missions of the school.
      • There is also the campus master planning process, this involves UCH, the VA, the Fitzsimmons Redevelopment Authority (FRA), Children’s, UCD, AMC, and the Aurora City Council, the last because of the roads. Lily Marks and Neil Krauss have four firms to help them. There are challenging but important issues with respect to transportation and other issues.
IV. Discussion Items:

A. Update on Tenured Faculty Retirement Incentive – Steve Lowenstein, MD, MPH, Associate Dean for Faculty Affairs. The buyout exists officially, but is not yet public. This should be available for 2012. It is for individuals with at least a 0.5 FTE. It is subject to funds available in 2012, and can be extended by the Chancellor. Those eligible for retirement are those who are 55 or older, and for whom the years of service plus their age is greater than 70. This is taxable income, so that those who take this can come back to work, but not at a salary that is greater than, or equal to, two times their base salary. This has different IRS requirements than the previous plan. The Dean will help insure that the department has funds. One question will be how to choose the faculty member if more than one wants to do this. President Gill: How will this be published? SL: Either by the Dean or the Chancellor, as soon as it exists faculty will be notified. Question: Faculty at which campus are eligible for this? SL: The downtown campus and the Anschutz Medical Campus, the guidelines will cover all. The school will have to work this out fairly for faculty.

B. Update from 2011 Curriculum Retreat: Potential Modifications of Curriculum – Stuart Linas, MD, Chair Curriculum Steering Committee. Dr. Linas began by reminding senators that the main group that the Curriculum Steering Committee (CSC) reports to is the Faculty Senate. Their retreat took place last Spring; one hundred individuals met for 8-9 days. Four key areas were identified for further discussion, there is no decision yet, these are at the task force stage. The committee welcomes input from all faculty and senators regarding these.

The four key areas are: Master Educator, Learning Communities, “First Course”, and Longitudinal Clerkships. Each area has a “champion”. Robin Michaels, PhD, Associate Professor, Cell and Developmental Biology, Assistant Dean, Essentials Core Medical Curriculum is the champion for the Master Educator. Many schools of medicine recognize that it is important to recognize faculty with skills as educators; CU has not had the resources to reward this. As basic scientists play an important role in medical school teaching, this will first be addressed for basic scientists. The task force will determine the definition and work effort of a true Master Educator. The questions for the task force include: Is a Master Educator more than a great teacher/content expert? Are they different than a Block Director? Should there be some scholarship in education, or a hybrid? What is the definition of scholarship in education, is it innovative teaching techniques, novel ways to assess students, publications in education, mentorship of junior faculty? There are different types of interests/expertise. Finally, where will these faculty be primarily housed, i.e., evaluated? The task force will address these questions.

Next are Learning Communities. The champion of this is Marsha Anderson, Associate Professor of Pediatrics. This is like the college system for undergraduates. Learning communities have been introduced in many medical schools throughout the US. These divide students into groups or “houses” and the houses are subdivided into smaller groups. Advantages are:
the curriculum can be delivered in small groups. This fosters building of interpersonal relationships with a group of individuals, increases interaction with a faculty mentor, allows opportunities for ongoing personal and career mentoring, allows opportunities for student interaction between classes (it will include 1st, 2nd, 3rd, and 4th year students) within the structure of the house, and it allows opportunities to improve wellness and support to students. The task force is currently developing a proposal for the CSC to consider, including: goals; logistics and structure, developing a structure that is cost efficient; considering ways to integrate students in Phase III and IV; budget; timeline; and the curriculum that could be delivered within this structure. This does allow the opportunity to deliver some Longitudinal Curriculum within Learning Community groups.

Marsha Anderson is also the champion of the “First Course.” This could be a home for the Longitudinal Curriculum. The Longitudinal Curriculum has several elements, these are: Foundations of Doctoring; Mentored Scholarly Activity; Problem Based Learning; Threads (Culturally Effective Medicine, Evidence Based Medicine, Humanism/Ethics/Professionalism, Medicine & Society); Interprofessional Education; Integrated Clinician’s Course; Tracks (elective) - Global Health, LEADS, Research, Rural, Women's Health, CU-UNITE (urban underserved). Most of these elements have a defined home, Threads are woven throughout the curriculum, but there is currently no place to develop a consolidated knowledge base. An opportunity for the Longitudinal Curriculum home is to develop a “First Course” that would occur during the first 1-2 weeks of medical school to provide framework for what students will be learning in medical school. This could include vignettes - standard and complex; ethics; life-long learning; and would carry through the 3rd and 4th years. We could partner with Student Affairs to build Learning Communities. The task force is currently meeting to define recommendations for: length of course (likely 1 week); logistics - add an additional week to the current curriculum, this is hard with the yearly schedule; budget; content. This likely would include introduction to a few virtual "patients" who would be referred to throughout the Essentials Core; likely will include base curriculum on thread topics; what is health?; Health system structure in the US (Medicine and Society); Health disparities (Medicine and Society); culturally effective medicine; professionalism (life as a medical student); timeline: with a possible roll-out 2013 or 2014 depending on logistics. The goal for the longitudinal curriculum home is to have a recurring curricular slot where the longitudinal curriculum is presented. This could be accomplished by utilizing the 1-3 PM time slot weekly in weeks that PBL (Problem Based Learning) does not meet, use of this timeslot would provide reinforcement of Longitudinal Curriculum on a weekly basis (PBL or other longitudinal content), curriculum could be delivered in "learning community groups" if Learning Communities are developed.

Last are the Longitudinal Clerkships. Brenda Bucklin, Professor, Department of Anesthesia; Assistant Dean, Medical Education is the champion. This is a schematic of the current third year. It is a standard block system. A student
rotates through in a structured way. An integrated clerkship looks different. On Monday a third year student starts at one hospital, and in the AM may be in Internal Medicine, in the PM in the ER, and in the evening is scheduled for reflection in a group. On Tuesday morning the student is in the Family Medicine Clinic and in the PM has self-directed learning which may be an opportunity to see a patient from a different clinic having a procedure. This was championed at Harvard and has been found to offer better learning opportunities and more long-term exposure to individual patients. For example, a student might see a patient in the hospital, and when that patient leaves the hospital the student would follow them in clinic and have long-term exposure to their care. This promotes patient-centered attitudes and promotes empathy and more patient-centered decision making. A 2009 article: Longitudinal, Integrated Clerkship Education: Better for Learners and Patients, *Academic Medicine* 2009; 84:821 included the advantages as: better clinical learning opportunities, more longitudinal exposure to disease, promotes patient-centered attitudes, prevents erosion of idealism and empathy, greater understanding of ethical decision-making and how social context affects patients, and students are more likely to receive feedback and mentoring. The goal is to meet the core clinical education in the longitudinal curriculum. Students can participate in the comprehensive care of patients over time, have continuous learning relationships with clinicians, and meet the majority of core clinical competencies across multiple disciplines simultaneously. It is an integrated approach. This could first be piloted at Denver Health and then expanded.

The process for moving forward is that the champions present proposals (including budgetary needs) to the Curriculum Steering Committee (CSC) for an up or down vote-2/3rd vote of CSC required for approval. Input from any faculty member is encouraged. The CSC is to prioritize the order of enthusiasm of the four proposals; the Faculty Senate will review this and provide input. The CSC will present the recommendations to Dr. Celia Kaye, Senior Associate Dean for Education, to give final approval based on budget availability. Dr. Linas then asked for thoughts, questions, concerns.

There were many questions. The first was: how many medical schools are doing this? Dr. Linas replied that none have all four items in place. The 25 – 30 top medical schools have one or more. Fewer have the integrated curriculum. Comment: this works well for great students and great teachers, others could be stuck. Dr. Linas replied that we are working toward an individual student curriculum. This is a start in this direction. This curriculum is flexible and allows time for self-directed reading. Comment: But the students aren’t reading now. Dr. Kaye: The self-directed time is time to follow their patients, they are still expected to be the knowledgeable person about their patient to the ward team. Students apply for this, it is very hard in the beginning. The students self-select this, and are selected. It is not for all students. Question: What does the 4th year look like? Response: The 4th year looks the same. Comment: this has a downside for different services. The ER doesn’t fit this. ER physicians are shift workers, we don’t see the
same patients, the students won’t see the same physicians. Also, do they get enough exposure; is this too piecemeal? Dr. Bucklin: This has had positive student outcomes; South Dakota has had this for 20 years. Students exhibit better empathy, they have less erosion of empathy over time. They have a better idea of the social situation of the patient. In the block system they have 8, 6 and 4 week blocks, in the longitudinal clerkships that time is still built in. Surgeries take priority. If a chronic renal patient goes to surgery, they follow that patient. Or a student might go to Labor and Delivery when a patient is admitted. They have proportional shifts; we still have to deliver the equivalent amount of content. Comment: They might learn more about a patient or a disease, but they will learn less about a specialty.

Question: Do they get enough experience with DKA, trauma surgeries? What about intensive clinical experiences? Dr. Linas: When programs and students are surveyed they love it. The students are as well or better prepared. 

Comment: But part of learning is the intensity and the total immersion. There may be as many content hours, but they lose the total immersion. Some manual and visual skills can only be learned by contact with a mentor. They won’t integrate this if you dilute it over time. You learn better with intensity; this seems Family Practice oriented. Dr. Bucklin: The research shows the opposite, students have longitudinal mentoring. They log cases and see the same number as those in the block rotations.

Comment: I am in Orthopedics, one student is with me every Friday; the students feel like they are working in five places in one week. Question: How does this work in the inpatient world? There’s no team, as a medical student it was important to be part of the team. Dr. Bucklin: There is a 2 week initial start up inpatient rotation that is a team experience. The emphasis is moving away from inpatient to outpatient care. Some students will flourish. Dr Kaye: The third year is a different time. The 4th year is still a block elective, students will hone skills of professionalism and discernment in the third year.

Comment: You lose the feeling of what it is like to be a surgeon. Dr. Linas: It is not for all students, it is for a small group in the right setting. President Gill: Based on the interaction I have had with the first year students, the majority are reluctant to pursue integrated sorts of things, they want immersion. Also, how taxing is this on the faculty? Dr. Linas: I agree it takes special faculty. It is not for all of us, because of time, rvus. Dr. Bucklin: We will do faculty development pieces. It is easier on the preceptors, they get to know the students. The student is their partner. The outcome is that the preceptors are more engaged. President Gill: Are those people available to serve that role? Will it work logistically? Comment: This is about the Master Educator, what is the impact on the curriculum, and how are they different? Dr. Linas: That is what we are asking the task force, this should be accurate and fair.

President Gill: Regarding the Master Educator, this could be a particular person who is a content expert following through several blocks, or this could be one person teaching pharmacology; in the last case there is continuity, students know the style and the content flows.
Comment: Yes, there is one person who is only a teacher and is the block director for their field in Medicine and Dentistry, but are the basic sciences going to have the budget for this? Dr. Linas: There will be a budget and support for part of an FTE. President Gill: It is the school’s responsibility to have these people. Dr. Lowenstein: If we invest in a Master Educator what happens to the other faculty? Dr. Kaye: We have no intent to replace faculty, they are high level experts in their field. A goal is to provide four years of continuity. We have an unfulfilled promise; we shortened the basic sciences in years 1 and 2. We need to bring it back in years 3 and 4. What is different about physicians as health-care workers? Physicians know the basic science and apply it. Comment: Why change? Dr. Kaye: We live in a larger educational world. The concept of integrated learning is being developed. It will work for some. Board scores go up, empathy and ethics stays high. Dr. Linas: We are trying to do what is best for groups of students. One way is to introduce an important new way to educate medical students, we will pilot it to see if it will work. Dr. Lowenstein: This is hard for the faculty. But Dr. Hirsch said that the purpose of education is not to re-make ourselves.

Dr. Linas: Thank you, I will keep you informed. President Gill: I am sure there is more lively discussion to come.

The meeting was adjourned at 5:55 P.M.

Respectfully submitted, Renata C. Gallagher, MD, PhD.