Frequently Asked Questions about the new Curriculum Proposal
3-25-10

1. Faculty CDT Town Meeting January 27, 2010 Part one of the curriculum only

Q.1.1a: How will the CDT plan affect post graduate training, i.e. interns, residents and fellows in terms of flow, integration, team composition and faculty development needs?
Q.1.1b: How will the new curriculum affect the interactions of medical students with residents?

A. The CDT plan assumes the same team structure as we currently have but students will be better prepared, due to clinical training and early clinical exposure, to assume a more significant team role and contribute more. Ground school and competency based evaluation should improve the preparation of students and release post grads from many routine duties. The use of individual student portfolios should focus student education on the competencies that they need to accomplish and help the interns/residents/faculty know what the student needs to accomplish during the clinical experience. In addition we believe that our students will be more clinically capable and advanced in the application of foundational sciences to clinical problem solving. Residents will spend less time working with students on routine house-keeping and basic skills training and more on advanced problem solving and evaluation skills.

Q.1.2: How will the CDT plan affect admissions and recruitment?

A. The 100 year post Flexner Report Redux and other trends in medical education are leading the way for curriculum change across the nation, change is coming. The 2+2 model; is being challenged by many other schools including UCSF, Harvard and UKMC. We plan to be a leader in curriculum innovation and produce demonstratively superior graduates and believe that this will improve our applicant pool. Students applying to medical school in 2012 will be ready for change and innovation, more interested in flexibility and choice, will be attracted to early and sustained longitudinal clinical experiences, and the ability to accelerate as well as slow down their education and avail themselves of dual degree and MD-PhD training. The CDT blueprint should prove to be very exciting and more of a draw if anything.

Q.1.3: Student interest in research is growing, top 20 schools offer research options to medical students how will this plan allow for “meaningful research options” of sufficient length to accomplish research training.

A. Students can accelerate and investigate research as well as career exploration throughout part one of the CDT curriculum. The break within part one as well as the end of part one are designed to provide such opportunities. Part three offers opportunities of two to three months for research or specialty exploration. The CDT proposed curriculum has been designed to provide more opportunities for MD-PhD and research oriented students as well as physician scientists and clinicians.
Q.1.4: How many weeks are there in the planned curriculum and will students be able to graduate early?

A. 139 weeks of “contact” time. Part one will require 18 months including breaks and optional experiences, part two will require 12 months and part 3 is designed to be 12 months with graduation the first week in May. It is anticipated that this will match university semester graduation timelines. Due to longitudinal clinical exposure and small group projects it would be difficult to graduate earlier, but students demonstrating competency in all areas (including: history taking, physical exam, patient centered care, clinical applications and problem solving, systems-based practice and practice-based learning) will be able to explore advanced topics including specialization and research.

Q.1.5: Some sub-specialties are not represented in part two, how will students gain exposure to these and other possible careers?

A. In part one there are designated times for career exposure and exploration experiences. It is anticipated that departments will create opportunities for students to preview their specialty during these times. In part two there are 16 weeks of time for more in-depth explorations and cross-disciplinary options. Also the projects in part two can be met in multiple ways involving research and clinical exposure.

Q.1.6: Will guidance for career development be provided in the new curriculum?

A. Yes. It is intentionally emphasized throughout the curriculum. Career development is integral to the faculty mentored educational portfolio and in the longitudinal small group activities as well as formal electives.

Q. 1.7: Will ISP and dual degree programs be continued?

A. Yes, independent study and dual degree flexibility will be offered within the prescribed portion of the curriculum. This curriculum preserves and enhances choice of learning style. The MD PhD program will be maintained and enhanced. Flexibility for student learning styles will allow switching back and forth between learning styles unlike the current curriculum which requires repeating a year if students switch pathways.

Q. 1.8: Specialty pairing in part two looks like a continuation of the current clerkships – what’s really changed?

A. Part two like the rest of the curriculum will be planned and implemented by foundational scientists and clinical scientists. There will be more integration of the sciences that are foundational to understanding clinical problem solving and treatment. Student portfolios will focus on competencies that will be best accomplished in interdisciplinary experiences. Ground school and common evaluations of clinical knowledge, skills and attitudes will require breaking down of specialty silos and closer integration of disciplines.
Q.1.9: *Musculoskeletal subjects are not included in the diagram yet they are essential for physical exam, diagnosis and treatment in primary care.*

A. It is included in other documents, diagrams and descriptions. At this level of overview we are unable to provide that degree of granularity. There are documents which map the objectives to the curriculum which will be in the final report. In the current blueprint MS topics are contained in the first sections of part one along with PE and anatomy. There is built in “reinforcement” (as opposed to redundancy) throughout the curriculum. MS topics will be contained in part one and then reinforced in the ground schools in part two. In this way we plan for less “binge purge” learning and more long term, deep levels of applied and integrated learning.

Q.1.10: *How will the new curriculum effect board preparation and scores?*

A. The new curriculum, will have an integrated and longitudinal board prep throughout. Shelf exams will be given throughout all three parts which will help in preparing students to take USMLE exams. Students will be required to post a passing score on Step 1 before entering part three. We assume most students will take Step 1 at the end of part one but those who desire more competitive scores for residency applications can delay until later in part two.

Q.1.11: *How will the new curriculum affect the MSPE (deans letters)?*

A. No doubt many of the same assessments will be available for inclusion in the MSPE. In addition portfolios better prepare our students for residency program applications. Subsequent use of portfolios in residency training, as is becoming an ACGME requirement, will give our students an advantage. Common evaluations in part two and intercessions will provide consistent evaluation data on student progress.

Q.1.12: *Will there be enough practices to implement the empanelled patient small group activities?*

A. When this plan was reviewed with several clinical and basic science chairs there was strong agreement that there would be sufficient practices to implement the empanelled patient program. We believe it will be a struggle at first like anything new. The current plan is of course subject to change in planning and implementation based on feasibility and faculty-student input, but our initial plan requires 50+ practices in the first two years.

Students will meet in groups of 9 assigned to a practice, but only one student from the group will be at the practice for a half day each per week. In the second and subsequent years two groups will be assigned to the same practice with peer teaching required of 2nd year students. Also these students will be trained from early in the curriculum to be contributing members of the practices through appropriate procedures, taking H&Ps, checking labs and other functions. In addition to empanelling patients, whose medical problems correspond to curriculum topics, they will gain tremendous experience in
practice-based and systems-based learning, doctor patient relationship, team work, relationship skills and communications.

2. Faculty CDT Town Meeting February 9, 2010, all three parts of the curriculum

Q.2.1: How were clinical foundations selected? As a surgeon I wonder where oncology and solid tumors are covered on this diagram.

A. The CDT followed the LCME requirements to assure compliance with the required baseline of basic and clinical sciences. In addition to assuring competence in the new general educational objectives we also took into consideration USMLE guidelines. We tried to anticipate future changes in USMLE exams to the extent possible and this curriculum allows for flexibility to accommodate potential USMLE changes. We also looked at recent recommendations from national and international associations in all areas of medicine. Although the CDT could not look too granularly at content, the implementation teams and detail planning teams will be composed of foundational sciences and clinical sciences faculty. The new curriculum will be more systems than discipline based and consider content longitudinally rather than the typical 2+2 system of basic and clinical science that only serves to reinforce binge-purge memorization and not integration and long term deep learning.

Q.2.2: With team-based projects and a longitudinal curriculum, will students still be able to take LOAs?

A. Yes, there is more flexibility in the design to allow students to be able to take LOAs at the built-in natural breaks. In addition to two planned breaks in part one of the curriculum, the part two flexibility of entering rotations at differing times will more readily accommodate dual degree programs. The new curriculum will be more in sync with the university semester plan. As it is now in the current curriculum there are some issues with accommodating LOA’s but these involve only 2-3 students per year not completing their medical education. Although we do not like it, we believe a 1%-3% failure to progress rate is in line with National data.

Q.2.3: Will this new curriculum require a different kind of student than we currently recruit, possibly more independent in learning style and able to set their own learning goals and judge their own progress?

A. We find today’s students very technically savvy and able to choose between various learning styles with ease. They are probably more self-directed than we give them credit for already. The student who will best thrive in this new environment will be able to critically assess their own learning deficiencies and strategies for accomplishing their own goals. While mastery and competency assessment will be key features of the new curriculum, students will be guided by careful self-reflection and in consideration of their educational portfolios, with appropriate faculty mentoring. We feel that early clinical
exposure, flexibility and student choice will be some of the key student recruiting features of the new curriculum.

**Q.2.4: Given that answer, will the CDT and the Admissions Committee work together to recruit the best students possible?**

**A.** Yes of course. We believe that recruiting the best students possible will always lead to better prepared residents and practicing physicians. We think the emphasis in part two on core requirements combined with student selective and elective experiences and longitudinal faculty mentoring will lead to students who rival our current PGY 1 residents and be measurably superior in GME.

**Q.2.5: With the emphasis on teamwork, will there be opportunities to work with non-medical students and other health sciences students?**

**A.** Portions of the two interdisciplinary projects are designed for just those opportunities. The new general objectives require competence in practice-based and systems-based education and competencies involving team work, communication and working with other types of health care providers. Not only is the new curriculum more “semester friendly”, but the longitudinal empanelled patient experiences will offer opportunities for students to accompany patients on visits with many different health care team members.

**Q.2.6 Are other medical school curricula adopting early clinical experiences, longitudinal integration and clinical thinking early in their curricula. If so what outcomes have they discovered?**

**A.** As part of its deliberations the CDT reviewed every accredited medical school curriculum the US and Canada. Most were found to still be based on the 2+2 model. A few are just beginning to reconsider the basic model of medical education. Many innovations we read about do not yet have outcomes. The new Flexner post 100 year report will stress relationship and patient-centered care and the importance of longitudinal faculty-student relationships in preparing better residents and physicians, both features of the new curriculum. The more students and faculty know each other and work together the more competent the students become and the higher the expectations are raised for their education. Many of our fourth year students will rival PGY 1 residents due to these close associations with faculty.

The CDT’s blueprint incorporates many of the trends in medical education that others are just beginning to understand, while maintaining the best of the OSU COM’s long tradition of medical education innovation.
3. Community Physician Advisory Committee (CPAC) Meeting
February 9, 2010

Q.3.1: Has the CDT considered the use of free clinics as a method to engage students in longitudinal clinical exposure? This may reduce the need for some individual practices.

A. The free clinics were considered in the discussion of possible sites for student practices, as were prison clinics and the VA. However, the implementation teams will need to consider the venues that can meet the student practice requirement. If free clinic patients are stable enough over time to be followed for 3-4 years they might meet the curriculum needs. When we asked chairs if they thought the empanelled patient portion of the curriculum could find sufficient practices to meet our needs the answer was a firm yes.

Q.3.2: Will the career exploration opportunities be graded or evaluated in some form? If not there is the potential that some students will not take these opportunities seriously.

A. Yes, in that they will be written up in the student’s portfolio and reviewed with faculty mentors. Early and ongoing career exploration is an item that students want very much in the new curriculum. The anticipated design of these experiences with reflection and discussion would better engage the students and lessen the possibility of students not taking it seriously.

4. Student Council CDT Presentation, January 13, 2010

Q.4.1: How will departments create learning opportunities in Part 2 and how will they be scheduled?

A. The implementation team will set specific guidelines for clinical immersion experiences. Departments that wish to offer a clinical experience that meets the guidelines will be encouraged to apply. A central oversight committee will work with departments to ensure that the clinical immersion experiences meet the requirements. Scheduling for these experiences will be done through a central process as it is now.

Q.4.2: What is the minimum length of time in any one “clerkship”?

A. This has not been determined. It is anticipated that there will be certain clinical immersion experiences of a particular length that are required. For example: 4 weeks of general surgery. Then it is anticipated that there will be clinical immersion experiences that are two or three weeks in length with greater student choice.

Q.4.3: What is the flexibility in scheduling interview months given the structure of Part three?
A. Part 3 contains 4 conceptual frameworks with an additional four months of flex time that can be taken at the student’s discretion for interviewing and away rotations. It is anticipated that departments would be able to create 1-3 month offerings for students within the Advanced Competences Track and Advanced Clinical Track that can be schedule at any point in Part 3.)

Q.4.4: What problems with the current curriculum are we trying to fix and how will we know if we fix them?

A. There is not necessarily a problem with the current curriculum. However the committee looked at creating a curriculum that would specifically address all of the aspects of the core objectives for medical curriculum adopted in 2008. The new objectives require that the graduating student have a skill set different than the current design. The new objectives and the proposed curriculum will ensure a skill set that will be essential for the practicing physician of the future.

Q.4.5: What are the dollar costs and benefits of new curriculum and will it be “worth it”?

A. Although it is anticipated that the new curriculum will require a redistribution of the way we use curricular dollars, it is not anticipated that this design will cost substantially more than the current curriculum to delivery. The benefits are many, to mention a few; reduced attenuation of foundational science knowledge, specific focus on students learning to be self-directed learners, creating a framework that integrates foundational and clinical sciences, early clinical experiences and clinical skills development and enhanced opportunities for students to excel.

Q.4.6: Is there time to study for Step 1 and 2 and when will students be required to post a passing score? Will shelf exams still be used?

A. It is anticipated that students will take USMLE subject (shelf) exams through all three parts, which will allow students to become accustomed to the testing format of the Step 1 and Step 2CK exams. The use of OSCEs throughout the curriculum will also help students prepare for Step 2CS. At the end of Part One students will need to pass a comprehensive subject exam, which would be similar to the Step 1 exam. It is anticipated that most students will also sit for their Step 1 exam before beginning Part Two of the curriculum. Ultimately though, students will need to post a passing Step 1 score before the are allowed to enter Part 3 of the curriculum. It is anticipated that students will begin to take Step 2 CK and CS soon after beginning Part 3. Passage of Step 2 CK and CS will still be a graduation requirement. There will be a longitudinal board preparation built into the curriculum to help student prepare for the exams. Time between Part One and Part Two will also be available for students to use as independent study time to prepare for Step 1. It should be noted though that during this period of time, a light schedule of curricular activities is still in place.

Q.4.7: How will dual degree and MD/PhD programs be affected?
A. Students in the MD/PhD program and other dual degree programs will be integrated into this structure in accordance with the requirements of the dual degree. In many ways this structure provides natural breakpoints for students to participate in a dual degree and allows for the possibility of an individual student maintaining a clinical association with their student practice if needed for the dual degree. This might specifically be the case for students in the MD/PhD program.

**Q.4.8: How much time will be scheduled in class per day?**

A. This will vary greatly depending on how students choose to master the material. Students can learn material through classroom sessions, podcasting, and ISP like modules thus allowing them to choose the best method for learning the required material. It is anticipated that material within the ground school will be available in a similar fashion in part two.

**Q.4.9: How will you assure quality control of preceptor practices and provide faculty development?**

A. This blueprint would require a greater degree of faculty expertise in both the way they teach and how they assess students. Thus there is an entire team in the implementation process that is dedicated to faculty development. This team will ensure that the faculty participating in the curriculum will have the requisite skill set. There is a separate implementation team for assessment.

**Q.4.10: What are the empanelled patient program details?**

A. Student practices will have a list of types of patients they need to empanel and when that coordinates with the curriculum. Individual students within the practice will ensure that the correct number and types of patients are empanelled. In addition to individual student reports on patients, the electronic medical record will be essential in allowing all of the students within the practice to be informed of and up-to-date with the empanelling program.

**Q.4.11: How will we measure outcomes?**

A. There is an evaluation and assessment implementation team that will look at both the evaluation and assessment of students and the different aspects of the new curriculum.

**Q.4.12: Is advanced work graded?**

A. It is anticipated that all of the work students do will be evaluated in some fashion.

**Q.4.13: If students are allowed to test out early in some parts of the curriculum will they be able to use this time to explore careers and research, or to get ahead or in the curriculum?**
A. Yes students will be able to explore both careers and research with this time. It will be difficult for students to get too much further ahead in the curriculum due to small group empanelled patients and project work. They could use this time to study, or prepare for boards, or pursue explorations as suggested.

Q4.14: Will advanced explorations and activities be evaluated/graded?

A. Not necessarily graded, but they will be reflected in student portfolios and may factor into deans letters and composite grades. i.e. letters and honors. These activities will be in addition to minimum competencies and should be reflected in their deans letters.

Q4.15: What happens if a student doesn’t pass step 1 in time? When and how can this be made up?

A. Much the same as now, students will have to stop out of course work and complete this requirement. It will have to be dealt with on a case-by-case basis as it is now. Some accommodations for re-starting Part 2 or 3 will have to be provided. What that is will have to be determined. It is anticipated that there will be fewer first time Step one failures than currently (approximately 4%) due to better curriculum preparation and student choice as to when to sit for the exam.

Number 5. Student CDT Presentation, March 9, 2010

Q5.1. Will students be held accountable for advanced work and if so, how?

A. Students who test out during parts 1 and 2 of the curriculum will be able to explore topics within that block content area. Although not totally defined at the present time, students may be allowed to pursue advanced topics other than those related to the current block they tested out of. Advance work will be documented in the student portfolio and dean’s letter. It is up to the Implementation Team how they will actually “grade” or otherwise hold students responsible for these activities.

Q5.2. Will the impaneled patients be standardized patients or real patients?

A. The intent is that students will impanel real patients in a real practice so that they can review the basic sciences in relationship to specific diseases and then revisit these patients to follow-up on their progression and/or resolution. These will be ongoing projects with real patients, for the entire four years. We may have to use some simulated patients for uncommon or unavailable diseases and patient conditions.

Q5.3. Students are enthusiastic about many of the changes proposed by the new curriculum, especially opportunities for early career exploration, early patient contact, career counseling and opportunities to explore advanced topics. Our concerns revolve
around any disconnect between USMLE Step 1 and the Part 1 of the curriculum and how they will be addressed.

A. Part 1 of the curriculum, essentially, Med I and II currently, will be board preparation continuously and throughout. OSU students performing well on high stake USMLE exams is important to all of us, therefore, we will also be utilizing shelf exams throughout Part 1 and 2 to ensure that students have an idea of the testing and assessment and style of integration of questions like those used in the USMLE exams. It is planned that there be more longitudinal integration throughout Part 1 and 2 of USMLE content and evaluation. There will be a shelf test at the end of Part 1 and students will chose when they wish to take the board exams, i.e. those who wish to score well in the more competitive residencies may take more time to prepare themselves to take the boards. The only real requirement is passage of USMLE Step 1 before they can enter into Part 3 of the curriculum.

Q5.4. Why is the CDT recommending such drastic changes in the curriculum rather than gradual changeover time?.

A. The design of the new curriculum requires longitudinal integration of patient care throughout all four years and over the entire curriculum. Although we will run pilots of specific programs over the next two years, we need to implement this program in total in 2012. It will be rolled out in stages year by year maintaining the old curriculum for those students currently in that curriculum until they are able to complete their education. The CDT has discussed introducing parts of the new curriculum, such as early clinical exposure into the current curriculum, not only as a pilot, but in order to improve the current curriculum.

Q5.5. What is the timeline for the proposed curriculum?

A. Part 1 of the curriculum includes what is now known as Med I and Med II. This will run approximately eighteen months with Part 2 beginning in April to May of the second year. Student will continue through the curriculum with a Part 2 and Part 3 with graduation in May to accommodate the university changing from quarters to semesters. Because students will have at least one clinical rotation block completed by the end of what traditionally is Med II dual degree students will have at least one of three clinical rotation blocks before taking time off to pursue their PhD work or other degrees. The new curriculum will hopefully better prepare students for residency by starting them earlier and getting them more integrated experience. Working together with faculty mentors over a longer, more protracted period of time will make our students some of the best prepared residents in the country.

Q5.6. With so much of the curriculum depending on impaneled patients, what plans do you have for preceptor training?

A. Faculty development will be integral to implementing the new curriculum. Currently there is a faculty development sub-committee on the Implementation Team to address
just these issues. As discussed, students will be assigned to a practice and having received advanced training early in their curriculum, be an asset to that practice. By the time students begin being integrated into their practice, they will have developed history and physical exam skills as well as “rooming” a patient in order to contribute more to the practice. Because students will be assigned to the same practice over time, this will build firm relationships with the faculty rather than the current periodic and sporadic relationships they have in the ambulatory arena. This will not necessitate nearly as much reorienting to a new practice; it will improve coaching by preceptors as well as evaluation; and all activities will be monitored and integrated into the curriculum by OSU faculty in small group activities. As students advance through the curriculum in Part 2 and 3, they will become peer mentors to entering classes and not only be able to orient students to the practice, but assure feedback to curriculum leaders on any further faculty development needs.

Q5.7. The new curriculum revision seems overwhelming. In previous classes, we have been able to get support and assistance with making curricular choices from advanced classes. Publications such as the Tadpole and other services provided by more advanced students will not be available. How do you plan to accommodate this issue?

A. While it is true that there will be no previous class experience with the new curriculum, that is always true with any curriculum change. Quite often, we realize students feel like “guinea pigs” being the first class through any new curriculum. We also realize that the proposed curriculum involves a lot more student choice and we will provide more advising for the first few classes to assist students in making these choices. As previously discussed, as students advance through the curriculum, Part 2 students will become mentors to Part 1 students and we will continue the traditional student interest groups, which also have served to advise underclassmen.

Q5.8. You put a great deal of emphasis on projects. How many projects will we have at any one time?

A. Students will have no more than two projects at any one time with the understanding that the portfolio is not a self-contained project, but continues over the entire four years. Projects have been carefully designed to integrate with the curriculum as it progresses to not be an added extra, but to be carefully integrated into preceptorship experiences and educational activities.

Q5.9. Many students really value the Learning Communities currently offered by our faculty. Will these continue in the new curriculum?

A. We would strongly encourage that these activities continue. We believe the small group projects will allow many of the same functions that occur in the Learning Communities with the faculty mentor over the four year curriculum. These will be forums to raise issues as well as to mentor other students. This will not preclude Learning Communities per se, but the intention is that many of the functions of Learning
Communities will be contained and continued within the impaneled patients projects with small groups of no more than nine students and one OSU faculty member involved with a practice preceptorship.

**Q5.10 How will these practice impaneled patient groups impact other small groups such as those in anatomy and CAPS?**

**A.** You raise a very interesting issue. We expect the Implementation Team to grapple with this question. The nine students in any practice would be paired with other students throughout Parts 1, 2 and 3. We will consider having different groups composed of different students for the projects, but currently we are hoping to maintain the group of nine students throughout the four years and when necessary, combine two groups of nine for other activities if necessary. But the final answer to this question will rest with the Implementation Teams. As you realize, none of these things are set in stone at the current time. The new curriculum has presented broad, general guidelines and many of the details are yet to be worked out by the Implementation Teams.

**Q5.11 In the longitudinal practice impaneled patient activities, will students be able to select their half-day shifts to best fit their own personal schedule?**

**A.** Yes. Many alternative ways of learning will be offered i.e. podcasts for missed lectures or pre-recorded experiences will be available. We will be banking lecture recordings so that students can, if they wish, proceed at their own pace, even in advance of the regular curriculum. When small groups are split into A and B, we can try to arrange it so that all students will be able to participate in the activities, but not be scheduled all at the same time to accommodate their preceptor experiences. As is currently true, students will be able to swap out half days based on their interests and learning style, much as they do now throughout the curriculum.

**Q5.12 How can students be more involved in the new curriculum?**

**A.** Students are encouraged to provide input, not only through these kinds of meetings and frequently asked questions, but by becoming members on the implementation teams. Students have opportunities to volunteer through their student council. In addition, students can post questions or review progress by visiting to the new curriculum website.


**Q6.1. With grant and funding sources “drying up” and becoming more competitive how will the CDT attract busy basic scientists to participate in planning and delivering the new curriculum?**

**A.** Hopefully basic scientists will be engaged in this very innovative curriculum design. It is anticipated that though the use of already funded COMER positions that curricular leaders in specific disciplines will be asked to participate in the redesign.
Q6.2 These are exciting plans but how will we evaluate the success and know that our graduates got into the most competitive residencies?

A. We think that this curriculum will attract gifted applicants to begin with. Many of the recommendations contained in the Flexner post 100 year report are contained in this curriculum. Students will be evaluated based on the documentation of specific competencies and objectives developed with the ACGME guidelines in mind. They will have closer and more longitudinal contact with mentors and clinical faculty to improve their competitiveness in the match. Ohio state graduates are very good residents – this curriculum is intended to make them excellent. A subcommittee on evaluation and scholarship has already been appointed to evaluate and publish findings on the new curriculum.

Q6.3 How will other residency programs understand that OSU graduates are better residents?

A. A subcommittee on Communications is working on that very issue. As in any major curriculum change the dean’s letter will emphasize the new curriculum and its impact on graduates preparation for residency. We expect USMLE scores to improve more than they have in the past again going from great to excellent. Also since our educational objectives are based on the ACGME competencies we believe the students will perform as well as many PGY1 residents across the nation.

Q6.4 The new curriculum promises to provide closer working relationships with clinician faculty and preceptors and better integration of foundation sciences which will improve faculty confidence in students abilities and allow them to take on more advanced work. How will this impact the need for faculty development of our teachers?

A. John Mahan is leading the Faculty Development Subcommittee. His group will be instrumental in faculty development for the new curriculum. Paired teams of foundational science and clinical science faculty will need to work together to integrate the basic sciences, behavioral sciences and clinical sciences to plan and deliver the curriculum. We believe that these teams will better integrate foundations and clinics to provide better problem solving and patient care by making the best use of all faculties’ talents.

Q6.5 What will we call the new curriculum to stress the scientific and medical foundations?

A. Naming rights are extremely important. As we roll out the curriculum plan to more audiences we plan to have a naming contest that emphasizes the unique features of the new curriculum highlighting the science and art of medicine.
Q6.7 *This is a very innovative curriculum, compared to the traditional two plus two year model, in its emphasis of one continuous course over four years rather than four or more separate ones. How will it promote critical review and evaluation of medical literature beyond just reading the results and conclusions?*

A. The CDT agreed that this is a critical skill for all physicians and scientist, therefore it is included in the first weeks of the new curriculum in the Foundations of Healthcare and continuously emphasized by combining scientific foundations with clinical practice. The new curriculum will be more evidence-based with planned redundancy revisiting the basic science foundations throughout the four years.

Q6.8 *Do you plan to publish the results of the new curriculum?*

A. Yes, there is a subcommittee already charged with student, program and curriculum evaluation and scholarship headed up by Cynthia Ledford. Part of its charge is to publish on the new curriculum and its results.