

Curriculum Connections

A newsletter of the Education Council
July 1997

Challenges of Implementation - A Message for Students

As we begin the challenge of implementation, it is important for all of us to keep open minds. We ask the students beginning our newly organized curriculum to continue to be good communicators and provide honest feedback and suggestions. As we all experience the new curriculum for the first time, we promise to respond quickly and appropriately to unanticipated problems.

The membership of the Education Council is dedicated to assuring that students who begin the new curriculum elements be given careful consideration as we gain experience with the revised program. Our Executive Dean, all faculty involved in teaching the new curriculum and the Education Council want to make this effort successful and create a more effective learning environment to better prepare students for the practice of medicine in the 21st century. Your help in constructive critique of the curriculum is critical.

Finally, as work continues on the elements of years two and four which will be implemented in 1998, we look for your continuing input and involvement in completing this long and difficult, but very important process. The redesign of our curriculum for the M.D. degree brings better correlation between, and coordination of, the various courses and clerkships and addresses the rapidly changing world of medical practice.

Allen B. Rawitch, Ph.D.
Chair, Education Council

Nine Medical Education Grants Approved

Earlier this year the Office of Primary Care, in cooperation with the Education Council, asked faculty to develop innovative grant proposals that would enhance the new curriculum. Seventeen proposals were received and nine that showed both educational quality and synergy with the new curriculum were funded for further development.

Many of the approved grants are for computer-based or enhanced education. For example, one grant will focus on the use of handheld computers in medicine. Others use the Internet to help students learn online, specifically in the areas of pediatrics, neonatal care, nutrition for geriatric patients and physiology.

"These grants have helped us capture the bright ideas of faculty," said Anne Walling, M.D., associate director of education, Primary Care. "We encouraged collaboration among departments and across departmental lines and faculty did just that to help lead the curriculum initiative," she said.

Students are expected to begin benefiting from several of the grant projects as early as this academic year.

Medical Education Support Unit Helps in Curriculum Development

This past spring Giulia Bonaminio, Ph.D., became the director of the newly created Medical Education Support Unit, part of the Dean's Office. One of her foremost responsibilities, in addition to supporting primary care initiatives, is to aid faculty developing the new curriculum, particularly those serving on the Education Council and its planning committees.

Bonaminio is very experienced in the area of curriculum guidance, having most recently been the Curriculum Office director for the University of Kentucky College of Medicine. "I am very excited to be working with the faculty and want to assist them in whatever areas of medical education they request," she said. In addition to advancing the curriculum effort, the office can provide support in the areas of teaching methods, program evaluation, student assessment, research and publication.

Bonaminio received her doctorate degree in genetics from Ohio State University and completed her postdoctoral work at Stanford University.

Committees Report Progress

As summer progresses, plans for clerkships and courses for years one and three have been finalized. An integrated year-one schedule of courses has been produced by the Dean's office for students who begin in August. Students who began year three in June participated in a lottery that assigned each person to a clerkship track on either the Kansas City

or Wichita campus. Extensive planning has made clerkship experiences on both campuses more equivalent than in the past.

Efforts are ongoing to develop new or expanded off-site teaching venues. "As the various clinical disciplines become more ambulatory or outpatient-based, our off-site teaching sites gain even more importance," said Allen Rawitch, Ph.D., chair, Education Council and the year one/two committee.

Executive Dean Shares Thoughts on Medical School's Mission

Medical schools have multiple missions - education, research, patient care and public service. Of these, none is more important to a medical school than its educational mission. First and foremost, we educate medical students to become physicians.

Central to our teaching mission is the development of a curriculum for our training programs. The curriculum is a dynamic entity which needs to be constantly refined and revisited. Teaching faculty are aware of this need and practice it themselves. Whether they teach at the bedside on clinical rotations or lecture to large classes of students, they recognize the need to update and revise their teaching materials frequently. However, despite our individual knowledge of this need, curriculum revision on a large scale is fraught with difficulties and anxieties. Certainly, it is time-consuming and ideally requires the work of large numbers of faculty, students and educational specialists. It involves an appraisal of what has been done and honest discussion of how it can be done better. It also requires thoughtful consideration of the types of practices and the knowledge base that our graduates will experience and need during the decades of their practice and the realization that this might be different from what we ourselves needed at a different point in time.

Many of the underlying principles of medical education have not changed. Medicine is still both an art and a science. Students cannot successfully practice in the next century without a solid foundation in the sciences basic to medicine. The explosion of new scientific knowledge has made this a very challenging task. To practice in the future, students will need an understanding of molecular biology and genetics to a degree that was not even known 30 years ago. Because of this explosion of new knowledge, we must not only decide what to teach but what not to teach. This requires the need to instill in our students the understanding that they are beginning a profession which will require lifelong learning and that medical school only establishes the foundation for this process.

The art of medicine still mandates the need for students to learn from gifted clinicians and teachers by observing them and their interactions with their patients. This is as valid today as it was 100 years ago. However, the sites for these learning experiences have changed. More and more patients are being treated in outpatient settings rather than hospitals. Our traditional venues of wards and operating rooms have changed to outpatient clinics and surgery centers. Moreover, the way that students need to be prepared for lifelong learning is different. Today's medical school graduate must be familiar with computer technology and able to gather data from a variety of electronic sources. This means that not only what we teach, but how we teach must be different if we are to prepare our students adequately for successful careers in medicine.

As we develop our curriculum, we must be cognizant of the principles of graded responsibility which are so important in our residency training programs. We must build in opportunities for our students to assume more of a role in patient care as they approach the end of medical school and the start of residency training. During the third year particularly, but also during the first two years of medical school, students are introduced to the diagnosis and care of patients. They learn to take histories, do physical examinations, and through their first clinical rotations, to view the spectrum of diseases and conditions that patients bring to practitioners in different specialties. In the 4th year, we are not only continuing this process of medical education, but also helping our students begin the transition to residency programs. We must consider the number and types of independent experiences that would provide valuable training for students as the foundation for their clinical residency practice. Internships where students become active contributing members of the health-care team can be very valuable components in facilitating this transition.

We must also be mindful of the fact that career development for students begins in residency, not in the undergraduate medical program. Students must have enough exposure while in medical school to make reasonable and informed choices about residencies. However, we must not turn the fourth year of medical school into mini-residency. A student who has decided that he or she will pursue residency training in surgery, and ultimately fellowship training in cardiothoracic surgery, will greatly benefit from additional experience in other areas, such as internal medicine, diagnostic radiology and primary-care rural practice during his or her final year of medical school.

At the University of Kansas School of Medicine, our major curriculum revision should involve as many people as possible. We must spend as much time as necessary and remember that a curriculum is always a work in progress. This is one of the most important endeavors a medical school can undertake. I wish all the best of success.

Deborah Powell, M.D.
Executive Dean

Curriculum News on the Web

Curriculum Connections is published on the Internet under the Office of Primary Care's Web page <http://www.kumc.edu/opc>. The direct address to the newsletter's location is <http://www.kumc.edu/opc/CC/ccindex.html>. Back issues of Curriculum Connections can also be accessed through the Web site.

Editorial Comments Invited

Questions, concerns and suggestions for future issues or committee discussion are welcomed by Allen Rawitch, Ph.D., chair, Education Council, at arawitch@kumc.edu.