Minutes of the meeting of Committee on Educational Policy and Curriculum
SUNY Downstate College of Medicine
November 30, 2011
Seminar Room 2-1

Present: L. Eisner, J. Libien, M. Erogul, S. Ostrow, R. Ovitsh, S. Hrabetova, B. Trauner, K. Perkins, S. Hahn, K. Twomey, C. Brunson, J. Lampert, J. Odackal, S. Regev, D. Cucco, D. Papanagnou

Guests: Dr. Jeanne Macrae and Anne Shonbrun, Registrar
Due to other commitments, Dr. Anziska has resigned from CEPC.
Dr. Dimitri Papanagnou has joined the CEPC.

Electives

Anne Shonbrun presented data on fourth-year electives from 2008-2010. Electives were broken down into two reports; electives with no enrollment and electives with enrollment. Based on the three-year study, there were 179 electives with no enrollment. Annually, the Registrar's office contacts faculty sponsors of electives to update elective and contact information. The Registrar's office makes several attempts to contact faculty who do not reply. It was suggested that the letters also include an option for faculty sponsors to discontinue the elective if there has been no enrollment. CEPC will include a message to faculty sponsors in this year's Registrar's email.

A member proposed that at the end of electives, each student should be required to fill out an evaluation. Dr Eisner added that she has an appointment with Dr. Klara Papp and hopes that se will come to the January meeting to talk about developing an official student evaluation form for each elective. Shelly Regev, Daniel Cucco and Sue Hahn are working on revising the informal CEPC survey sent out to the Class of 2011. This will be ready for mailing March 2012.

Clinical Medicine Clerkship Block Schedule Proposal

Dr. Macrae presented a proposal to begin the core clinical year block schedule for clerkships (in Doc 2) July 2012. Dr. Macrae submitted a proposal to CEPC that had been prepared for the Steering Committee and outlines the rationale for this earlier implementation. The proposal (attached) has 9 points: the first five deal with emotional issues for faculty and students and items 6-9 deal with the logistics of implementing the new curriculum.

Dr. Macrae reviewed the nine advantages for the proposal as presented in the attached document referring to the need to increase credibility among faculty that the new curriculum will really happen and confirming that there will be changes to the clinical curriculum as well as the basic science curriculum. She referred to the need to eliminate the "last class phenomenon" with current medical students. She talked of the logistical problems of waiting until April 2015 and the nightmare of running two medical schools at the same time for four months. In April of 2015, we will have an existing class finishing up their third year clerkships April, May, June, and some of them, July. As of April, we would have a second medical school class overlapping the previous one. They will share the same clinical facilities but have entirely different schedules and different clerkship experiences, with different expectations and goals. If the new clinical curriculum in rolled over earlier, we can resolve some of these logistical problems.

She expects students to like the proposed four weeks of electives for career exploration in the 3rd year as well as the opportunity to see patients longitudinally in a pilot for a longitudinal clinical experience. The longitudinal "clinic" experience has to run through Medicine, Primary Care and Surgery and will be gradually phased in incrementally with 50 students over four years. Much discussion between student and faculty members of CEPC continued on current problems with electives in the third year and the pros and cons of the proposed new block schedule. In conclusion, everyone agreed to accept the proposal to implement the clerkship block schedule in July 2012 contingent on the following conditions:

1. There be a sufficient variety and number of electives of the appropriate level and structure available for MS3 students.
2. Consideration should be given to adding a Spring vacation week between blocks 3 and 4, or allow the use of elective time for vacation if the student is on schedule to have enough credits to graduate on time.

This motion was passed unanimously with one abstention and will be presented to the Executive Committee on December 5.

Proposal to the Steering Committee:

To begin the core clinical year block schedule for clerkships, as outlined in Doc 2, as of July 2012.

Advantages of this proposed implementation date:

1. It is a highly visible step in implementing the new curriculum that should lend additional credibility to our efforts and help offset any sense of lost momentum from the push back to 2013 of the new foundations curriculum.
2. It should provide reassurance to the basic scientists who are skeptical about our willingness to change the clinical curriculum as well as the "pre-clinical" curriculum.
3. It allows all students beginning with our current second year students to participate in the new curriculum to some extent and, we would hope, to feel that they received some benefit from it. By August 2013 when the new Foundations rolls out, there will be no "last class" receiving all four years of the old curriculum.
4. Students will have immediate access to one of the most visible benefits to them – the four weeks of elective in the third year for career exploration and all students will have their third year end by the end of June, unlike the current schedule.
5. It will resolve within one year the perennial difficulties neurology faces of senioritis in their fourth year students and the difficulties Emergency Medicine faces of comparing performance between third and fourth year students.
6. It will allow us to deal with the logistical issues of the transition and resolve them in that first year before we have to make more substantial changes in the teaching and assessment within the clerkships. For instance, whenever we transition, anesthesia and neurology will have approximately a 50% increase in student load through the first year. It would be unreasonable to expect them simultaneously to implement new and potentially more labor intensive teaching and assessment methods. Similarly, Medicine will have double the usual number of students in the first block after the transition whenever it occurs.
7. It allows us to plan a pilot of the longitudinal "clinic" experience (which has to run through Medicine, Primary Care and Surgery) and, if necessary, to plan a gradual implementation of the longitudinal experience in increments of 50 students over four years.
8. It allows the clerkship directors to plan and pilot changes, particularly those involving co-teaching, and implement changes gradually to their clerkships within their pairings in the new curriculum over a two and a half year period from July 2012 until April 2015 (or three and a half years if we start now). Thus, when the students from the new Foundations period arrive to their clerkships in April 2015 these rotations can be tested and ready, not being rolled out for the first time.
9. It would mitigate the serious difficulties we will inevitably encounter from April 2015 through the end of the academic year when we will have total overlap of the third year class and the second year students beginning their clerkships. If we have not implemented the "new" clerkships by that time we will have the equivalent of two different medical schools with different schedules and different clerkship formats, all in a clinical arena that barely holds our current student population.

Disadvantages:

1. We would have only eight months to put together a pilot longitudinal experience and whatever other changes we would want to make prior to July.
2. Since some of the Doc 2 changes are controversial, implementing as early as July 2012 might create resistance and unpredicted reactions.

Specific impact on each clerkship of a 2012 block scheduling start (instead of 2013, 2014):

1. OB/GYN – none
2. Pediatrics – none
3. Psych – none
4. Neuro – need to make a decision re: 4 weeks/2 week elective scheduling now
5. Medicine – in-patient blocks go from 5 weeks to 4 weeks; need to notify affiliates now
6. Surgery – need to plan merger with anesthesia and out-patient experiences in time for July 2013 instead of 2014, 2015, etc.
7. Anesthesia – need to plan merger with surgery for July 2013 instead of 2014, 2015
8. Primary Care – block goes from 6 weeks to 4 weeks; need to notify preceptors now (some may not be needed?). Need to make a decision about the honors project. Need to make a decision about joining Friday didactics between the two arms of the clerkship.

Emergency Medicine – will have less than 50% usual student load, all fourth year; need to re-define clerkship v. elective now. May be asked to contribute manpower for teaching and assessment needs of other departments over 2012 – 2013.