

Keys to Designing and Implementing a Six-Year Curriculum

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Develop a Rationale for Change

- Must have faculty buy-in that is near unanimous...
- Critically look at applicant pool for past several years...discuss entering resident skill sets similarly
- Look at your resident performance metrics of recent
- Develop a strong faculty and resident consensus...or hold off on this change...

Faculty must agree to change

- Identify simulation champion(s)
- Identify Didactic curriculum leader(s)
- Appoint Saphenology instructors, open and closing tutors, valve repair/replacement teachers, etc...
- Will require more paperwork and documentation, not less, all faculty must be willing/ eager to accept these tasks joyfully...

A Group Effort

- Hold several strategic meetings to assign tasks and hold your team accountable or reassign
- In most cases the number of residents will triple, right size your support
- Not just the GME funding, but the administrative support will need to grow
- Planning must include the need for more performance metrics, more data collection, dashboards for each resident, etc.

Checklist

- Group consensus (are your faculty really ready for intern education from day one?)
- GME support
- Administrative support
- Then – go to DIO, Chair of Surgery, and others with your part done and ask for collaboration with imaging, cardiology, pulmonology, critical care, basic surgical skills rotations to create the curriculum you will control

PIF creation (there are still two)

- Allow time
- Assign some things to coordinator - CV's, case numbers if you can, conference minutes, educational logs, etc.
- Must write the rotation and curriculum change yourself
- Update faculty CV's
- Make sure you will have enough cases (not defined so far by the way at all)
- Assume 125 major cases each of last four years at a minimum (opportunity to train less people yearly better, yet increase resident service in an 80-hour week)

PIF

- Program specific
- Generic PIF
- You may cut and paste much, but it must all hold together, read it critically and often and assign others less familiar the task of comparing them, select your best editors to do this function and assign it early

Goals and Objectives

- Each rotation needs one...
- Must get them from GS, radiology, cardiology, pulmonary, critical care, etc.
- Allow time to develop them
- Many G&O examples available we and others have developed or utilized...feel free to plagiarize, but they must reflect reality and must document benefit to the student

Evaluation Tools

- Simulation metrics
- Didactic progress tools (Curricular module completion forms?)
- ITE changes?
- Critical Care skills documentation
- Judgment and maturity assessment
- Must be in place for each level or rotation

Program and Rotation support letters

- Need letters from each specialty helping to train our six year residents
- Draft letters of support available to give the PD in each area...
- Will need letters of support which express understanding of the program from your DIO, Department Chair (if applicable), and health system partners

Program Performance

- Our specialty needs committed educators now more than ever
- ABTS pass rates, and PD and programmatic support of residents who have stumbled will be of concern to the RRC, ABTS, and DIO
- Strong and stable faculty as well as letters of support from your faculty will likely also help an application

Recap

- Joyful faculty consensus and support
- Start early – identify deadlines of RRC, and your DIO travel plans, etc. early
- Identify simulation, curriculum, and surgical mentors
- Right size your program and your programmatic support
- Examples of G&O, support letters available

Closing Remarks

- TSDA office and staff will strongly support programs genuinely interested in this initiative
- Integrated programs seem right – how to get there and what options should remain are a ?
- A move to performance based metrics in areas of didactics, technical, profession, and personal maturity seem strongly the next step in our process