PERSPECTIVE

BY **Steven A. Wartman**
MD, PhD, MACP
AAHC President / CEO

Our members often comment that "we need to change the culture" and "culture change is hard." These repeated observations led to the current issue's focus on new schools, in which culture needs to be *developed* as opposed to *changed*. Starting from scratch has advantages and disadvantages, but, in terms of preparing healthcare providers for the 21st century, perhaps the advantages prevail. In this regard, I asked leaders of four new schools of medicine to share perspectives that apply to all new health professions schools.

At the Texas Tech University Health Sciences Center El Paso, Dr. de la Rosa articulates the advantages of being able to think like clinicians in developing a nontraditional curriculum. Another important theme, echoed in many new schools, is establishing a culture of community involvement and creating a new kind of departmental structure.

Dr. German, at the University of Central Florida, describes how they "intentionally created a 21st century institution." Hallmarks include a peer coaching program that recognizes all students should have help, and a focused, individualized research experience to expand students' horizons. All of this is taking place within a "medical city" construct that combines the resources of hospitals and research institutes.

Florida International University, under the leadership of Dr. Rock, integrates basic sciences throughout all four years and utilizes the flipped classroom. Key components include developing interdisciplinary teams to provide on-site care in patients' homes—giving students a deeper perspective on the social determinants of health—and a focus on recruiting experienced academicians to develop a high-performance team.

In Greenville, South Carolina, a model was developed that placed the healthcare system at the heart of the academic health center. Dr. Taylor notes the efficiencies and economies of scale that arise from working strategically with other universities in the state, as well as the ability of the health system to support the school. Advantages include a sharp focus on the patient at every level and expanded opportunities for real-world experiences.

There is a tendency to think of new schools as having to play an enormous game of "catch-up." But, as is evident in these commentaries, a progressive vision and lack of embedded culture fosters the creation of new and innovative models with minimal baggage. It is, indeed, a pleasure to see new schools leading a new wave of 21st century medicine.

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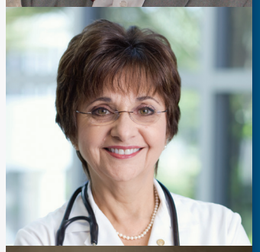
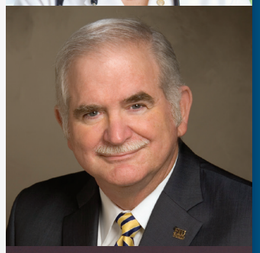
LEADERSHIP PERSPECTIVES

New and Emerging Schools: Opportunities and Advantages

Jose Manuel de la Rosa, MD, MSc
PROVOST AND VICE PRESIDENT FOR ACADEMIC AFFAIRS
Texas Tech University Health Sciences Center El Paso



Deborah C. German, MD
VICE PRESIDENT FOR MEDICAL AFFAIRS
DEAN, UCF COLLEGE OF MEDICINE
University of Central Florida



John A. Rock, MD, MSHCM
SENIOR VICE PRESIDENT FOR HEALTH AFFAIRS
FOUNDING DEAN, HERBERT WERTHEIM COLLEGE OF MEDICINE
Florida International University

Spence M. Taylor, MD
PRESIDENT, GHS CLINICAL UNIVERSITY
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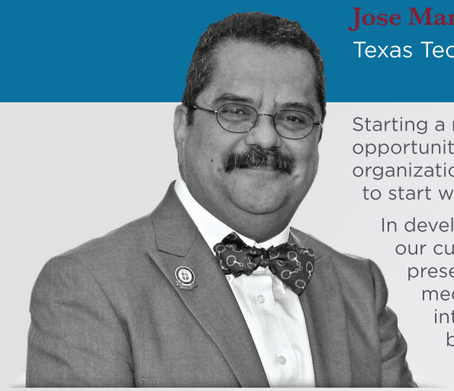


Jose Manuel de la Rosa, MD, MSc

Texas Tech University Health Sciences Center El Paso

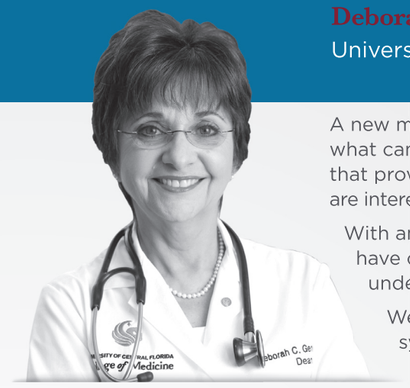
Starting a new medical school by building on an existing school created an opportunity to develop a modern curriculum without being hidebound by existing organizational structures or entrenched political agendas. This was an opportunity to start with a *tabula rasa*.

In developing the new curriculum, we were able to think like clinicians. Thus, our curriculum is organized in a very nontraditional manner around clinical presentations and 120 major patient complaints. Unlike in most traditional medical schools, where students wait until their third year before they are introduced to the clinical sciences, students here are immersed in both the basic and clinical sciences in their first year. Scenarios designed around the chief medical complaints allow students to start thinking like doctors from the beginning.

Another major achievement was to establish a culture of community involvement. Many well-established schools have that tradition, but tend to be focused on the academic enterprise. By contrast, our mission statement evolved directly from our desire to serve the community. We have embedded community involvement as both a structural and a cultural expectation.

We also built a nontraditional organizational structure. While traditional schools typically have separate departments of physiology, biochemistry, microbiology, etc., we created a Department of Medical Education completely devoted to our curriculum and full-time educational endeavors. We also have a biomedical sciences department that focuses on interdisciplinary research. Basic science researchers here are not isolated in a specific division or department, but have the opportunity to collaborate across disciplines with other researchers.

My experiences here have taught me to not shrink away from innovation, but to leverage what is transpiring in the new medical school movement and see it as an opportunity to experiment and break down traditional barriers. The recent evolution of new medical schools provides academic health center CEOs opportunities to reset the curriculum needle, as well as the institutional culture, and to challenge faculty to be more creative and innovative.



Deborah C. German, MD

University of Central Florida

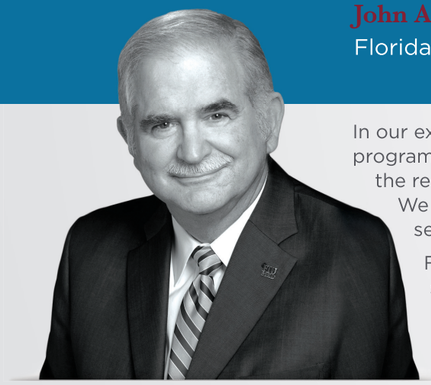
A new medical school begins without barriers. The absence of preconceived ideas about what can or cannot be done organizationally and educationally allows us to create a program that provides continuous improvement as part of its core. This greenfield attracts people who are interested in innovation and have a pioneering spirit.

With an integrated organizational structure we have built an integrated curriculum. Faculty have office neighbors from diverse medical disciplines, broadening their horizons and underscoring their ability to work in an interdisciplinary, "no-silo" atmosphere.

We have intentionally created a 21st century institution with our use of technology. Our systems for admissions application, data management, and student assessment are all innovative. The assessment system, for example, applies an advanced infrastructure that supports student evaluations in ways that are very helpful to the faculty. It is hard to introduce that kind of infrastructure with a program already in place.

We also have a peer coaching program. To remove the stigma of getting help, we acknowledge that every student needs coaching and every student wants help. Our scores on national exams reflect this innovation. A great addition to our curriculum has been an innovation called FIRE—Focused Inquiry and Research Experience—which encourages students to pursue their dreams through research and helps them differentiate themselves as physicians. Our institution may be unique among other new medical schools; we are building more than a medical school—rather an entire medical city sited on 7,000 acres, combining our medical college with the resources of eminent hospitals and research institutes.

Vision is a CEO's greatest asset. Communication of the vision may be easier to achieve at a new school. If the leader is fully and passionately committed to that vision and communicating it to the entire team, great things happen.



John A. Rock, MD, MSHCM

Florida International University

In our experience, starting a medical school in a university with no medical education program gave us the flexibility to develop our own culture. We did not have to face the resistance to change that an institution with an existing program might have. We could be innovative and creative without the pushback to change that is often seen in more established programs.

For example, we designed a very innovative curriculum that introduces our students to clinical experiences early in the program and integrates basic sciences through all four years of their education. In several of the basic science classrooms, we "flipped the classroom," encouraging students to review lectures before attending class, thus promoting more active learning during face-to-face class meetings. Another curricular innovation is our decreased dependence on cadaver dissections and, instead, a greater emphasis on students learning and understanding the importance of anatomical relationships, particularly in regards to imaging.

We recruited experienced academicians from across the United States with established careers in academic medicine. This high-performance team was able, through their own experiences, to implement changes and innovations in the curriculum that other institutions try to put in as reforms. Implementing innovations was much easier for us than would be for more established institutions.

Our innovative Green Family Foundation Neighborhood HELP™ (Health Education Learning Program) teams medical students with peers from other disciplines to address the complex medical, social, and ethical issues experienced by medically underserved families in South Florida—not in theory, but in practice. Students actually go into homes in the community and provide on-site care, and we have a mobile van that provides care within communities.

In the U.S., there is a great need for the next generation of physicians to be socially conscious, community based, and expertly trained. Here, we are working to create not just great physicians, but community leaders who think holistically, globally, and locally.

Spence M. Taylor, MD

Greenville Health System

A new medical school can be inventive because it doesn't have to manage legacy infrastructure and ideology. For instance, universities are typically at the center of most academic health centers with affiliated hospitals; we flipped that model, putting the healthcare system in the middle, affiliating with multiple universities to create a shared academic health center with leveraged resources and non-duplicative services.

As for cost structure, we use the basic science labs of Clemson University, the University of South Carolina, and Furman University, so we do not have to build those costs into our plan—allowing us to keep our fixed costs low. Also, we receive no state money and are not encumbered by the political considerations that come with such funding. Nor are we tuition-driven. Our health system has $650 million in cash or equivalents to support its mission. Structured as an endowment, it underwrites the medical school.

What also makes us different is our emphasis on practical patient care. Our research is focused on health services research, implementation science, and comparative effectiveness. As an example, all of our medical students are trained to be certified Emergency Medical Technologists during the first nine weeks of school. Apart from testing students' clinical, problem solving, and communications skills in challenging circumstances, that experience helps them understand through on-the-ground experience how and where our patients live and the challenges they face. It provides a genuine perspective as to what the real world is about.

We think averseness to change is probably the biggest potential barrier to most major academic health centers moving forward. The market is changing, the economic model is changing, the needs of the public are changing, and the rules are changing. Leaders should also be open to change and be willing to take a little bit of risk. "Milk and honey" is not flowing like it used to. Instead of running in place, trying to hold onto the past, we should embrace and take responsibility for change.