

Title: Curriculum change implementation in a Colombian school of medicine

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Context and setting: Based in state examinations results, former students and employees surveys we identify the need to introduce a curricular improve despite the success of our graduates. Redefining medical profile and evaluation of importance and fulfilled competencies with the existent curriculum were done and are described in a separate paper. With that information we are proposing a new curriculum whose main changes are: Early clinical exposure, integration of basic sciences, integration of basic and clinical sciences, increase practices on primary care scenarios, increase flexibility.

Why the change was necessary: Medical graduates from PUJ are well known as good clinicians prone to specialization but with deficiencies in primary care and administrative knowledge, two very important factors to work as a GP in Colombia. Teaching by disciplines and separation between basic and clinical knowledge avoid our graduates to use diagnostic test and pharmacologic treatment with a more rational approach. Defining the new profile and looking importance and accomplishment of competencies in the actual curriculum were the base to develop the new curriculum map and to define activities in order to get defined competencies.

The aims of this project are to develop a curriculum map and built a net of activities and competencies, fulfilling needs already diagnosed.

What was done? Five groups work in parallel looking for a group of competencies as follow:

- Professional values, attitudes, behavior, and ethics;
- Scientific foundations;
- Clinical medicine;
- Public health and health systems,
- Communication, Research and critical thinking, Information management.

We will try to fill the gaps introducing students to clinical practice earlier in order to improve their ability to communicate with patients and families and to be exposure to administrative aspect of Colombian health system. Increasing number of practice in primary care facilities; assuring that students will know at least 80 of the most prevalent and important diseases, from epidemiology to rehabilitation going trough clinical, diagnostic aids and therapeutics; our medical graduates will be ready to work as a GP or go to clinical, research or administrative specialization. Integration of basic sciences into systems normality and abnormality, introducing imaging and clinical diagnosis laboratory early in the career, will prepare students for rational use of diagnostic tools in clinical practice. Research, critical thinking and ethics will be developed longitudinally from first to final semester.

Evaluation of the results: Results from five groups allow us to have a new curriculum map with competencies and activities integrated in an interdisciplinary net.

Students will start clinical exposure in second semester instead of fifth semester. Primary care scenarios practices will increase from 20% to 45%. None of basic sciences will be teach as disciplines. Gross anatomy will decrease from 12 credits to 6 credits and imaging and surgical morphology will replace these credits. Students will have one week on each clinical semester to go back to basic sciences. 300 conferences of clinical sciences will be replaced with 80 weekly teaching activities of main diseases based in national prevalence and public and clinical importance. These activities will be developed using PBL and structured clinic case strategies considering ethics and administrative aspects as well as epidemiology, clinic and therapeutics.