

the Front Line

A newsletter for preceptors of the UNC-CH School of Medicine

The University of North Carolina at Chapel Hill - Office of Educational Development

Volume 12 Winter 2006

Conferences and Continuing Education

MARCH 21-22

25th Statewide Conference, Prevent Child Abuse North Carolina. Sheraton Imperial Hotel, Durham. Contact 1-800-CHILDREN.

23-24

Lipid Clinic Training Program. The Siena Hotel, Chapel Hill. Contact Deirdre Boyer, 919-843-6382.

24-25

12th Annual Community Faculty Workshop. The Blockade Runner, Wrightsville Beach. Sponsored by Eastern, Area L, Coastal, and Southern Regional AHECs and East Carolina University Division of Health Sciences. Open to preceptors from all AHECs. Contact Katherine McGinnis or Mary Esther Sabados, 252-744-3082.

31

Acute Stroke Treatment Update: 2006. Moses Cone Hospital, Greensboro. Contact Ann North, RN, BSN, at 336-832-8210 or ann.north@mosescone.com.

APRIL 5-7

30th Annual Internal Medicine Conference. The Friday Center, Chapel Hill. Contact Gail Wilkins or Hope Murdock, 919-962-2118.

(continued on page 2)

Medical Curriculum Continues to Evolve

The evolution of the UNC School of Medicine curriculum that began with implementation of the revised Year 2 curriculum in 2004-2005 (see *The Front Line*, Spring 2005) has continued this year with a re-engineered Year 1 and will reach students in all four years with the launch of the new clinical curriculum this summer.

Reforms in the first-year curriculum, which are being phased in gradually over a three-year period, are based on the successful reorganization of the second-year curriculum and build on previous efforts to integrate the first-year courses. According to Medical Alumni Distinguished Teaching Professor Stephen Chaney, PhD, co-chair of the First-Year Curriculum Task Force, in spite of “significant effort to integrate material between courses [and] to eliminate gaps and...redundancies, these efforts have been hampered by the departmental ‘boundaries’ between courses.”

He also noted that “because of the time required to achieve and maintain top level research programs and the fact that the research focus of most basic science departments has moved away from the topics that are taught to freshman medical students, the first-year course directors had become concerned that it would be

(continued on page 7)

Curriculum for Year 1

1st Semester		2nd Semester	
The Human Body: Molecules to Cells Cell Biology Biochemistry Mol. Biology Genetics Preclinical informatics	The Human Body: Structure & Development Anatomy Embryology Radiology	The Human Body: Integrative Function & Its Cellular Basis Physiology Neurobiology Histology	The Human Body: Host Defense & Microbial Pathogens Microbiology Virology Immunology Pathology
Clinical Applications Breast Cancer PBL Motor Vehicle Injury PBL Hyperlipidemia / Diabetes / Geriatrics PBL			
ICM			
Medicine and Society			

Conferences and Continuing Education

(continued from page 1)

APRIL

6-9

NCAFP Spring Family Physicians Weekend. Embassy Suites, Charleston, SC. Contact Christy Ayscue, 919-833-2110, ext. 101 or cayscue@ncafp.com.

8-9

Therapeutic Advances in Lupus. The Friday Center, Chapel Hill. Contact Deirdre Boyer, 919-843-6382.

21-22

Spring Medical Alumni Weekend. George Watts Hill Alumni Center, and The Friday Center, Chapel Hill. Contact Alumni Office, 919-962-8891.

21-23

Update in Gastroenterology and Hepatology: Advances in Diagnosis and Management. The Friday Center, Chapel Hill. Contact Hope Murdock, 919-962-2118.

29

Pain, Addiction, and the Law. The Friday Center, Chapel Hill. Contact Iretta Litchfield, 919-962-2118.

MAY

3

Carolinas Healthcare Presents: The Competitive Edge 2006: Excellence in Healthcare for a Diverse Community Conference. Westin Hotel, Charlotte. Contact Isis Hanna, 704-512-6508.

4-7

North Carolina Obstetrical and Gynecological Society Annual Meeting. Grandover Resort and Conference Center, Greensboro. Contact 919-833-3836 or ncobgyn@ncmedsoc.org.

5

Disease Registries in Primary Care Practice: A Necessity for Care Management in 2006 and Beyond. Hosted by the North Carolina Healthcare Information and Communications Alliance. Sponsors include North Carolina AHEC and the American Board of Pediatrics. Contact laura@nchica.org.

MAY

12

Current Concepts in Ob/Gyn 2006. Renaissance Suites Hotel, Charlotte. Contact Tamara Tillman, 704-512-6534.

JUNE

15-18

Carolina Refresher Lectures: Care of the Surgical Patient. Amelia Island Plantation, Amelia Island, FL. Contact Hope Murdock, 919-962-2118.

23-24

4th Annual Landes Symposium on Genitorurinary Malignancies and Urologic Diseases. The Rizzo Center, Chapel Hill. Contact Jennifer Mayfield, 919-962-2118.

JULY

2-8

2006 Mid-Summer Family Medicine Digest. Kingston Plantation, Myrtle Beach, SC. Contact Christy Ayscue, 919-833-2110, ext. 101 or cayscue@ncafp.com.

9-14

7th Annual Adult and Pediatric Allergy and Pulmonary Disease Update. Bald Head Island. Contact Jane Radford, 336-832-8226 or jane.radford@mosescone.com.

20-23

Heart Failure Management: Established Therapy and New Frontiers. Amelia Island Plantation, Amelia Island, FL. Contact Deirdre Boyer, 919-962-2118.

31-Aug. 5

35th Annual Emery C. Miller Medical Symposium. Kingston Plantation, Myrtle Beach, SC. Contact Office of Continuing Education, WFU School of Medicine, 336-713-7755 or 800-277-7654.



OFFICE OF EDUCATIONAL DEVELOPMENT

The Front Line is published by
The Office of Educational Development, School of Medicine,
University of North Carolina at Chapel Hill, CB #7530,
MacNider Building, Chapel Hill, NC 27599.

Phone: (919) 966-3641
<http://www.med.unc.edu/oed/frontline/>

EditorKatherine Savage, M.A.
Katherine_Savage@med.unc.edu

Editorial Advisory Board:

Marco Aleman, M.D.
Alan Brown, M.S.W.
Harvey Hamrick, M.D.
Merry-K. Moos, R.N., F.N.P., M.P.H.
Lisa Slatt, M.Ed.

Lunch and Learn Goes Online

Busy preceptors will soon have a new tool for expanding their knowledge and skills in the area of geriatrics, thanks to the UNC School of Medicine Program on Aging (POA). Designed for non-geriatricians by professionals in the field, Lunch and Learn focuses on specific information that all physicians need in working with older patients.

A grant from the Donald W. Reynolds Foundation is supporting the development of 30-minute online learning modules that can be completed during a lunch break. Rather than attempting to address an entire domain of knowledge, each module focuses on a single, specific topic via a simple PowerPoint-like presentation.

The first module, "Prescribing for Older Adults," was developed by UNC geriatrician Anthony Caprio, MD, and has been piloted by POA faculty at community practices in a program to teach geriatric issues and geriatric syndromes during the lunch hour. Once it is launched as a Web-based module, it will be available for either independent study or for review by preceptors who attended a "live" seminar. Ashley Davis of the Office of Educational Development is transferring the



module to a Web format that will be simple to navigate. He explained that it can also be made available as a self-booting CD for preceptors who do not have Web access.

Dr. Caprio presented the prescribing module at a conference of Reynolds grantees in February, where it was well-received. The 35 slides cover risk factors for Adverse Drug Events (ADEs) in older adults, how to recognize ADEs when new symptoms are reported, strategies for shortening medication lists and enhancing adherence, and potentially harmful medications for older adults. They also make use of four clinical cases with questions and answers. Dr. Caprio is planning a study of the Lunch and Learn approach to determine whether it results in short-term knowledge gains and

in changes in clinical practice over time.

Ellen Roberts, PhD, Coordinator of Geriatric Medical Education and a collaborator on the Lunch and Learn series, expects the "Prescribing for Older Adults" module to be available as a link from the POA Website (www.med.unc.edu/aging/) by mid-March. The second module in the series, addressing elder abuse, is under construction.

Survey Results Show High Satisfaction Rate

Ninety-three percent of preceptors who responded to a survey conducted by the Offices of Regional Primary Care Education (ORPCEs) expressed satisfaction with their experiences as community-based preceptors (55% satisfied, 38% very satisfied), and 91% said that they would probably or definitely continue as a community preceptor over the next five years. The median length of time that the 1419 respondents had precepted was eight years, and they reported a median of 10 weeks per year spent precepting.

The survey of currently active preceptors of medical, physician assistant, pharmacy, certified nurse midwife, and nurse practitioner students was designed to gauge their satisfaction and to determine the degree to which they value various incentives. In answering questions about why they chose to precept students, respondents indicated that the most important factors were their enjoyment of teaching and their desire to demonstrate community practice to students and to give something back to their profession. Also high on the list were intellectual stimulation and interest in being a role model.

Interestingly, three rewards that have sometimes been cited as inducements for community-based preceptors were rated as having "none to very little" importance in the decision to precept students: recruiting future partners, receiving payment for teaching, and receiving other incentives for teaching.

Questions addressing the degree of satisfaction with the incentives they currently receive found that 57% of preceptors were satisfied, while 35% were neither satisfied nor dissatisfied. Responding to a list of incentives, a large number of preceptors indicated that they did not receive various items on the list. When the "Do Not Receive" responses were eliminated, the most valued incentive was Category II CME for teaching, available to the physicians in the group. Other incentives chosen as having "some" to "very great" value by at least 60% were: no-cost access to the AHEC Digital Library, continuing education programs on clinical topics, academic appointments at university, financial compensation, and faculty development workshops.

Ninety-four percent of preceptors said they were satisfied or very satisfied with their professional lives. They indicated "great to very great" satisfaction with their relationship with their patients (87%), their control over clinical decisions (77%), and the supportiveness of colleagues and staff (65%). The largest area of dissatisfaction was "adequate personal time." Eighty-three percent of preceptors rated having a student in the practice as a positive influence on their overall job satisfaction. Having a student was also seen as a positive influence on patient satisfaction (55%), the preceptor's relationships with patients (57%), and relationships with colleagues and staff (57%).

(continued on page 5)

Challenging Cases

Challenging Cases is a regular feature in *The Front Line* intended to assist you in your role as a preceptor. It needs preceptor input in two areas. First, the editor is seeking suggestions for cases to be considered in future issues. If you have encountered a “challenging” situation with a student (or course director or university administrator) during your precepting, please consider sharing it through this feature as a teaching/learning tool. Fictional scenarios—cases that one might encounter—are also acceptable. Second, volunteers are also sought who are willing to serve as commentators on the general precepting issues the cases present.

If you will help in either of these ways, please contact Katherine Savage, newsletter editor, at UNC-Chapel Hill, Campus Box 7530, Chapel Hill, NC 27599-7530.

Case

The medical student you are precepting has a significant learning disability in reading. He comes to you and asks, “I’m worried; how will I manage in practice?” How do you help the student compensate in the clinical setting—reading records, taking histories—while remaining sensitive to the needs of both the student and the practice?

Charles S. Hayek, M.D., Shelby Childrens Clinic: In discussing this student’s reading learning disability, my first response would be, “Yes, that would be a concern, but what strengths and adaptability you have shown to get this far!” I would review with him his diagnosis, previous evaluation(s), and what adaptive skills or strengths he had developed to complete undergraduate and now medical education. This is certainly an issue he had to consider before! If he had not had a formal evaluation and diagnosis with psychoeducational testing, I would strongly encourage that he do so to assist in developing adaptive strategies.

What strengths and skills does he have? These “descriptions” will dictate the “prescription” for his approach to practice, patient care, and continuing education. If he is an auditory learner, oral histories, dictation, and audio digest CME may be useful. If he can process short lists and sentences better, problem lists and highlighting correspondence would be beneficial. A well-trained office assistant/nurse will be essential for him! Of course, as we explore these ideas, I would need to think about my practice and how to structure his month with our practice.

The technological advances we have seen in medicine will certainly help. There are numerous resources and organizations (UNC Center for Development and Learning, Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], Learning Disabilities Association of America, National Center for Learning Disabilities, National Institute of Mental Health) and web sites (www.chadd.org, www.idanate.org, www.ncid.org, www.nimh.nih.gov) that could offer information and help. Voice recognition software or dictation could be useful tools, along with printed templates and electronic medical records.

All of us are on a spectrum for our learning and attention abilities. While our student may be concerned and see this as a challenge, it may also provide unique opportunities to explore different methods of practice.

“All of us are on a spectrum for our learning and attention abilities.”

Linn Wakeford, M.S., OTR/L, Assistant Professor of Occupational Science, Department of Allied Health Sciences: My initial response to this is an optimistic one: this student clearly has managed to enter and complete medical school training thus far, and so must have already identified and used compensatory and assistive strategies to deal with the learning disability. The key now is to support the student’s realization that clinical practice holds challenges that are different from academic types of learning, to identify strategies that have been used successfully in the past, and identify potential needs for new strategies specific to clinical situations.

In supporting the student initially, I want to acknowledge that it likely took some courage to come to me and express this concern openly. In the competitive world of medical school, admitting that one has a disability that might impede competence or practice is unlikely to be taken lightly. This reflects to me that the student has significant concern about this issue, and that I am to be trusted to help address it. Knowing these two things influences the other actions I take in this regard, and allows me to set the stage for collaborative problem-solving. This should allay some worries while developing a true plan of action.

The first step in this is to find out from the student the extent of the learning disability in terms of the types of tasks that are difficult, and then to identify what tasks in particular have prompted the current concern. The process that follows may be started with me as the preceptor, but completed more or less independently by the student, with report back to me, or may be undertaken as a truly collaborative process, depending on the level of student, my time availability as a preceptor, and other circumstances.

The problem-solving first focuses on the methods and strategies already being used successfully by the student. Making a list may be helpful. These are likely to include organizational strategies, social strategies, use of mul-

(continued on page 5)

Challenging Cases (continued from page 4)

tisensory learning methods, and use of assistive technologies.

- Organizational strategies include such things as time management, using color coding to organize materials, starting with the most basic information first and building systematically from that, and having a set time and place to accomplish study/learning tasks.
- Social strategies include getting to know key people, such as professors or preceptors, so that knowing what they expect is simpler to ascertain, and there are open lines of communication that can support learning.
- Multisensory learning methods may include using auditory information (e.g., tape recording lectures or using books on tape) to support what is presented in text, and kinesthetic methods, in which “doing” supports learning of content presented in writing (e.g., building a model of the human heart to understand how it works).
- Assistive technologies include alternative formats for books, reading machines (e.g., Kurzweil reader), reading pens, computer hardware (e.g., screen enhancers) and computer software (talking word processor, reading scanned text, etc.). Because many people with learning disabilities in reading (or dyslexia)

have difficulty also with writing, output for written expressive language may need to be part of the conversation with the student as well.

The next step then would be to identify the ways in which clinical practice is presenting new challenges. We’ve already started this, actually in the first bit of our conversation, when current concerns were described—now we need to think through a day or a week of clinical situations and identify all that may seem difficult. It’s likely that time management and the lack of predictability in patient care will present concerns, simply because of the pace of the work.

Now that we have a list of current strategies and a list of tasks that may be difficult, we can match current strategies with new situations, identifying ways the “old” methods can be altered and used in clinical practice. For instance, the talking pen may be useful in reading patient records. A software package and scanner may be used for reading aloud scanned text and producing word-processed documents. A color-coded checklist and tape recording of patient histories may make that process more efficient, or use of adaptive software on a laptop

may allow patient histories to be input directly to an electronic file.

The last step at this stage of problem-solving is to see what challenging clinical situations are remaining for which there is no currently identified strategy. The student can then begin to research other methods, including technology, that may address those remaining issues. The website for the International Dyslexia Association may be a good place to start (<http://www.interdys.org>), and in North Carolina, the North Carolina Assistive Technology Program (<http://www.ncatp.org>) may be helpful for consultation and in obtaining new technologies to try before purchasing.

Using a logical problem-solving process that acknowledges the demands of clinical practice but also makes use of the student’s strengths and all available resources allows the preceptor to be responsive to both the needs of the student and the needs of the practice. In addition, the experience will allow the student to better evaluate strengths and needs, supporting future decisions about the types of practice and work settings for which he/she may be best suited, and the preceptor has enacted a collaborative process that may be useful in similar supervisory situations.

Survey Results (continued from page 3)

The only significant areas of negative influence were on patient flow (36% negative) and working hours (33% negative). When asked what they thought would be fair compensation for precepting a student, the preceptors specified various amounts, with a median response of \$125 per student week.

Although 72% of respondents agreed that they got adequate notification about upcoming student rotations, many appeared to have initiated no contact with their ORPCEs, as evidenced by a “Don’t Know” response to the statements “It is easy to contact my ORPCE office,” “The staff is responsive to my

needs or requests,” and “The ORPCE staff helps me deal with problems relating to students.” The survey results will be used by the ORPCEs to improve communication and services.

Preceptors who responded to the survey ranged in age from 25 to 84, with a median age of 45 years. The group was divided between 54% males and 46% females, and there were 1228 Caucasian preceptors (87%), 80 African American (6%), 55 Asian (4%), and one percent each Latino (19), Native American (15), and other (13) preceptors. The largest number (512, or 37%) practiced in rural areas, with 34% in suburban and 29% in urban settings.

The largest group of preceptors were physicians (817), with 254 nurse practitioners, 69 physician assistants, 287 pharmacists, and two other. Of the medical specialties, 37% were in family medicine, 16% internal medicine, 15% pediatrics, 6% OB/GYN, 17% pharmacy, and 9% other. The median number of years in practice was 13 years, with a median of 100 patients seen in a typical week.

To see the complete results of the survey, go to the link at http://www.ncahec.net/preceptor_survey/.

Students and Preceptors Tapped for Honor Society

UNC medical students and preceptors who have distinguished themselves in community service were honored at the Chapel Hill campus on Community Service Day February 18 when they were inducted into the Eugene S. Mayer Community Service Honor Society. The honorary organization, named for the late Director of the North Carolina Area Health Education Centers Program, was founded in 1995 to recognize the community service of students. It broadened its membership in 2001 to include preceptors for the UNC School of Medicine.

The 15 physicians inducted this year were Gideon Besson, MD, Shelby; John Burkard, MD, Raleigh; Robert L. Dough, MD, Asheboro; Daniel J. Frayne, MD, Linville; William A Hensel, MD, Greensboro; Ronald Hughes, MD, Whitakers; Jugta Kahai, MD, Oak Island; Joel R. Kann, MD, Mebane; Daniel Kubley, MD, Roanoke Rapids; Mark Powers Maier, MD, Winston-Salem; Bonzo Reddick, MD, Chapel Hill; Marsha Rhodes, MD, Charlotte; Rafael Torres, MD, Dunn; James Volk, MD, Hendersonville, and James Womble, MD, Cary.

The community service work of these preceptors spanned the globe, from rural eastern North Carolina to south Asia. In January, 2005, Dr. Kahai co-founded the non-profit organization T.R.Y. (Tsunami Relief and You), which raised more than \$40,000 that she personally delivered to tsunami victims in Sri Lanka as part of a team that included two pediatricians, an art therapist, and a sanitation and water specialist.

In Sri Lanka, they assisted in redevelopment of the village of Seenigama and established a pediatric clinic. Since its inception, Rainbow Clinic has seen more than 500 patients and has been vis-

ited by physicians and medical students from around the world. To ensure that it will continue to reach those in need, the Sri Lanka College of Pediatricians has adopted Rainbow Clinic and will provide services on an ongoing basis. Details of the work of Tsunami Relief and You may be found at its Website (www.t-r-y.org).

Back on the home front, Dr. Ronald Hughes was instrumental in ensuring the continuation of the Bloomer Hill Free Clinic, a project of the UNC chapter of the North Carolina Student Rural Health Coalition that reaches an underserved area outside of Rocky Mount.

In nominating Dr. Hughes for membership in the Mayer Honor Society, a student wrote, "Dr. Hughes played a critical role in supporting the Bloomer Hill clinic in 2002-2004 while the clinic's usual facilities at the Bloomer Hill Community Center were unavailable due to storm damage. Dr. Hughes allowed the clinic to operate in his practice's premises without payment until the community center was deemed safe to use. He and his staff also came in on the weekends to allow Bloomer Hill volunteers into his facility and assist with its usage and provided assistance with supplies. Through his generosity, Dr. Hughes enabled the Bloomer Hill clinic to continue to serve the Whitakers community at a difficult time."

The service work of the 45 student inductees into the Mayer Society was similarly diverse, addressing local, national, and international needs. Individual students and groups of students presented their work at a poster session during the Community Service Day brunch. In addition, five students were selected to give slide presentations prior to the induction ceremony. "Alternative Spring Break 2005: Rebuilding Hope



Art Therapy in Sri Lanka.

in the Wake of Disaster" highlighted Avik Chatterjee's organizing of a group of medical students who went to West Virginia to rebuild burned churches during spring break last year. After the success of that project, Avik has formed an officially recognized student organization called Alternative Spring Break that will continue to undertake service projects each year. The plan this spring is to work in the area devastated by Hurricane Katrina.

Two students who traveled to New Orleans in the aftermath of Katrina last fall presented their work in the Community Service Day plenary—Aram Kim and Sarah Nossov. Sarah explained, "I took a week's absence from my first month in medical school to immerse myself in relief work because I felt so strongly that I must help. I had many friends who were affected by the storm, and [I] felt the need to help in any way I could, even if it meant I needed to work extra hard upon my return and perhaps sacrifice a stellar score on my upcoming exam."

The final slide presentation, "Madre Sana: Nutrition and Physical Activity Education for Latina Mothers," described a project undertaken by Elizabeth Deans and Carrie Hamby.

Medical Curriculum Continues to Evolve

(continued from page 1)

increasingly difficult to find faculty to teach in the basic science courses if they remained departmentally run.”

In considering the adoption of an integrated curriculum, the task force observed that 15 of the top 20 medical schools had implemented some form of integrated curriculum for the first two years of undergraduate medical education. The experiences of those schools showed that integrated curricula work. They found

- Overall and individual subject scores on Step 1 of the USMLE increased.
- Clerkship directors reported that students were better prepared for their clinical clerkships. They had a stronger knowledge base and were better able to apply the knowledge. They were also more “clinically fluent and team savvy.”
- Students rated themselves as better prepared for clinical clerkships.
- Schools that had successfully introduced an integrated curriculum were able to recruit stronger students once the curriculum had been in place two years.

The plan for UNC’s new first-year curriculum emphasized, first, improving both horizontal and vertical integration of the curriculum, and, second, enhancing opportunities for individualized and self-directed learning. Four blocks of closely related courses, which are interdisciplinary and will be fully integrated, comprise 20 hours a week in the first-year curriculum. A clinical faculty member and a basic science faculty member are co-directors of each block. (See chart on page 1.)

In addition, the task force created a year-long clinical case integration course to integrate between blocks and provide clinical applications. The cases are designed to emphasize the major causes of morbidity and mortality in North Carolina, paying particular attention to the 20 conditions that account for 80% of annual health care costs. Two year-long courses—Introduction to Clinical Medicine, and Medicine and Society—are continuing as separate courses.

Planning is continuing for a framework for individualized learning opportunities. These might include special topic seminars, individual learning projects, individual research projects, online self-instructional modules, online self-assessment modules with opportunity for consultation with faculty experts, and individualized clinical experiences.

The first-year course committee will evaluate the new curriculum at least annually as part of continuous quality improvement.

Changes in Clinical Years

The next phase of curricular reorganization will culminate this summer. After meeting for a year, the Curriculum Evolution Task Force, composed of all clerkship and selective directors, submitted its report to Vice Dean Robert Golden, MD, last fall. He made the final decision on the options presented, and the directors are now designing their courses to fit the new scheme.

Highlights of the new plan for third- and fourth-year students include:

- Elective opportunities will occur earlier in the clinical years so that students will be able to explore specialties they are considering prior to interviewing for the Match.
- The opportunity to create additional interdisciplinary courses that reflect current medical practice. An example is the new two-month clerkship combining psychiatry and neurology that will debut in July. Faculty who are interested in creating such courses as electives will be supported in developing them.
- The clinical curriculum has been lengthened by a month. However, the increased flexibility built into the plan will allow students to schedule some vacation in Year 3 as their circumstances dictate.

A total of 22 four-week blocks will comprise the third and fourth years, and students must complete the core clerkships within the first 14 blocks of the combined 22-block experience.

Changes in the current curriculum include dividing the Medicine Clerkship into separate eight-week and four-week blocks and shortening the Family Medicine and Ob-Gyn clerkships to four weeks of core experiences. At the same time, elective and selective offerings in those disciplines will be enhanced. For sample clinical years under the new modular structure, see www.preceptor.org.

Dr. Cheri Hobgood, Associate Dean for Curriculum and Educational Development, anticipates that students will benefit from these changes. “Not only will the scheduling flexibility allow our students to develop more focused, individualized courses of study, but it will also enable them to achieve greater balance in the relative intensity of the third and fourth years,” she stated. Dr. Hobgood said that she feels that “our efforts to provide more flexible core experiences and create stronger selective and elective experiences, including interdisciplinary collaborative courses, will enhance all areas of our curriculum.”

Although the redesign of all four years of the curriculum is now complete, Dr. Hobgood emphasized that curricular transformation is an ongoing process as medical schools respond to advances in the biomedical sciences and changes in the health care system, with corresponding changes in the way physicians practice. She envisions the development of more required multi-disciplinary courses in the clinical years to bridge the divide between disciplines just as the first- and second-year integrated courses are doing.

As the School of Medicine continues to evaluate and improve its curriculum, Dr. Hobgood welcomes comments from preceptors as they teach students within the new curricular framework in the coming year. Her mailing address is UNC School of Medicine, Office of Educational Development, Campus Box 7530, Chapel Hill, NC 27599-7530.



**OFFICE OF
EDUCATIONAL DEVELOPMENT**

School of Medicine
The University of North Carolina
CB# 7530
Chapel Hill, North Carolina 27599

<http://www.med.unc.edu/oed/frontline/>

Information Please



In addition to providing UNC preceptors access to licensed clinical resources (journals, books and databases) from UNC Chapel Hill, the AHEC Digital Library (ADL) offers several options for locating patient information.

When you enter the ADL, you are presented with a list of **Clinical Resources**. Choose **Patient Education**. After you select your health specialty of interest, you will see a handy chart that not only provides direct access to patient education materials but also alerts you to literacy levels and available languages other than English. A direct link to patient information for your health topic in *MedlinePlus* is also included.

An alternate avenue for finding patient education materials from the ADL home page is to go directly to your **Health Specialty** of interest and choose the **Patient Education** section.

Several databases also provide patient handouts, such as *LexiComp* and *Natural Medicines Comprehensive Database*.

We invite you to explore these materials by logging into the AHEC Digital Library at <http://library.ncahec.net>.

Unsure of how to log in to the ADL? Please contact your local AHEC Librarian for questions regarding your ADL Preceptor Membership or send an email to adl-questions@listserv.unc.edu.