



The Academic Plan
for the **School of Medicine**
University of Missouri - Kansas City

This is the 8th edition of this Academic Plan. The essential plan remains intact. Appropriate changes to adjust to the growth of the School and to improvements gained through experience have been made. With subsequent experience, modifications will continue to be made. The following pages reflect the understandings of the Academic Plan as of December 31, 2009, 41 years after the first draft.

The Academic Philosophy for the School of Medicine

The Open Medical School: A Community of Scholars

*A statement of philosophy;
a definition of objectives and systems,
with special consideration for
organization and administration.*

A School of Medicine is a living social system; no master plan can set down fixed ground rules to regulate so sensitive an apparatus. A different, and we believe, innovative approach requires a different pattern of administration. As faculty and students join this School, it is logical that the philosophy of medical education be shared and endorsed.

The rules of any game are an essential part of the game, and as has been said, “a game without rules is not fun.” The following plan is deliberately detailed. We recognize what we are doing requires a very careful definition of both “why” and “how”.

I. Introduction

UMKC School of Medicine

The basic character of medical school is determined by the fact that the fundamental purpose is to educate professionals. The prime objective of these professionals is to apply a sophisticated body of knowledge and skills to the solution of problems faced by people. In doing so they will follow self-imposed standards of performance—standards which will be higher than those which could be legally required. Medical professionals are morally responsible, action-oriented, problem-solvers working on behalf of people in difficulty.

Critical to the education of medical professionals is the development of their capacity for “clinical judgment.” We believe this can best be accomplished by providing early and continuing contact between the student and a team of clinician-scholars, whom we call “docents”. We have defined a docent as a university scholar whose first responsibility is to the education of the students in his or her area. The Docents provide individualized attention to the needs of students by virtue of their geographic proximity to them and the presentation of a model of the integration of personal commitment and competence into a professional career of delivering health care services. In short, docents serve as guides and coaches in the development of clinical competence. In a real sense, the docent is society’s representative and carries the responsibility of escorting the uninitiated student through the complicated experiences resulting in a blend of knowledge, judgment, self-motivation, compassion and ethics, qualities which society expects from the physician.

We recognize, of course, that there are critical facts and data which one must have to practice safe medicine; we agree that this area can be, at least in part, verified by examination techniques. We suggest there are other qualities which can be served by a prolonged inter-personal, “same student-same docent” four year relationship. We endorse the human skill involved in a “valued judgment” of another human: quality, character, steadiness, discipline, motivation, kindness, compassion, tolerance, understanding. We believe this value judgment is reasonably possible through the docent concept. We acknowledge the fallibility of such judgments but submit that a mature, experienced physician has as reasonable a chance of mastering this skill as anyone.

We accept with enthusiasm every contribution the computer will make to scientific quantification and to easing the burden of memory; we remind ourselves of the negative value of the computer in codifying the inexact science of clinical medicine and the shades of human conduct which are fundamental in a physician.

We do not separate the several obligations of a medical school: to educate the student, the house officer, the physician; to attract new talent to the health care field and to persuade that talent to remain active and prepared; to maintain maximum standards of ethics and care; to have concern equally for the individual and for the community; to foster inquiry, to find answers, and to apply those answers.

II. Education Plan

School of Medicine

- A. The objective of the curriculum is to prepare physicians to practice medicine and to contribute to the medical profession in other ways.
- B. The basic premise of the curriculum is that all effective regional resources will be utilized, thus “opening medical education” to the full involvement of regional talent and facilities.
- C. The six-year program offers a double degree, baccalaureate and doctor of medicine, following a high school education. The combined degree program is thirty-six weeks for the first year and forty-eight each year for the next five years, a full 276 weeks of curriculum time.
- D. The first two years of the six-year curriculum are divided into three-fourths arts and sciences (liberal arts) and one-fourth medical science education. (Figure 1) This latter program is administered by an academic dean and includes coordinating community hospitals, health centers, private physicians, counseling, and examinations. The participant is offered a planned medical curriculum giving exposure to information in behavioral science, medical ethics, medical history, anatomy, physiology and biochemistry. (Figure 2) Practicing physicians are selected as teachers and counselors (Year 1 and Year 2 Docents). Though high school is not the only route of entrance to the medical school and a smaller percentage of students may enter from other educational backgrounds, when possible the six-year program will be the characteristic of the school and the intent a double degree upon completion: A Bachelor’s and a Doctorate.
- E. The general comprehensive medical experience is central to the last four years of the medical school curriculum under the guidance of a docent team. This general medical experience is based on a two month service of daily ward rounds, during each of the last three years with the same docent team and a weekly outpatient responsibility for continuing care of patients who come to a general medicine clinic during each of the years.
- F. The docent acts as a continuing counselor through the student’s final four years. The required knowledge, begun in high school, is, of course, not taught solely by the docents, but by members of his team, by other faculty resources in the School of Medicine, and by other university faculty members. The docent’s counselor role is not limited to the period of time the student is assigned to general medicine but throughout the entire curriculum, from Year 3 through Year 6.
- G. Throughout the four years (Years 3, 4, 5, and 6) the students have time dedicated to completion of their liberal arts education.

H. Standards for factual requirements are established by the Council of Curriculum and the Council of Evaluation.

I. Experience in basic science, humanities, social sciences and clinical fields are **is** required.

J. We consider first-class residencies as an integral ingredient of a first-class medical school. Recognizing that the medical student and resident are separated only by time and experience, there is a strong need for continuity of medical education. A key factor in the open medical school concept is coordinated residencies shared and participated in by affiliated hospitals.

K. A cadre of education professionals functions as staff to the Dean's Office and to the Councils.

L. Organization and Financing

1. The dean of the medical school, in his or her faculty relationships, relates primarily to the Councils, department chairpersons, associate deans and hospital CEO's. Contractual relationships with affiliated institutions are negotiated by the dean. A faculty council, with rules, regulations and responsibilities, meets regularly.
2. The medical school relates administratively to the training of residents through the Dean and the Council on Graduate Medical Education.
3. University financial resources are allocated by the Dean to defray the cost of medical education including those incurred with affiliate hospitals, using agreed-upon principles worked out between the University and the affiliate.
4. The training programs for residents are operated under the Graduate Medical Education Council with the University serving as the institutional sponsor. In contrast, the medical student education programs are directly operated by the University with appropriate cost sharing for direct added costs borne by affiliated institutions.
5. Affiliated hospitals are encouraged, in cooperation with the University, to organize their staff and programs in accord with their own special missions and patient responsibilities. Medical students who enter these affiliated institutions are expected, during their experience in those locations, to assume a limited, specially designed level of responsibility, recommended by their docents.

M. Docent Units Facilities

1. When possible, learning takes place in the student-docent area. The student also has classroom experience on the main University campus
2. The student-docent team is composed of an approximately equal mixture of students from each of the classes (Years 3, 4, 5, & 6). Thus, the twelve-person team has three students from each year sharing the general medicine experience, throughout the four years.
3. A docent unit consists of the senior docent, three other docents, residents, nurses, clinical medical librarians, doctors of pharmacy, ancillary personnel and the team of medical students. Student offices and discussion space are provided on each docent unit.

4. A student's office is open to him or her twenty-four hours a day for the last four years. It provides privacy, security for possessions, network access (internet), books, and a place for personal memorabilia. (Figure 8)
5. The medical school and hospital are planned so students, their offices, their docents, their related inpatient and outpatient services are all on the same horizontal level. (Figures 9 and 10) Within reason, all admissions to the hospital are made through the general comprehensive medical service. General medicine is construed to include practically all admissions to the hospital that are not related to obvious special problems: obstetrics and acute surgical cases, labor and fracture are obvious exceptions. The definition of the general medicine services is a responsibility of the hospital professional staff, but it is the expressed and requested desire of the medical school that this definition be all encompassing, thereby bringing to the general medical service a broad and undifferentiated patient care responsibility.
6. The medical school library supports the specific needs of the school and related teaching hospitals. Clinical medical librarians are active members of each education-care unit. The individual student offices are considered physical extensions of the library-information services network and, in a real sense, are a part of the information storage and retrieval network.
7. The Docent team is not only an education team but is a major demonstration of a coordinated health care team. The Docent unit is a living laboratory specially conceived to give students of all health fields a model of patient care by a cooperative team of health professionals.

On the following # of pages, Figures and Legends restate The Basic Plan.

Curriculum Content for Six Year Medical Education Program

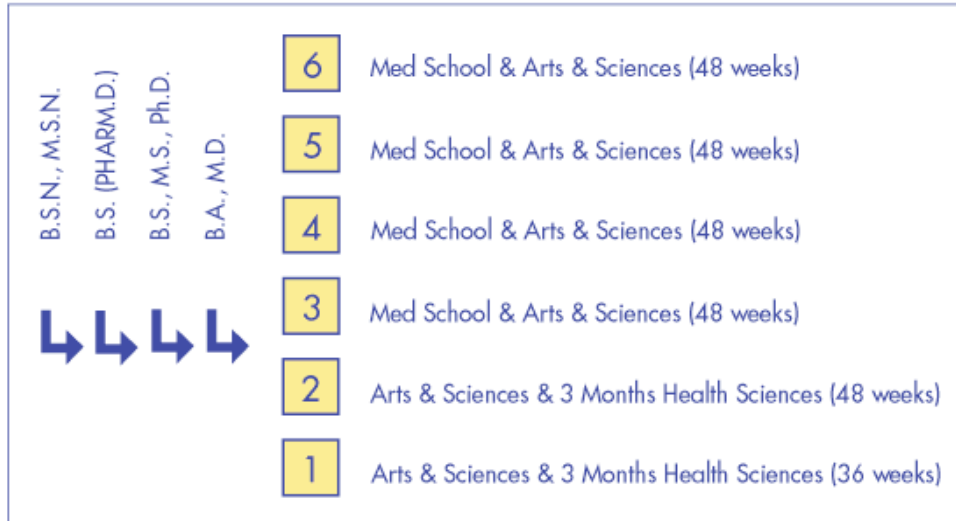


Figure 1

Figure 1 illustrates that a high school base is the primary point of origin for enrollment at the medical school. During the first two years the student is actively enrolled in the medical school and this two years represents a period in which the student and the school each see that desire and ability are matched to the requirements of medicine; if not, the student has an honorable way to choose another career while the school can bring in another student. The first two years (Years 1 and 2) are three quarters in arts and science education and one-quarter of time in the medical school program. From this base the student may continue in medical school or seek some totally unrelated career, health field or other. The student's health science credits will be accepted as bona fide medical school work or, if he or she elects not to continue towards a medical degree, will be accepted as credits toward a bachelor's degree. The third, fourth, fifth and sixth years are forty-eight weeks each with approximately three-quarters of the time in medical school and one-quarter of the time in arts and sciences.

Thus this is a six-year program after receipt of high school diploma. Students with other health career preparation may enter at advanced levels.

It is important to recognize that the student accepted as a Year 1 medical student is in medical school and is not competing for a position or opening. His/her place in the graduating class is secure; he has two provisional years in which to prove himself and in which to decide if he/she wants to be a physician.

Introduction to Medicine Program For Year 1 & 2 Medical Students

1. 5 hours a week for 32 weeks plus full time in work-learn position for two weeks. In Years 1 and 2.
2. Basic medical vocabulary and skills. Anatomy, physiology, biochemistry, ethics, medical history, physical diagnosis, awareness of total concept of health field.
3. Quarterly examinations.
4. Medical school aptitude?

Figure 2

Figure 2 defines some characteristics of the initial two year medical school program. This program is administered by an assistant dean working under the supervision of the Council on Curriculum. New students are assigned to a practicing physician-counselor, identified as a Year 1 Docent. A primary purpose of the Year 1-2 Docentship is to introduce the student to a basic medical vocabulary and certain skills. Equally important is the opportunity to make the student aware of the full concept of the health field and to give him or her the opportunity of understanding what is meant by a career in this field. An introduction to medical ethics and philosophy and to the behavioral sciences is also offered. The summer curriculum, at the beginning of Year 2 permits some useful work-learn employment. In addition to counseling, the program includes examinations. Counseling, examinations, and close observation of the students provide an unusual source of information for judging aptitude for medical school.

Year 3, 4, 5, 6 Medical School Curriculum

General Comprehensive Medicine	Weekly Continuing Care Clinic	Docent and Health Care Team
Basic Science	Fluid	Basic Medical Science Department School of Biological Sciences
Clinical Experience	Fluid	Truman Medical Center Children's Mercy Hospital Saint Luke's Hospital Community and Regional Hospitals Mental Health Systems
Liberal Arts	Fluid	UMKC College of Arts and Sciences

Figure 3

Figure 3 illustrates the overall breakdown of the curriculum with general comprehensive inpatient medicine occupying 24 weeks of the four year education. Responsibility for this is the docent's. The basic units of information, determined by the Council on Curriculum, are divided into the required and elective experiences, the latter varying with the student's interest and intent. The working committees of the Council on Curriculum define and plan the curriculum in both the basic medical sciences and the clinical experience. Other teachers are drawn from the regional resources, including the basic medical science department, school of biological sciences,, Children's Mercy Hospital, Truman Medical Center, Saint Luke's Hospital, Center for Behavioral Medicine and other community hospitals. The program in the arts and sciences has major elective opportunities selected by consultation between docent and student and the College of Arts and Sciences. An appropriate administrative relationship to the College of Arts and Sciences has been developed, and the obligations and requirements for a Bachelor's degree are accomplished over a six-year period, defined through coordinated planning. This includes a required course in medical humanities taken sometime in year 5 or 6 for the medical degree.

The Docent Unit



Figure 4

Figure 4 indicates that the docent unit is made up of the four docents who share the counselor responsibility, full-time clinic and inpatient staff, auxiliaries, and residents. The senior docent is actually a dean of a small medical school. In this central position the docent teams act to correlate the needs of the patients and needs of the students into an effective medical education-patient care unit, demonstrating the full range of general medicine. At the same time, the concept of health team care is demonstrated. Basic scientists can come into the clinical environment and provide correlative science support to the student's patient experience.

The Docent Unit

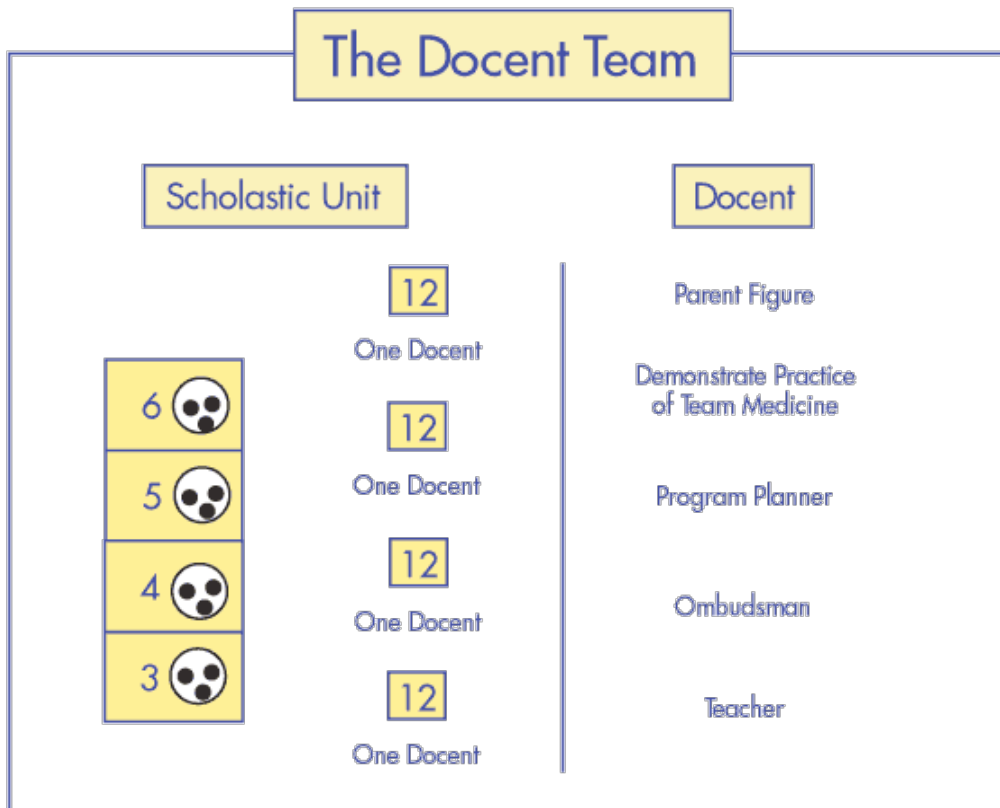


Figure 5

Figure 5. The rectangle on the left hand side of the page identifies all third, fourth, fifth, and sixth year students and the dots indicate a cluster of twelve students with three from each medical school year: a scholastic unit. The scholastic unit becomes a member of a docent team. The student is with the same docent throughout his school years. A parent figure, the docent demonstrates the practice of medicine with his team. He or she functions as counselor, program planner for the students and “writes prescriptions” to define the units of information the specific student needs. He/she functions as evaluator, ombudsman, teacher, and administrator. In the latter role he or she is responsible for personnel, space, equipment, students, outpatients, and inpatient areas under his responsibility. The student is officed with the same docent team throughout the school year, continuing his/her outpatient practice through the year, and each year except for Year 3, sharing an intensive 2-month ward round experience with the team.

Student's Office

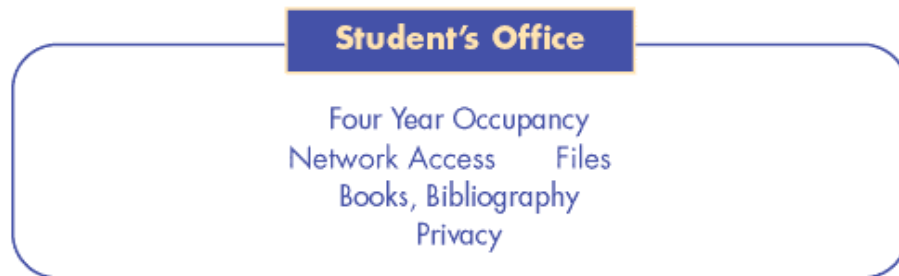


Figure 6

Figure 6: The student's office is a fundamental concept of the medical school. It is one of the distinct characteristics of this medical school. The student's office is assigned for four years. It includes a place for his or her books, papers, and television. It becomes the student's private library, the student's communication center, the student's command post.

Schematic Plan

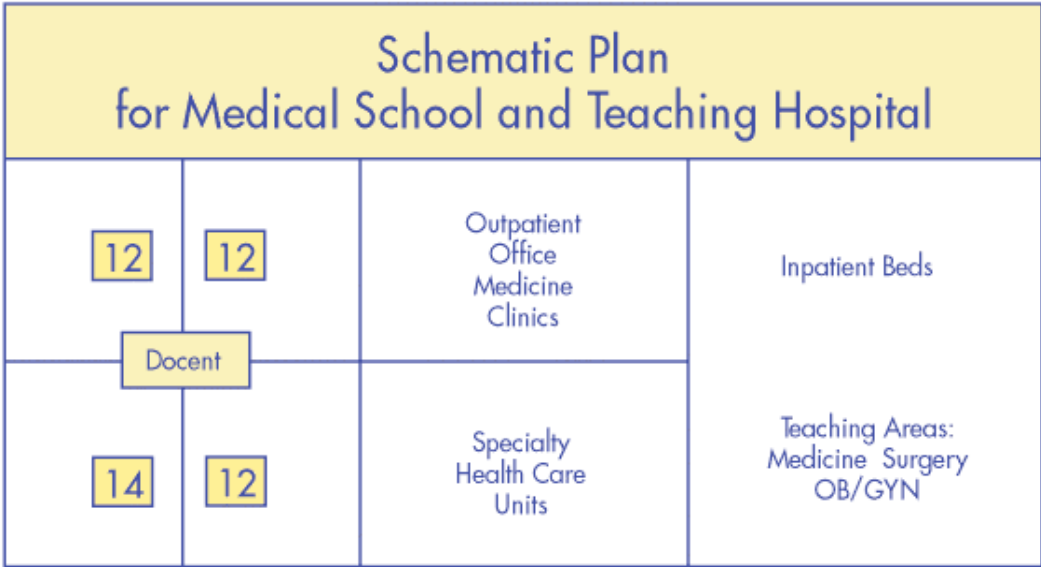


Figure 7

Figure 7 illustrates in a schematic manner the building plan of the medical school and the hospital, with function being restated by morphology. A central docent unit with its cluster of approximately fifty medical students is officed together in the medical school. They are immediately adjacent to the outpatient space and the inpatient beds, and teaching areas for which they have responsibility. . . The docent's area includes his or her offices and the clerical staff. The space assigned for each group of twelve students is demonstrative in Figure 10.

Floor Plan

Floor Plan for One Docent's Dozen			
Office	Office	Discussion Room	Central Office
Office	Office		
Office	Office	Docent's Office	
Office	Office		
Office	Office	Computer Terminal and Education	Laboratory Space
Office	Office		

Figure 8

Figure 8 illustrates the figurative floor plan, individual offices, and scholastic team facilities. The student's office becomes his or her domain during the full four years. Also illustrated is the territorial right of each small cadre of students. In addition to the individual offices, there are group discussion rooms and wireless network access and printing facilities.. The territorial integrity of the unit, plus the equal mixture of students from each year of the medical school should eliminate impersonal instruction and any loss of identity. This augmented by the fact that the docent team has a permanent responsibility for its combining care patients over a four-year period, should make it possible for each student to have a personal curriculum.

To restate the arithmetic of the docent teams: Students in years 3,4,5 and 6, in groups of twelve are the responsibility of a docent; four such groups are the supervisory responsibility of a single senior docent; who is assisted by his office, the hospital, associate docents, and clinic staff. Each of two floors of the medical houses four such docent units, a total of four hundred students. These are the two floors in the medical school which are the heart of the docent dominions and these floors are immediately adjacent to the general medicine clinics and beds of the major teaching hospital. For any community sites for docent teams, a similar floor plan is used in order to facilitate docent/student relationships and patient care.

III. Organization Plan

UMKC School of Medicine

- A. The governance of the medical school organization follows a council model. For the medical education program, Faculty relate to the curriculum and are identified by their own preference as:
1. representatives of the humanities and social sciences.
 2. representatives of the basic sciences
 3. representatives of the clinical sciences
 4. representatives of administration
- B. Faculty with full-time responsibility to medical education whether at the medical school or in an associated department, hospital or health center carry an appropriate appointment as professor, associate professor, or assistant professor. Those faculty members also involved in clinical disciplines in their respective hospitals have appointments in their respective academic clinical departments as well. In keeping with the philosophy of an Open Medical School, academic clinical departments span the discipline across affiliated institutions, such that, for example, a professor of internal medicine may be clinically located at any one of several institutions. Liberal arts faculty members have their usual academic appointments in the College of Arts and Sciences and may have joint appointments in the School of Medicine. Appointments at all levels are made upon evidence of a significant commitment to scholarship and the medical education program. Promotion is recommended by special Promotions Committees.
- C. Definition of the right for a voting membership on the faculty is determined on the basis of demonstration of commitment to the objectives of the medical school as modified by University rules. There is a faculty council which meets regularly. Its officers are elected by the faculty members.
- D. Senior organizational units within the medical school are the Coordinating Committee, Council of Docents, Council on Curriculum, Council on Evaluation, Council on Selection, Graduate Medical Education Council, Diversity Council, Council on Continuing Medical Education, Graduate Studies Council and Faculty Council It is recognized that many task forces and work parties are the effective mode of operation of these Councils and Committee. We believe an effective “shared governance” is built into this administrative system.
- E. Faculty representation on these major councils is obtained by direct election from the voting constituencies: Humanities and Social Sciences, Basic Science, Clinical Science. Membership in these constituencies is based upon participation in the medical education program. Faculty representation on these major councils is obtained both by direct election from these voting constituencies and by direct appointment by the Dean of the School of Medicine to procure continuity of experience and balance

of representation. These latter appointments are subject to the advice and consent of the Coordinating Committee and the Council involved. Membership on the Faculty Council is by election with representatives from basic science departments, and each of the major clinical affiliated institutions. .

- F. Representation on the Council of Docents is automatic for each of the Docents. The Chairman of the Council Docents presides at all meetings. Docents are elected to the other Councils by vote of all the Docents.
- G. Representatives on Coordinating Committee are chosen by election by each council from the membership of the respective Councils. Associate Deans from the affiliated hospitals are represented on the committee.
- H. An office of Medical Education and Research in Medical Education functions within the dean's office and provides staff assistance for the Dean and Associate Deans. This office has responsibility for the following:
 - 1. recommending improvements in systems of medical education and instructional development;
 - 2. collecting data necessary to judge the system of medical education;
 - 3. maintaining a record keeping system for the program;
 - 4. organizing, stimulating, suggesting research programs in medical education.
- I. The process of election to Councils is articulated with the bylaws for each of the councils.
- J. Student representatives are chosen by a vote of the Year 3, 4, 5, and 6 student body with representatives serving on the on Curriculum, Evaluation, docent council and Selection. A medical student is also elected to the Coordinating Committee. . Research space and research administration are managed centrally by report to the Dean and the Vice Chancellor for Research and are designed to support both clinical and basic research. All faculty are encouraged in scholarship in research, education, and/or clinical practice in keeping with the philosophy of a Community of Scholars.
- K. An elected or appointed member must attend two-thirds of all Council meetings in any one year to retain membership in the Council. Further, a member can be removed by a two-thirds vote of ninety percent of the members of the respective discipline (i.e., Humanities and Social Science, Basic Science, Etc.). Action for such a vote may be initiated by the Coordinating committee upon receipt of a petition signed by twenty-five percent of representation of the individual discipline.
- L. To initiate the Councils and Coordinating Committee in the formative years of the school, initial membership was selected by the dean in consultation with the provost for health sciences. These initial appointments were followed by a formal elective procedure held at the end of the second calendar year. These elected representatives have staggered tenure so that a regular cadence of change has resulted.
- M. All Councils and Committees operate under Robert's Rules of Order. A pre-typed agenda is circulated at each meeting. Minutes are recorded and circulated to all members and copies sent to the dean and appropriate senior administrative officers. All Councils are chaired by a member of the faculty, who may also hold the administrative rank of assistant or associate dean. The Chairman of a Council has one

vote relating to ordinary business. The agenda is prepared by the chairman but all members have the privilege of placing items on the agenda.

- N. Elected membership to any one of the Councils excludes one from holding a membership on another Council at the same time. Thus there are different basic scientists on the Council on Curriculum, the Council on Evaluation, and the Council on Selection. This is equally true for the clinical scientist, et cetera. Thus there should be no sense of lack of participation. The working or task force committees of these Councils may involve all members of the faculty and the learning community at large.
- O. All final actions by the Councils need endorsement by the coordinating committee before they become effective. Thus the Coordinating Committee provides checks and balances over an activity of a Council which may be unacceptable to the other Councils. If a specific recommendation of a given Council is disapproved by the Coordinating Committee, the specific Council may review the recommendation and strengthen their argument and return the recommendation to the Coordinating Committee.
- P. The Councils have the authority to appoint task forces or work committees. It is expected that much of the work of the Councils will be carried out by such teams. Membership on the teams may be held by any resource person deemed appropriate by the Council; faculty appointment is not necessary. All such appointments must appear in the minutes of the Council.
- Q. The Coordinating Committee and the Councils, under Robert's Rules, may function in executive session and execute confidential minutes. The regular minutes shall show such an exception and state the problem discussed and the reason for confidentiality. Other than this exception, records are made available to the faculty members. When required by concern for discretion any chairman of the Councils may call for executive session of the Coordinating Committee, restricting membership to the Dean and the associate and assistant deans. Again, the regular minutes shall show cause, reason and source for the call for the confidential session.
- R. Elections to the Councils of Curriculum, Evaluation and Selection are administered by the Office of Medical Education, with secret ballot, validated by the coordinating Committee, and publications of results in the formal minutes of the Coordinating Committee, and publications of results in the formal minutes of the Coordinating Committee. The deanship must be occupied by a tenured faculty member. The term of office for the dean is for a seven-year period with one additional term possible.
- S. The dean bears the University's responsibility for matters of budget and funding. Daily matters relative to students, staff, buildings, affiliations, et cetera, will be handled by the dean with executive authority. The dean has responsibility for interpreting the original philosophy and administration as defined in this monograph. His/her task is to lead the faculty and students toward these objectives, to adapt where there is cause, to persevere until the experiment has been adequately tested, and encourage critical analysis of the results.

Coordinating Committee

Coordinating Committee

- Chairman (Associate Dean for Academic Affairs, Appointed)
- 1 Council on Curriculum member (Elected)
- 1 Council of Docents member (Elected)
- 1 Council on Evaluation member (Elected)
- 1 Council on Selection member (Elected)
- 1 Office of Medical Education (Associate Dean, ex officio)
- 1 Office of Student Affairs (Associate Dean, ex officio)
- 1 Office of Diversity & Cultural Affairs (Associate Dean, ex officio)
- 1 Resident (Elected)
- 1 Medical Student (Elected)
- 1 Docent (Elected)
- 10 Chairs for all other Councils (Appointed)
- 4 Associate Deans from Affiliated Hospitals (Appointed)

Figure 9

Figure 13: The Coordinating Committee is comprised of representatives from each of the councils and ex-officio members. It is responsible for reviewing recommendations advanced by each of the councils. The committee also can exercise initiative to develop, review, and recommend educational policies and practices. It is the ultimate governing body reporting directly to the dean for final decisions. Chaired by an associate dean, the committee meets monthly.

Another subcommittee of the Council on Evaluation forms the school's Honor Council that upholds and implements the school's Standards of Professional Conduct for medical students.

Council of Docents

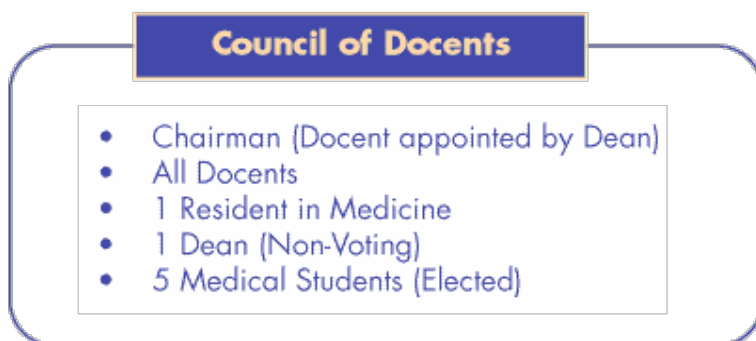


Figure 10

Figure 10: The Council of Docents represents those individuals having responsibility for coordination of programs designated by the Council on Curriculum. Figuratively speaking, the Council on Curriculum prepares a “pharmacopeia” and the docents prescribe from it, writing prescriptions for each student’s individual needs in education. One docent is eligible for election to the Curriculum Committee. The docents do not prepare the curriculum: rather they function by coordinating the curriculum, advising and preparing the students, functioning as ombudsmen for the students, and demonstrating the art and science of medicine.

The chairman of the Council of Docents automatically is the representative of this council to the Coordinating Committee.

The Council elects one additional member from their group to the Coordinating Committee.

The Docent Clinical Pharmacists of the School of Medicine are members of this council

The Residents in Medicine are important members of the teaching and care program and their representative to this Council yearly.

Total Voting Members: All Docents, All Clinical Pharmacists

Council on Curriculum

Council on Curriculum

- Chairman (Associate Dean, Appointed, 7 Years)
- Vice Chairman (Appointed, 2 Year)
- 1 Docent (Elected)
- 2 Basic Medical Science Faculty (1 Elected, 1 Appointed)
- 2 Clinical Science Faculty (Elected)
- 1 Medical Student (2 alternates) (from Year's 4 – 6) Elected)
- 1 Faculty member from St. Luke's Hospital (Appointed, 3 years)
- 1 Humanities/Social Sciences (elected) 3 years
- Associate Dean for Medical Education (ex-officio)
- Associate Dean for Student Affairs (ex-officio)

Figure 11

Figure 11: Members of this council include basic and clinical scientist faculty, docents, social science and humanities faculty, and students. The bylaws ensure wide representation of medical fields and disciplines relevant to the practice of medicine. At least a simple majority of the members must be elected by their peers. Others may be appointed at the discretion of the dean. The council is responsible for the design and management of the core curriculum leading to the M.D. degree as well as for the review and approval of elective courses. It approves student petitions for changes in curricular plans and as necessary oversees the development of curricular prescriptions for students with special learning needs or interests. This council meets monthly.

Council on Selection

Council on Selection

- Chairman (Appointed, 7 Years)
- 2 Representatives St. Luke's Hospital (Appointed)
- 1 Docent (Elected)
- 1 Docent, Alternate (Elected)
- 1 Faculty Member, Social Science (Elected)
- 2 Basic Medical Science Faculty
- 2 Clinical Science Faculty (Elected)
- 2 Medical Students (from Year's 3 – 6, Elected)
- 8+ Additional Physician & Non-Physicians

Figure 12

Figure 12: This council consists of faculty elected by their peers from the basic and clinical sciences, the humanities, and the social sciences; docents; community representatives; and students. They may also appoint members not to exceed the number of elected members. The council's charge is two-fold: 1) the development and implementation of policies and procedures for selecting students for the school's program and 2) recommendation of admission of specific students. Its meetings primarily coincide with the selection cycle. A retreat occurs annually.

Council on Evaluation

Council on Evaluation

- Chairman (Appointed, 7 Years)
- 1 Appointed by the Dean
- 1 Representative from Humanities (Elected)
- 2 Basic Medical Science Faculty (Elected)
- 2 Clinical Science Faculty (Elected)
- 2 Clinical Reps. from St. Luke's Hospital (Appointed)
- 1 Docent (Elected)
- 1 Docent, Alternate (Elected)
- 1 Resident (Elected)
- 2 Medical Students (from Year's 3 –6, Elected)
- 1 Medical Student (from Year 2, Non-Voting, Elected)
- Associate Dean for Diversity & Cultural Affairs (ex-officio)
- Associate Dean for Student Affairs (ex-officio)
- Associate Dean for Medical Education (ex-officio)

Figure 13

Figure 13: Members of this council include faculty elected by their peers from the basic sciences, clinical medicine, and the social sciences and humanities. It also includes elected representative from the student body, dean's appointments, and ex-officio members. Its charge is the development of policies and procedures to assess the academic and professional development of students as they move through the curriculum and to apply those standards in evaluating student performance at all year levels. It originates recommendations for student promotion, non-promotion, graduation, and dismissal. This council meets at least 10 months out of the year.

Another subcommittee forms the school's Honor Council that upholds and implements the school's Standards of Professional Conduct for medical students.

Faculty Council

Faculty Council

- Chairman (Elected from the 10 member council),)
- 2 School of Medicine Basic Sciences
- 2 Truman Medical Center (1- Hospital Hill, 1 Lakewood campus)
- 2 Saint Luke's Hospital
- 2 Children's Mercy Hospital
- 2 Center for Behavioral Medicine

Figure 14

Figure 14: Meeting quarterly, the council provides a communication channel for all faculty who are members of this council. The dean and associate deans attend to report and discuss issues of interest to the faculty.

Council on Graduate Medical Education

Council on Graduate Medical Education

- Chairman (Associate Dean for Graduate Medical Education, Appointed)
- Vice Chair (Appointed)
- 11 elected by faculty
- 4 elected by residents

Figure 15

Figure 15: Members of this council include faculty elected by their peers from the basic sciences, clinical medicine, and the social sciences and humanities. It also includes elected representative from the student body, dean's appointments, and ex-officio members. Its charge is the development of policies and procedures to assess the academic and professional development of students as they move through the curriculum and to apply those standards in evaluating student performance at all year levels. It originates recommendations for student promotion, non-promotion, graduation, and dismissal. This council meets at least 10 months out of the year.

IV. Summary

Basic Concepts

- A. Mobility
- B. Fluidity
- C. Increasing Responsibility
- D. Continuity
- E. Case Data Base
- F. Docentship
- G. Visiting Physicians
- H. Faculty Development Programs
- I. Checks and Balances

To re-state some of the characteristics of this entire program:

First, there is great mobility for a student who can sample the health field during Years 1 & 2 and find that he or she does or does not want to study medicine. There is mobility of entrance to the medical school: directly from high school, from the standard pre-medical background, from a nursing background, from a Ph.D. background, et. cetera. There is mobility of access to the system, the opportunity to enter directly from high school removes the major financial barrier now offered by the lengthy pre-medical education requirement. Students from all walks of life have an equal access.

Second, there is a fluidness of curriculum with the opportunity of the curriculum adapting to the individual student's needs and ambitions.

Third, with the twelve-student team, mixing all four years, there is the opportunity for the student to teach the student to teach the student to teach the student and an unusual opportunity for increasing responsibility or responsibility to fit one's maturity. The continuity of care in the outpatient clinic also permits logical increases in responsibility, with the equally important fact, protection of the patient. The entering Year 3 medical student joins a Year 5 student and a staff physician to provide outpatient care.

Continuity also expresses itself by the makeup of the docent teams and by the physical permanence of the student's office. There is continuity of patient care over a four year period; there is continuity of contact with professional personnel, including nurses, pharmacists, technicians, and administrative staff.

Faculty development programs to enhance scholarship in research, education and clinical practice provide students with relationships with the Community of Scholars. Students are encouraged to participate in research activities from conception, through data collection, through analysis, to presentation and publication. It remains the hope that all participating hospitals will make a full commitment to electronic medical records to support clinical outcomes research, thus linking the clinical activities with education and research.

The general medical program is the central theme of the curriculum; adequate breadth of knowledge, both cultural and medical, should be possible through wise use of the full 6 years. Note these are calendar years, not college academic units.

The docentship effectively limits the student's persona medical school to but fifty students, no matter how large total enrollment becomes. Problems of loss of identity and locking of students into rigid blocks of curriculum are eliminated. The docent provides a career model, an image. Undifferentiated general medicine is seen as whole, inpatient and outpatient, with a team care approach demonstrated. The docent watches the maturation of the student over a sustained period and has personal knowledge of the student's pressures, stresses, family problems, dollar problems-all issues essential to know in the balanced evaluation of a student.

The system of governance and administration eliminates the rigidity of departmental structure and the block assignment of curriculum which effectively locks the student into basic science years and clinical science years or chops his education into organ concepts. Access to the Councils by election effectively gives any energetic, enterprising teacher and student the opportunity to be involved. . The limited terms of service give wide opportunity for involvement. The Dean remains the senior administrative officer and gathers his or her strength through the real sense of participation by all.

V. Conclusion

Throughout this discussion we have not fully developed the economical values that are inherent. By use of existing physical resources, by not assuming total fiscal responsibility for patient care facilities, by separating the cost of under-graduate medical student instruction from that of residencies, research, et cetera, we believe a significant decrease in the building and operating costs of a medical school can be made. We have not elaborated on these advantages of economy because we do not want to obscure or lessen our conviction that this plan may well be a better way to provide medical education regardless of cost. The fact that it may be less costly is certainly a satisfying parallel benefit.

We realize that this program is based upon major changes in organization, management, and execution in medical education. Thoughtful consideration makes us believe these changes have merit. The six years, year round, of curriculum does not attempt to offer a short-cut to becoming a physician. Our initial years of experience indicate that the graduates have maintained a humanistic, caring concern for the ill. Their records as house officers have been impressive.

Two phrases have been used to define this program: an Open Medical School and a community of Scholars. By spreading the teaching responsibility over the widest possible selection of regional resources we hope to make clear that this is an open medical school. By making it possible for the teachers and the taught from all participating institutions to share in the full planning and changing events of this school, we suggest we have the possibility of creating a community of scholars.

To this point, this description of the UMKC Academic Plan has stated philosophic goals involved in the undergraduate medical preparation of a physician. Much of the discussion has dealt with administrative mechanics. The students and faculty come together from two separate backgrounds: the students with no prior exposure to a medical school, and therefore able to accept the UMKC Plan on its own merits or demerits depending upon their own experience, personal satisfaction, growth and development. The faculty, by obvious truth, is the result of a host of traditional medical schoolings. They bring with them a vocabulary and administrative reference framework, subconsciously imprinted and endorsed by their own acceptance and participation on the rites of passage. Note again the second paragraph of this plan, a game without rules is no fun-rules are but roads, direction signals, fences and gates, making a visible route for all who share the journey.

Earlier we have not touched thoroughly enough on the intellectual origins of this alternative route to becoming a physician. In a series of articles and essays, beginning in the 1950's, I gave a monologue of debate, developed through experience, analysis and alternatives, of criticisms of the American medical education system. The UMKC effort is a goal-oriented direct answer to those criticisms.

By a coincidence of time, UMKC was launched in the late 1960's, a time of national activism and dissatisfaction, much of which was associated with the Vietnam experience; at the same time, several

experiments in medical education centered on a three-year curriculum. To understand UMKC and its fundamentally different educational methods and objectives, it is necessary to disassociate it from the frictions in education and society related to the Vietnam War and the tensions and torment of the cities in the mid-1960's. Equally, it was not conceived as an alternative response to the motivations producing the "three-year" experiments.

The UMKC effort began with the goal of preparing physicians who would be freed of the inborn competitive aggression built into the premedical education selection process – yet give the physician an adequate exposure to the civilizing wisdom offered by the humanities.

No one should be allowed permission to care for the sick who does not understand the sciences of medicine, just as permission must be denied those who have only the sciences. An artificial separation dividing basic sciences from the human correlation has been an obvious flaw of medical education. Not stated adequately in the prior pages has been the interlacing of the patient, the emotions, the sciences, and the pharmacology which is fundamental to the UMKC System.

Guided, increasing, repetitive exposure to all that makes a physician . . . not a block of time for cadaver anatomy unleavened by the living human imperatives. Anatomy not as an initiation rite to be gained before its clinical strengths are understood, but instead a repetitive return to it, building on experience and relevance. For it is relevance perhaps above all that motivates learning. This truism of all living things is a fundamental educational base of the UMKC Plan. Other characteristics of how living things best learn and gain confidence are repetition, encouragement, peer stimulus, trust in counseling, competition, evaluation, reward-and all within highly visible guidelines. Finally, whether lambs, baboons, elephant seals or humans, we all need a piece of space that is ours, a territorial imperative.

To strengthen the significance of these basic learning concepts, we brought into the program young, intelligent, highly motivated candidates, still maturing. We did not close out those individuals, because of chance or other variable, who turned later to medical education. We have found excellent candidates from all ages, and from this experience believe an effective mix of young and older students, perhaps nine to one, fosters an exciting environment.

These have been the issues from which this education system developed. Such concepts are not specific for medical education. They equally apply to learning to walk, to driving a car, or farming, creating a wine or a painting, or being an adjusted, reasonable happy human being – which is obviously a first essential of a safe physician.

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