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Using the Faculty Learning Community Model to Design Medical Student Learning Communities

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The faculty learning community (FLC) model was used to design student learning communities (SLCs) at Wayne State University School of Medicine (WSU SOM), because decisions about SLCs require scholarly, considerate, and dedicated input from a wide variety of stakeholders. The WSU SOM Faculty Learning Community to Design Student Learning Communities (FLC4SLCs) includes faculty, medical students, and administrators. Additional stakeholders from curriculum and student governance were included as needed for additional input. After meeting every other week for seven months, the FLC recommended the number, naming, curriculum, administration, student governance, funding, and next steps for implementation of the SLCs. Their recommendations have been accepted by the Vice Dean of Medical Education, and implementation will begin with the class of 2021, entering in August 2017.

Wayne State University School of Medicine

The Wayne State University School of Medicine (WSU SOM), founded in 1868, is deeply embedded in and committed to the city of Detroit, Michigan. WSU SOM accepts 290 students each year, making it the largest single-campus medical school in the nation. The School of Medicine's core mission is to "educate a diverse student body in an urban setting and within a culture of inclusion, through high quality education, clinical excellence, pioneering research, local investment in our community and innovative technology, to prepare physician and biomedical scientific leaders to achieve health and wellness for our society." Historically, the SOM has struggled with building student engagement and community, not only because of the size of the school, but also because of the traditional, lecture-based (and streamed) delivery of the educational program. Students were able to stay home and view lectures online, seldom coming to campus or interacting with other students.

In 2014, the SOM underwent a site visit by the Liaison Committee for Medical Education (LCME), the medical college accrediting agency. The outcome of the visit revealed several areas of concern and revealed to the SOM leadership that a new model of medical education delivery needed to be designed and implemented. The SOM was lacking in small-group experiences and needed to develop a process for medical education delivery that was both individualized and personal and available to the 1200-person student body. An area of specific concern by the LCME was the need to build programming that increased student engagement.

It is the School of Medicine's belief that we can facilitate better learning by building connections among the students, school, community, faculty, classrooms, and the overall medical education program. We will create a culture of openness, safety, and support for WSU SOM. Our end goal is that the student experience be one of engagement and success. MacGregor, Tinto, and Lindbald (2001) have shown that the support of a student learning community (SLC) aids in student retention and that all students, especially those who are at-risk, fare better academically, socially, and personally in an environment where there is community. In addition, students' learning in an SLC has been shown to go deeper and is more integrated. Sensitivity to and respect for other points of view, other cultures, and other people are enhanced by participating in a student learning community. Finally, the faculty members involved in learning communities achieve gains in personal, social, and professional development. In an effort to create a better learning environment in which students would feel supported and engaged, the SOM decided to use the

faculty learning community (FLC) model to investigate how SLCs could be adapted to the school's culture.

The Faculty Learning Community (FLC) Model

Faculty learning communities (FLCs) are groups of 8-12 faculty members, professional staff, and students who have a common interest in a subject and are willing to research the topic and make decisions on how best to bring it to their campus. The WSU SOM FLC is topic-based, which means the members come together from a variety of places in the school with a common interest in a specific topic. As a topic-based FLC, community members designed a curriculum for their efforts that addressed the special campus learning need of creating engagement through development of SLCs.

FLCs are more structured and intensive than most approaches that gather together a collection of faculty to meet and work on teaching and learning issues. For example, teaching circles, book clubs, seminars, courses, or a group coming together over "brown bag" lunches to read and discuss articles on teaching are much less focused. FLCs are more than just a seminar series, formal committee, project team, self-development, or counseling groups. FLCs meet for a period of at least 6 months; have voluntary membership; meet at a designated time and in an environment conducive to learning; develop empathy among members; operate by consensus, not majority; develop their own culture, openness, and trust; engage complex problems; energize and empower participants; have the potential of transforming institutions into learning organizations; and are holistic in approach. While including the efficiency of getting things done, FLCs have an explicit focus on the social aspects of building community. They include an emphasis on the team aspect and on the ultimate beneficiaries of the program: the students (Cox & Sorenson, 1999).

Another reason WSU SOM selected the FLC model was because our topic—designing student learning communities appropriate for our students—was itself a community-building enterprise. We needed scholarly, considerate, and dedicated input from a wide variety of stakeholders. WSU SOM's FLC4SLCs included the following members:

- 2 students, originally first and second years (M1 and M2), who are now M2 and M3); a new M1 will join the group when identified
- 2 alumni: one prior to and one since 1991
- 2 faculty members

- The Assistant Dean of Student Services
- The Director of the Counseling Office
- The Director of the Office of Service-Learning
- The Director of the Office of Learning and Teaching (an experienced FLC facilitator)

Additional stakeholders from the curriculum and student governance were included as needed for additional input. They included the Assistant Dean for Clinical Affairs, the Course Director for Clinical Medicine, and the President of the Student Senate.

Student Learning Communities in Medical Schools

In medical schools, SLCs go by many names, such as societies, colleges, docent teams, houses, and mentorship groups. While schools and communities may differ greatly on whether the predominant focus is curricular (for instance, clinical skills training) or extra-curricular (for instance, advising/social), medical school SLCs typically comprise individuals who share common values and purpose, a sense of personal membership, and personal influence and fulfillment of individual needs.

Medical school learning communities are learning environments created within larger settings, where students and faculty members of these communities can establish close and sustained professional and personal connections, common goals, and, most important, can learn together and from each other (Osterberg, Gilbert, & Lotan, 2014). The number of medical schools with learning communities is increasing rapidly, with 81 out of 141 accredited MD-granting institutions and 31 accredited DO-granting institutions in the United States reporting having SLCs (Smith, Shochet, Keeley, Fleming, & Moynahan, 2014).

Within U.S. medical schools, typical SLC activities may include advising, mentoring, and career planning; training in clinical skills, medical professionalism, and/or ethics; fostering relationships between students and faculty and among students; community service and team building; curriculum development; and social networking and vertical integration of students across class years. However, they are hardly monolithic. It is widely recognized that "if you've seen one medical student learning community, you've seen one medical student learning community."

An additional benefit of medical school SLCs is that academic clinical faculty members reported that serving as a mentor in an SLC was a strong source of job satisfaction. SLCs may be a tool for avoiding burnout and retaining clinical faculty members in academic careers (Wagner et al., 2015).

Decisions Made by the FLC for SLCs

1. Number/Size of SLCs

With the goal of taking a large community and breaking it into smaller, more intimate communities, the FLC's first decision was how to effectively divide the 290 students each year into groups. The primary question was, What size of community leads to the best learning environment? One of the first courses in the first-year curriculum is Anatomy, where students work as a team around an anatomy table that accommodates 6 students. We named the unit of 6 students a "Learning Team" and took 6 as a grouping number. This meant that the number of SLCs had to be a factor of 48 to accommodate the approximately 290 students in each class. Therefore, the FLC discussed creating 6, 8, or 12 communities.

We decided that 48 students (6 SLCs) was too large a group and that 12 SLCs would be too expensive to staff. We ultimately chose 8 communities, which means that 36 MS1 students (6 Learning Teams) enter each community each year. Each community will equal no more than 144 students for all four years. It is our belief that 36 students is small enough to build strong connections, while large enough to have good diversity.

2. Naming the SLCs

Student learning communities at medical schools go by many titles. We felt that the name "Wayne House" most fully communicated the upcoming roles these communities would play in student and faculty life at WSU SOM. With this decision, we aimed to express the welcoming nature of these communities as well as their place in the professional and intellectual development of WSU SOM's future physicians. We did not consider names with an overly academic connotation, such as "student learning community" or "academy," because we did not want names that could limit the potential of Wayne Houses in the minds of their members. In contrast, we believe "Wayne House" imparts a sense of openness, where one can just as comfortably and effectively learn and relax with peers as engage in the hard, ethical conversations crucial to a physician's identity. Furthermore, by naming these communities "Wayne Houses" instead of just "Houses," our goal is to further develop a sense of school pride so that when students graduate, they graduate not just as physicians, but as Wayne State physicians.

Each Wayne House will be named after a notable WSU SOM alum or an Emeritus faculty member. We are still working on how and when those names will be chosen.

3. Administration and Staffing

Administration

Overall program administration is the responsibility of the Office of Learning and Teaching (OLT). Staff/faculty will be selected by the OLT House Advisory Committee, composed of members of the FLC. Preparation will include OLT, Advisory Committee, and other WSU SOM personnel, as well as off-site training.

Staffing

Staffing requirements are based on the proposed activities and curriculum (see item 4, below) called the Profession of Medicine (POM) course (see Appendix A) that will take place utilizing the Wayne Houses' division of students. POM includes activities currently or previously provided in the Clinical Medicine course or the Population, Physician, Patient (PPP) course, as well as additional activities taking advantage of the House setup.

4. Curriculum for the Wayne Houses

Overall

While student learning communities can be established for the purpose of increasing engagement with extracurricular activities alone, incorporating curricular elements increases the impact and effectiveness of learning communities. In order to incorporate the current curriculum into the new Wayne Houses most efficiently, we first analyzed the current curriculum. Many of the elements of the curriculum simply require restructuring or reorganization to facilitate their incorporation into the Houses. We mapped curriculum to include the elements of timing, content, format, and method of assessment for each component of the current curriculum. Factors that we considered for each of the elements are summarized in Table 1. The FLC will be assessed on ideal elements of FLCs (see Beach & Cox, 2009) as well as on the success of the implementation of the eight SLCs. The SLCs will be assessed on the achievement of the stated learning objectives in Table 2.

The basic School of Medicine science curriculum is driven by its content. The science curriculum will not need to be restructured with the introduction of the Houses; however, several course activities will be influenced. For example, small groups within these courses will now draw students from the same House. We focussed our efforts on other

Table 1
Factors for Analysis of Curriculum

Timing (Where taught)	• First year, second year, etc. • Longitudinal over 2 years, over 4 years
Content (What taught)	• What content is covered • Corresponding LCME curricular content
Format (How taught)	• Lecture • Self-Directed Learning • Small Group • Large Group • Faculty
Method of Assessment (How assessed)	• Examination • Quiz • Narrative Assessment • OSCE • Evaluation Form

aspects of the curriculum, such as clinical medicine, physical diagnosis, physician health and wellness, pre-residency skills, service-learning, and more. This led to the development of the POM course, which will exist in the context of the Houses.

Profession of Medicine Course

Concept. The Profession of Medicine course will reside within each Wayne learning community. POM lays the foundation for the development of a physician. This course aligns with the School of Medicine's Mission Statement, which states that its core goal is to "educate a diverse student body in an urban setting within a culture of inclusion through high-quality education, clinical excellence, and investment in and understanding of the Detroit community." POM is a 4-year longitudinal course that provides students the opportunity to learn, practice, and apply knowledge and skills as a physician-in-training in clinical settings as well as in the community. Through large-group sessions, small-group sessions, computer modules, and self-directed reflective assignments, students will participate in activities demonstrating the interconnectedness of the population, patient, and physician. (See Appendix A for Elements and Progression of the course.)

Table 2
Learning Objectives for Profession of Medicine Course

Population Health • Describe how to assess the health status of populations using available data. • Describe the role of socioeconomic, environmental, cultural and other population-level determinants of health on the health status of individuals and populations. • Develop strategies to work with the community to enhance the health of the population.
Collaborative and Constructive Relationships • Demonstrate effective, caring, and collaborative doctor-patient relationships. • Demonstrate working relationships with other health care providers. • Demonstrate collaborative relationships with community service providers.
Patient Interviewing • Conduct organized streamlined patient interview. • Demonstrate the ability to be an active listener. • Demonstrate patient-centered counseling skills to facilitate behavior change. • Demonstrate empathic patient interactions.
Physical Examination • Demonstrate basic components of the physical examination. • Demonstrate making the patient comfortable during the physical examination.
Oral Presentations and Clinical Documentation • Present organized clinical data in a clear, concise manner. • Report normal and abnormal physical findings. • Demonstrate basic and advanced oral presentations.

Table 2 (*continued*)
Learning Objectives for Profession of Medicine Course

Clinical Reasoning
• Integrate, organize, and interpret information gathered during the medical history and physical examination.
• Use Hypothetico-deductive model to develop differential diagnoses.
• Evaluate health literature and its implications for patient and population health by applying clinical epidemiology concepts and calculations.
Professional Identity
• Demonstrate professional behavior and active participation in all aspects of the course, including intellectual honesty, as well as respect for patients, families, colleagues and faculty.
• Demonstrate role as a team member and inter-dependence with the members of a collaborative team.
• Reflect on process of becoming a physician, including the challenges and opportunities of the role of a physician.
• Demonstrate a healthy work-life balance.
• Demonstrate leadership skills.

Methods. Two Learning Teams (12 students each) within each Wayne House will be paired with a faculty house leader to comprise the Profession of Medicine group. Groups will remain stable throughout the 4 years of the curriculum. Sessions will be held weekly during years 1 and 2 and monthly during years 3 and 4. The faculty for each learning community and for this course will include physicians who teach, coach, advise, and support students. M3 and M4 students will act as mentors to create support and guidance.

Student learning objectives. At the end of POM, students will demonstrate proficiency in fulfilling the objectives shown in Table 2.

Service-learning and co-curricular activities. All students, beginning with the current class of 2020, are required to complete 35 hours of service-learning activities. This part of the POM course will be an integral part of the Houses. Each learning team of 6 students will be assigned to a clinic (10 hours) and work on a project together (10 hours). The students will self-select to attend seminars, journal club, and reflection sessions (5

hours), and complete mentoring outreach (10 hours). On completion of the service-learning activities, they will have the option to continue in the co-curricular program.

The co-curricular credit program was initiated in the fall of 1998 in response to the extraordinary service investment that WSU SOM students have historically made to the Detroit metropolitan area. The program recognizes those students who have dedicated themselves to building partnerships with surrounding communities through a variety of sponsored outreach and volunteer activities. Students acquire a greater understanding of human needs, concerns, interests, and values through their participation in these programs, learning to interact with area residents by providing services in their communities. In order to participate, students must be in good academic standing.

Wellness and social programs. Scientific evidence suggests that there is a relationship between student wellness and academic success. The LCME understands this connection and mandates that all medical schools have health and wellness programming. Additional research by Dyrbye (2005) confirms that with the loss of student wellness, students can experience a loss of empathy, substance abuse, depression, anxiety, burnout, and, ultimately, a decline in the quality and safety of the care they provide. Full integration of the health and wellness curriculum is the best way to ensure that all students benefit from and participate in programming related to their personal wellness. Nationally, there is a trend in this direction as the importance of wellness to physicians' satisfaction in their careers as well as direct links to the quality of their patient care is being recognized.

As a result, there is a strong drive to incorporate immediate changes as well as develop long-term plans to fully integrate health and wellness into the curriculum. A review of national websites of other medical schools indicates that health and wellness is certainly an important element of curriculum. Many schools have already adopted the pass/fail model of grading. Exactly how health and wellness is integrated into medical programs is extremely variable, and its successful integration into the Wayne Houses presents an opportunity for the School of Medicine to distinguish itself. Learning communities will offer an opportunity to incorporate health and wellness activities as well as other social and team building initiatives.

Currently, the Wellness Program is divided into five sections: Physical, Psychological, Academic, Social, and Community. For each section, there are activities that promote health and self-care. Students participate on the planning committee for the Wellness program and assist in the coordination of social events, workshops, speakers, and other relevant activities.

The wellness planning committee would help promote a balanced life for all medical students and help ensure emotional and physical well-being. This Wellness planning committee would help promote a balanced life for all medical students and help ensure emotional and physical well-being. It is our belief that a healthy environment is one in which there is not only an absence of harmful conditions, but an abundance of health-promoting ones.

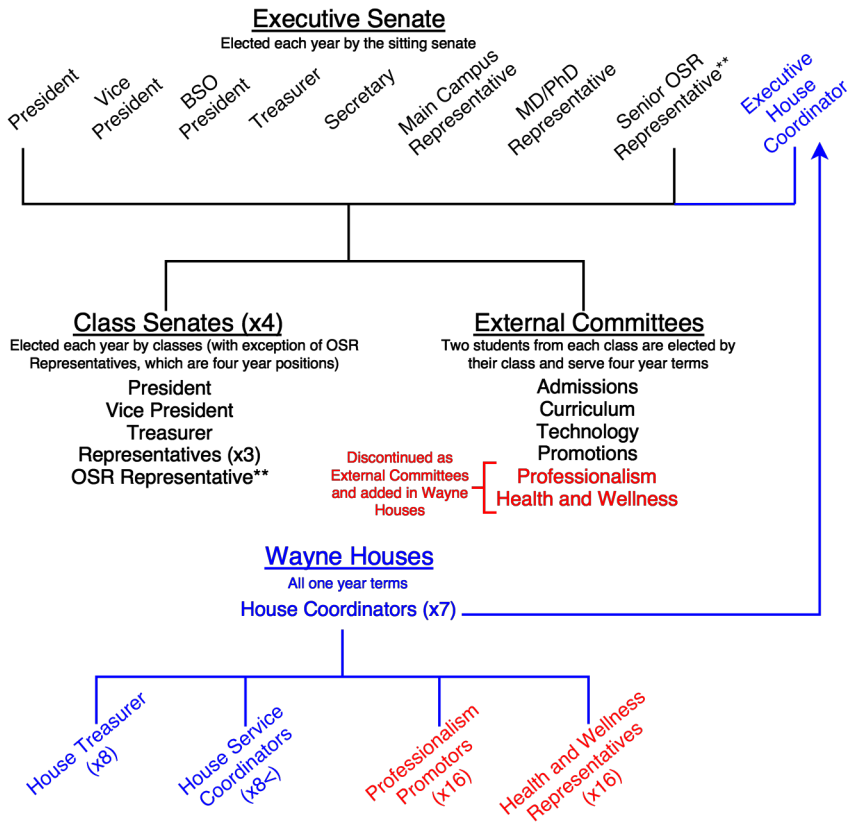
Personal counseling. Personal counseling will not be a part of the House curriculum. Student Affairs counsellors traditionally have been assigned to one class and follow those students through their entire four years. The FLC members recommend keeping this role within Student Affairs, separate from the Houses. However, individual counselors may provide additional programming to the Houses.

5. Student Governance

One of the challenges with implementing SLCs at WSU SOM is how the Wayne Houses will be governed and how that governance relates to the current campus-wide governance. WSU SOM has a long history of an independent Student Senate, whose primary purpose is to represent the students and to serve as a liaison between the SOM student body, the SOM administration, the WSU main campus, the hospital affiliates of the SOM, and the community at large. Student Senate consists of an 8-member Executive Senate in addition to a president, vice president, treasurer, AAMC Organization of Student Representative (OSR), and three representatives for each class. There are also 6 external committees, to which 2 students from each class are elected during their first year for 4-year terms (see Figure 1).

The challenge of governing the Houses will be creating a leadership structure that supports the stated aims of the SLC while maintaining student leadership that is still able to execute the purpose of the WSU SOM Student Senate. The first step in overcoming this challenge was to get the Student Senate directly involved in the FLC decision-making process. It was recognized that any decisions about House or campus governance had to align with the purpose of the current Student Senate Constitution and be approved by the current Student Senate before implementation. The result of this was twofold: First, it gave the FLC a clearer understanding of what kind of representation students felt would be needed with the new SLCs; and second, it allowed the FLC to gather valuable student input on the medical campus's needs so that it could focus on how governance in the new Houses could support these needs. Beyond serving as a liaison,

Figure 1
WSU SOM Student Senate



as described earlier, the FLC found that the primary campus needs for Student Senate included the following: discussing and investigating any and all issues of interest to the student body of WSU SOM, appropriating funds for approved student projects and events, overseeing and regulating current student organizations and the creation of new student organizations, and planning and hosting various social events for the student body. Using this information, the FLC proposed the format for governance for each House and the campus shown in Table 3.

Given this information, Student Senate formed an *ad-hoc* committee to

Table 3
FLC Suggested House Governance

House Governance	*Campus Governance*
House President	8 Presidents could be the Executive Senate.
House Vice President	8 Vice Presidents could be responsible for all social activities in their own Houses and coordination of events across the campus.
House Treasurer	8 House Treasurers would implement in-house decisions and, as a group, be the Senate Finance Committee; alternatively, the group could select one of themselves to be the campus-wide Treasurer.
House Service Learning Activity Coordinator	8 Service Learning Coordinators would implement in-house decisions and work as an 8-person group with the Service Learning Program.
House Wellness Activity Coordinator	8 Wellness Coordinators would implement in-house decisions and work as an 8-person group with the Wellness Program.
4 Class Representatives (one for each class)	8 Class Representatives (for each class) would implement in-house decisions and work as an 8-person group with the other Class Representatives from their class.

determine the best way to move forward. The *ad-hoc* committee decided that the best course would be to form a transitional model of governance where both Student Senate and Wayne House governance exists, at least at first, until the Wayne Houses are fully established with students from all four years who have been participating in SLCs from the moment they matriculate (that is, excluding the grandfathering in of current students). For this reason, the *ad-hoc* committee proposed that all current Student Senate members on the committees/in the positions mentioned below remain in these committees/positions to help guide the new Wayne House

governance. Finally, the committee proposed this transitional model with the goal of reassessing this model annually (all proposed positions are only one-year terms) to determine whether changes should be made as the student landscape and program needs shift.

The *ad-hoc* committee first looked at the purposes of the Wayne Houses and Student Senate and identified areas of overlap. There were two external committees that Student Senate felt would integrate well into the Wayne Houses: Professionalism and Health and Wellness. Student Senate proposed that 2 students be elected from each house to serve as Professionalism Promoters and 2 more as Health and Wellness Representatives. It was further suggested that one of these students be an M1 or M2 and the other an M3 or M4 from each House to ensure that the professional development and wellness of all classes and the needs of pre-clinical versus clinical students will be well understood and nourished. One of the Health and Wellness Representatives will be responsible for all social activities in their own Houses, and all 8 Health and Wellness Representatives will work as a team for the coordination of events across the campus (the Vice President role proposed above).

Next, the *ad-hoc* committee discussed other positions that they could predict will be needed in the Wayne Houses. They proposed that two other positions be created in the Houses: Treasurers and House Service Coordinators. They felt that one treasurer from each House would be adequate to handle the financial stewardship of specific House funds; Student Senate class treasurers will continue to oversee class funds in the proposed transitional model. At least one House Service Coordinator from each House will work with the Service-Learning Program to organize service activities for their House and with other Houses. The number of House Service Coordinators per House shall be reassessed as the Service-Learning Program is implemented as a translational component of the curriculum.

Furthermore, the *ad-hoc* committee focused on what leadership will be necessary to bring the new house positions together. The committee proposed that a House Coordinator for each House be elected by the respective members of that House. These individuals will be responsible for overseeing and meeting with all of the above-mentioned Wayne House positions. They will serve as the go-to persons for students in their House if they have any House problems or concerns that they would like addressed. The *ad-hoc* committee, supported by a unanimous vote from the Student Senate, decided against calling these individuals "House Presidents," as proposed above, to avoid confusion while this transitional model of governance is executed; Class Presidents will continue serving on Student Senate.

Finally, it was decided that a leadership position will be necessary to bridge the gap between Student Senate and the Wayne House governance during the transitional period. The Student Senate proposed that an Executive House Coordinator position be created. This individual will be responsible for meeting regularly with all House Coordinators and will serve on Executive Senate and attend all Student Senate meetings. Any House Coordinator who would like to run for Executive House Coordinator can do so and will be elected by the sitting Student Senate.

The need for 4 class representatives in each House was discussed extensively, both by the *ad-hoc* committee and then again by the entire Student Senate, but it was unanimously felt that these positions were unnecessary in this transitional model. There was worry that their existence might dilute the leadership roles proposed. The *ad-hoc* committee recognizes that this may not be the case when Houses are fully realized with 36 students in each of 4 classes, so as with all of the above, the Student Senate will reassess this decision on a yearly basis.

6. Costs

Personnel

Cost estimates for personnel vary depending on the number of volunteer positions that can be used. For instance, clinical skills sessions currently are taught by volunteer physicians and that can be continued. As during 2016-2017, clinical skills groups will be assigned by the Learning Team. The three House positions will be a House Director (@ .2 FTE) and 2 House Leaders (@ .1 FTE each). Ideally, House Directors would be physician faculty with course release time. The House Leaders would be specialized for particular requirements of House management, including facilitation of House events and teaching portions of the Profession of Medicine course. Job descriptions are being collected from other medical schools in order to determine how we should design and advertise the positions. We plan to have the three main House positions begin February 1, 2017, to provide time for training.

Activities

The FLC has considered a wide variety of House activities beyond the curriculum, including competitions among Houses, team-building sessions both on-and off-campus, House meals, and House resources to be shared by community members. These will be chosen and designed by the House Directors and House Leaders, in consultation with the House Advisory Board (the FLC).

Facilities

The FLC is in the process of considering a wide range of facilities that can be designated for use by each House. We are asking for an estimate for renovating existing space and are investigating other possible areas both on and off campus. The Houses will need large lounge space with sofas and chairs, tables and desks, lockers, and usable kitchen space where food can be stored and prepared.

7. Original Distribution of M1 Students (Class of 2021) and Integration of Current M1, M2, and M3 Students

Because the only restriction on student group size is that the anatomy tables can handle 6 students each, we have used the number 6 as the grouping number for students. During the 2016-2017 academic year, we began the process of assigning M1 students to Learning Teams of 6 students using the algorithm shown in Figure 2.

Figure 2
Algorithm

Male	Female
In-State	Out-of-State
Under-Represented Minorities	Non-Under-Represented Minorities
Graduate of University of Michigan	Non-Graduate of University of Michigan
Graduate of Michigan State University	Non-Graduate of Michigan State University

This assignment was implemented at the 2016 M1 Orientation so that students met each other in their Learning Teams at their first official event. The class of 2021 students will be assigned the same way, into Learning Teams of 6 students, then grouped into a Wayne House of 6 Learning Teams (36 students entering each House each year). The question that the FLC4SLC members debated was how to incorporate the M2, M3, and M4 students into the Houses. Because the M2 (class of 2020) students are already divided into Learning Teams, it would be possible to assign existing Learning Teams to Houses. The M3 and M4 students could be assigned or invited to Houses. If invited, their joining would be optional.

If they *did* join, their House activities would *not* be optional—they would participate in appropriate (by year) House activities. Advanced students not in Houses would be invited to participate in some campus-wide House activities.

FLC Recommendations for WSU SOM SLCs

The FLC on SLCs has made the following recommendations:

1. The creation of 8 SLCs with 6 Learning Teams of 6 students each (36 students) entering each SLC each year.
2. That SLCs be called Wayne Houses; the naming of each house is still to be determined.
3. That administration of the Wayne Houses be by the Office of Learning and Teaching; staffing of each House is to include one House Director (@ .2 FTE each), 2 House Leaders (@ .1 FTE each), and additional staff as needed.
4. That the curriculum for the Profession of Medicine course (currently PPP) be embedded in the Houses. The curriculum has been designed and mapped to LCME standards; this will affect other courses in that assignment for participation in other courses needs to utilize the House learning teams assignment. The Profession of Medicine course will include population health, collaborative and constructive relationships, patient interviewing, physical examination, oral presentations and clinical documentation, clinical reasoning, professional identity, service-learning and co-curricular activities, and wellness and social programs.
5. That student governance, including House and campus governance, be designed as a transitional model by the Student Senate.
6. That funding will follow from where the curriculum is currently being taught to the House budget; additional funding may include property rental and House-centered activities. Support is being sought from alumni and others.

7. That beginning with the class of 2021 in August 2017, M1s will be assigned to Learning Teams and to Wayne Houses prior to their arrival. Belonging to a House would be optional for M2s, M3s, and M4s in 2017.

Discussion: Challenges and Benefits of Using the FLC Model to Design SLCs

Challenges of Using the FLC Model

At the beginning of our meetings, we faced three challenges:

- First, to understand the similar and different aspects of faculty learning communities and student learning communities
- Second, to develop our team as a real FLC while studying SLCs
- Third, to develop SLCs appropriate to our campus

Within a month, we were given a fourth challenge: moving up the timeline for SLC implementation from Fall 2018 to Fall 2017.

Confusion Between FLCs and SLCs

Both FLCs and SLCs were new to our members. In the spirit of "put on your own oxygen mask before helping others," the facilitator gave preference to our developing as an FLC.

Developing as an FLC

We began by working our way through the decisions in the Program Preliminary Planning Guide (PPPI) in the *Faculty Learning Community Planning Guide* (Cox, Richlin, & Essington, 2014), modeling the process of open discussion and breaking bread together. Because we met at 7:30 a.m., we had breakfast at every meeting.

Developing SLCs

At the beginning, it seemed as though we went about the process in reverse order. We tried to determine appropriate numbers and sizes of SLCs before we knew our goals and purposes. We struggled with the

number of students per SLC at the beginning, and the discussion kept coming back to, "Well, it depends what is going to happen in the Houses." Also, the early discussions were not conducted in a vacuum. As we were discussing House size, we kept bringing up ideas like the role of the Houses, staffing, curriculum, and the like. We came to realize that these items were all interconnected; perhaps this is why we came back to House size again and again, even after we thought we had it settled. It may have been better to start with our goals, curriculum, and plans for the SLCs; then the details like naming and sizes would have come more naturally. This approach would have helped with the staffing/budget because there would have been a better idea of the needs. However, because SLCs were a new concept to us, it also is possible that the first tasks we addressed would have been difficult no matter what they were. In hindsight, it is clear to us that SLCs can be whatever you want them to be, but you need to decide on your goals from the start. From there, you can think about the logistics. A lot of this, of course, is hindsight. We hope this description of our process will be useful to other schools.

Pressure to Advance Timeline

Early in our process, the Vice Dean for Medical Education asked the FLC4SLCs to move up our implementation of the SLCs to August 2017 (the incoming class of 2021) from August 2018 (the incoming class of 2022). To accomplish this, we decided to implement a transitional model in August 2016, where we identified and utilized Learning Teams of six students for the incoming class of 2020, based on the anatomy table groups we had already developed. However, we implemented two essential changes: (1) The teams were no longer assigned randomly (we used the matrix described above), and (2) the teams were introduced to each other at First-Year Orientation and continued through as many activities as possible, including the Service-Learning and the Clinical Medicine courses. We were able to make these changes so quickly because two of our members, who understood the SLC development project, were the Assistant Dean of Student Affairs (in charge of Orientation) and the Director of the Co-Curricular/Service-Learning Program. We also received timely assistance from the Office of Admissions, who were able to put the incoming students into the heterogenous groups prior to Orientation.

Benefits of Using the FLC Model

The advantage of the FLC model was that it allowed us to gain valuable input from stakeholders of various (perhaps all) aspects of the medical

school. It allowed people with the most experience on a particular topic to take the lead while still receiving input from others, which helped bring in new perspectives. We needed all of the players at the table not only to come up with something with vision, but also to manage the logistics. The inclusion of stakeholders in an open forum like an FLC was a key point and influenced our final product. It was also helpful to use an FLC to plan the SLCs, because it gave us a sense of what a learning community is supposed to be. We were able to share and discuss common values and purpose, while keeping in mind individual needs like health and wellness and service-learning, which currently are individual activities.

While we may have been able to accomplish our goal as a committee or task force, we do not believe that the final product would have been as successful. The FLC was a great way to get all of the stakeholders involved; we do not think committee members would have invested as much and taken as much ownership. Also, the FLC process added an academic component and allowed us to learn better what an SLC really is all about. A major difference between our FLC and a committee or task force was the former's atmosphere and openness, and this certainly had an impact on our final SLC decisions. Everyone felt free to talk and bring up discussion points. The FLC model provided flexibility in our ground-up approach to developing SLCs. Members appreciated the ability to return to and adapt certain decision points as we progressed. This dynamic approach would be more challenging within the tight structure of a committee or task force.

The involvement of the students in our FLC was also vital. Such open participation is not always the case with a committee or task force, which can be dominated by a subset of the members. Also, we are not sure that a committee or task force necessarily would have brought in other stakeholders with their perspectives, such as the President of the Student Senate and faculty members responsible for the clinical training part of the curriculum.

Another, more generalizable advantage to the medical SLC community at large is that it brings more attention to the process of designing SLCs. The majority of SLCs discussed at the 2016 Learning Communities Institute (LCI) were created fairly hastily by a few people at a medical school. The LCI reports suggested that most of the SLCs were started with limited input, and then improvements were made. Now, with so many SLCs in existence, it will be helpful to bring some attention to the planning and design of SLCs, which will help other schools in our position. We believe it was an original idea to teach ourselves about learning communities by becoming one! We *became* a learning community, which was an important developmental experience. Using FLCs to design SLCs demonstrates a method of SLC planning that other institutions can adapt as well.

Conclusion

In this article, we have described our experience using an FLC to develop medical school SLCs. The process of discovering what learning communities actually are as we worked to develop the SLCs was a major contributor to the success of our FLC. The inclusion of input from all stakeholders also was important in the process. We believe that the use of the FLC to develop the WSU SOM SLCs resulted in a much better product than we would have achieved using a different process, and we highly recommend the use of this model in the development of future SLCs.

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Appendix A
Elements and Progression of Profession of Medicine Course

Elements

The Physician/Patient Relationship

- Biopsychosocial aspects of illness
- The doctor-patient relationship
- The art of communication
- Interprofessional collaboration and teamwork
- Diagnostic and clinical skills
- Physical exam skills
- Giving oral presentations
- Clinical reasoning and judgment
- Developing a differential diagnosis
- Person and family-centered care
- Adolescent medicine
- Geriatrics medicine
- Continuity of care
- Compliance
- Alleviating suffering and optimizing health

Professionalism/Health and Wellness

- Professionalism and professional identity
- Social responsibility
- Managing stress
- Physician impairment
- Physician burnout
- Fatigue management
- Medical ethics
- Law and medicine
- Humanism in medicine
- Leadership skills
- Maintaining empathy
- The business practice of medicine

Appendix A (*continued*)
Elements and Progression of Profession of Medicine Course

Population Health

- National and regional health statistics
- Population based medicine
- Healthcare financing
- Bioinformatics
- Global health issues
- Medical socioeconomics
- Patient advocacy

Cultural Competence

- The determinants of health
- Cultural competent care and health care disparities
- Complementary medicine
- Human sexuality
- End of life care
- Service-learning

Translational Research

- Study design
- Using the literature to make health care related decisions
- Evidence based medicine
- Critical appraisal of literature
- Biostatistics and epidemiology
- Communicating evidence to patients

Patient Safety/Quality

- Patient safety
- IHI Open School
- Quality, cost and value
- Medical errors

Progression of Elements

During the first year, the course will focus on:

- how a patient's health is related to the population's health
- population vital statistics through the use of large bioinformatics databases
- patient interviewing skills
- basic physical examination skills
- components of the doctor-patient relationship
- social determinants of health
- health disparities
- clinical reasoning skills
- team building
- collaborative communication skills
- clinical epidemiology and critical appraisal competencies
- self-identification as a competent, caring, ethical physician-in-training
- physician health and wellness
- service-learning

During the second year, the course will focus on:

- biopsychosocial aspects of illness
- components of the doctor-patient relationship
- basic physical examination skills
- basic diagnostic and clinical skills
- patient oral presentation
- adolescent medicine
- geriatric medicine
- social responsibility
- managing stress
- physician impairment
- physician burnout
- global health issues
- complementary medicine
- human sexuality
- patient safety
- IHI Open School
- service-learning

Appendix A (*continued*)
Elements and Progression of Profession of Medicine Course

During the third year, the course will focus on:

- components of the doctor-patient relationship
- advanced physical examination skills
- patient oral presentation
- advanced diagnostic and clinical skills
- patient centered and family centered care
- continuity of care
- professionalism
- fatigue management
- humanism in medicine
- maintaining empathy
- healthcare financing
- patient advocacy
- end of life care
- using the literature to make health care decisions
- communicating evidence to patients
- quality, cost and value care
- service-learning

During the fourth year, the course will focus on:

- compliance
- professional identity
- medical ethics
- law and medicine
- coping with medical errors
- giving bad news
- business practice of medicine
- leadership skills
- service-learning