General clinical science curriculum Scribe document

Please note and remind yourself frequently: The intent of this document is for it to lead to a public-facing record of your workgroup's activity. By the day of the Summit it will be accessible to anyone at the Summit, and after the Summit it will be turned into a fully public-facing document. This means that although you should take notes however makes sense for you, it will be important to refine the notes to be comprehensible to others.

Guiding Committee:

Caroline Boyd	Molly Nikolas	Michael Treadway	Alytia Levendosky

Moderator: Bob Levenson
Scribe: Molly Nikolas

Describe intended product of the workgroup: White paper/position paper in CPS or other similar journal

Who is willing to lead on this topic (future efforts at the Summit and beyond):

Main Notes Area

Thursday May 4: 1:50-2:45 p.m.

5 Introduction (overarching core question and principles for discussion in small groups)

25 minutes of group (10 minutes facilitator check-in to see if we need to make an adjustment)

25 minutes of groups sharing themes – organized for moderator

5 minutes - summarize what our read out will be for the full group

Leading Core Question that Defines Curriculum Conversation: How much flexibility can there be in clinical science curriculum?

 Ideas about facilitation in the Introduction: encourage flexibility and perspective taking, willingness to consider alternative perspectives, ensuring grad student voices are prioritized.

Break into small groups with each guiding committee member acting as a facilitator. Goal/action item is to consider a potential white paper or position paper focused on the future and flexibility

of clinical science training. To help identify components, all groups will focus on 4 core questions.

1. How much flexibility should clinical science programs have in determining content and delivery of content?
       a. Should there be a standard clinical science curriculum?
       b. Can programs develop subspecialities in CS best suited to expertise of faculty?

2. Should we consider different models of curriculum delivery? Most programs offer all elements simultaneously, but would it make sense to focus on sequential delivery in a manner more similar to MD/PhD or other training models (i.e., courses first, then research, then clinical training)?

3. How should the clinical science curriculum be expanded to best prepare students for 21st century clinical science careers?

4. How might programs pool or share resources to facilitate training and/or advance adoption of relevant research methods and/or clinical approaches?

Workgroup guiding committee – touch base during lunch on Thursday to check in and make any adjustments.

1. **How much flexibility?**

Berenbaum paper – what should be covered? Philosophically informed approach to what should be covered but no prescription on how it should be delivered.

· Assessment, intervention, data science, ethics, research methods

· Good way to start developing a standard curriculum – specialization within certain bins

· Not courses but domains of knowledge

2. Delivery

· Not in favor of sequencing due to cost of losing integration

· Better integrate training structure so research and training activities are more closely linked

· Incentives for alternatives (what do we know about those as faculty)

3. How should the clinical science curriculum be expanded to best prepare students for 21st century clinical science careers?

· Community engaged research/translational science to deliverable treatments and break down barriers

· Other intervention models (internet-delivered)

· More training in policy, public health, more possibilities

· Alternative career paths

· Thought experiment – what are the skills that we have and how do we communicate – can we identify paths that are more common?

· What is the core part of our training that makes us attractive to alt-ac careers?

· Leveraging technology to answer questions with data but not sole data scientists

· Research methods related to evaluating mechanisms of interventions

· Focus on principles of behavior change and mechanisms

· Qualitative and mixed methods approaches

· Science communication

· History of clinical science psychological science and failings/controversies – what to do when science conflicts with popular culture

· Open Science methods to quicken dissemination methods

4. Pooled resources

· Flipped classrooms and pooling of coursework across programs

·   Open access curriculum – shared readings/centralized resources for foundational readings as well as how things intersect with DEI and other specializations

·   We have resources that are not being used – we have our own dissemination problem

General Discussion
- We cannot do everything - not all programs can cover everything. Some programs will cover some things while others cover others. Also within-program flexibility
- When does specialization begin? Development of individualized education plan but also advertisement on website on specializations that are offered by a particular program
- Is there a core CS - what are the benefits of breadth and exposure to breadth of information early on in training? Goal is not to acquire expertise but to gain exposure to better understanding how to engage with other colleagues, to conduct team science.
    - Some core early on in training - is it principles? Is it ways of learning and knowing rather than specific content knowledge?
    - Putting the Doctor of Philosophy back into the training
- For students - do they have enough exposure and experience to specialize from the start? Could we have a Master's program who have core training of which only some go deeper into research? If practice could be a real option, could these Master's programs be more viable?
- De-adoption science and what is at the core in order to advance inclusion of new areas of pursuit. De-adoption decision-making conducted with value-based centering rather than picking and choosing. If we remove things, how do we decide what to remove? Or can we shift what is prioritized so it doesn't feel as though we are just adding more things?
- How does this intersect with regulatory bodies (Boards of Psychology, CoA, PCSAS) and regulatory environments are becoming more rather than less rigid?
- Collaboration methods more explicitly included in different aspects of curriculum rather than working as individuals
- Interest in contributing to a product on curriculum in CS or other ideas
    - White paper/article
    - Talk at conferences to bring in different stakeholders
    - Less enthusiasm for White Paper - proposal for APCS for programs to adopt
    - Centralized area for key readings in Clinical Science that programs could draw from for their courses and commitment to update those
    - R25 or other grant mechanisms to fund a resource repository
    - Programs that do things without courses, different delivery methods
    - Strategies programs that have used to negotiate or leverage teaching credits to improve innovation in curriculum delivery

Parking Lot

The parking lot is for anything that was noted during the group that does not fit well on the topic. You may wish to refer this information to other groups after your group meets.