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Physicians, especially those practicing family medicine, will be caring for the rapidly growing number of older adults in the coming decades. Over 40 percent of medical school students indicate that the geriatric curriculum in their medical school is inadequate. Among the areas that lack sufficient detail are the detection and treatment of domestic abuse.

Residents report that they are challenged by their lack of training and skills in areas needed to treat older people. There is also a need for better training in the area of end-of-life issues for older adults, especially with regard to communication skills with patients and their families. A study of family medicine residents was done at the St. Elizabeth Family Medicine Residency Program in Utica, New York, using a 14-item Geriatrics Attitudes Scale (GAS) that employed a five-point Likert scale.

Also done was the completion of a multiple-choice version of the Palmore’s Second Facts on Aging Quiz (FAQ2) as an indicator of residents’ and preceptors’ geriatrics knowledge. In addition, an in-depth personal interview was developed, pretested, and administered by two trained interviewers not affiliated with the program who collected qualitative information assessing the views of the residents’ geriatric educational experiences.

There was a 96 percent response rate from residents (25 residents) and a 78 percent response rate from preceptors (7 preceptors). Residents and preceptors had more positive than neutral attitudes toward older people. Preceptors had significantly more positive attitudes than residents did in this small study.

Residents indicated that they would benefit from more training in identifying and treating abuse of older people, in increasing communication skills with older patients in end-of-life decision making, and would benefit from more exposure with older people in good health as well as with those who are frail.

(Laditka SB, Fischer M, Mathews KB, Sadlik JM, and Warfel ME. “Geriatrics education and attitudes in family medicine residency: Elder abuse, end-of-life preparedness, and training.” Gerontology & Geriatrics Education. 23 (2): 83-98; 2002.)
The Need to Change Psychiatric Education

Scientific advances will likely have dramatic effects on psychiatric practice, necessitating the need for psychiatric education in medical schools and residency programs to be increasingly based on molecular and cognitive neuroscience, genetics, and epidemiology. Psychiatry departments need to prepare to incorporate the “coming avalanche of information” into psychiatric education.

It is suggested that psychiatric educators should become more involved in the basic science lectures that occur during the earlier years of medical school. They should also participate in interdisciplinary conferences involving neurology, pathology, genetics, and radiology that would update the image of psychiatry among students and colleagues. In addition, in the clinical years there should be integration of psychiatric consultation into required primary care ambulatory rotations.

This would increase the understanding of the influence of psychiatric disorders on primary care medicine. Common medical conditions such as diabetes and coronary artery disease are made worse by comorbid depression, and treating comorbid psychiatric illness can improve medical outcomes.

(Rubin RH and Zorumski CF. “Psychiatric education in an era of rapidly occurring scientific advances.” Academic Medicine. 78: 352-354; 2003.)

Human Patient Simulator at PCOM

A new mannequin at the Philadelphia College of Osteopathic Medicine called Stan (short for standardized patient), breathes, has a heartbeat, and contains pupils that respond to light and medications. It mirrors human responses to CPR, intravenous medication, intubation, ventilation, and catheterization. Stan was acquired through a $197,000 grant from the Health Resources and Services Administration. It is also being used at the National Space Biomedical Research Institute to train astronauts and flight surgeons.

The device was originally created as a training tool for the U.S. military. While the simulator does not take the place of real-life scenarios, it allows students to practice outside the chaos of hospital settings. They can repeat the procedures as many times as it takes until they become proficient.


Applicants Epitomize Diverse Life Experiences

About 70 percent of the applicants who enrolled in the University of California San Francisco did something else between college and medical school.

One spent several months in Antarctica as a scuba diver who was sometimes immersed 130 feet into the frigid waters as part of a scientific expedition. Another student was a climbing guide at the top of the Himalayas, while yet another served as an attorney doing litigation.

Still others served in such eclectic positions as deputy sheriff, homeless-clinic manager, and as a member of the Puerto Rican national field hockey team.

While only a quarter of the entering class were women, today women make up 57 percent of the UCSF class. As a result of this new mix of medical students, the young, white, male biochemistry major today may seem like an underrepresented minority.

Case Discussion in Teaching
Epidemiology and Biostatistics

It has been traditionally difficult to teach epidemiology and biostatistics to medical students. However, the principles of these disciplines are important so that students can critically evaluate the scientific literature. Faculty at the Albert Einstein College of Medicine from the Department of Epidemiology and Social Medicine participated in a two-day training workshop in preparation for a course taught to 163 first-year medical students. The course in epidemiology and biostatistics included three lectures that were accompanied by a detailed syllabus and then followed by a multiple-choice examination. In addition, there were six case-discussion groups with 23 or 24 students.

The case-discussion method was adapted from the Harvard Business School in which two master educators led each group. This used a student-centered, interactive model. Sufficient faculty were sought to be able to have 5-to-7 student groups such as is optimal in problem-based learning or even using groups of 15 students. However, this was not possible and 7-to-10 faculty led groups of 23 or 24 students. Multiple-choice examination results were comparable to earlier years and student evaluations were positive.

National Board of Medical Examiners scores indicated a mastery of the material. While the use of lectures was the most efficient method of distributing information, it fell short of achieving all the course goals (i.e., critical analysis, clinical judgement, internalizing and retention of knowledge).


Effects of Pregnancy During Residency

Whether convenient or not, residents will become pregnant. Stresses related to pregnancy during residency affect all residents, staff, and directors of the pregnant resident’s program. Twenty-seven research reports concerning pregnancy during residency were studied, including questionnaires that were mostly completed by female residents and physicians. All the reports suggested an increased risk of complications, particularly those associated with adverse pregnancy events. Anger and resentment toward the pregnant resident were common by the nonpregnant resident especially because of expectations of increased workload. It is advocated that there be clear maternity and parental leave policies.

There is a recommendation for a large prospective study to more clearly outline the specific risk of late pregnancy adverse outcomes. However, the author—a women physician and certified midwife—concludes that there is no need to wait until such a study is concluded to acknowledge that long work hours with excessive standing and physical exertion would not be recommended. It is also concluded that pregnancy and parenthood can be very valuable learning experiences for a resident as well as humanizing for a medical department.

(Finch SJ. “Pregnancy during residency: A literature review.” Academic Medicine. 78: 418-428; 2003.)

NSU College of Osteopathic Medicine
The John A. Hartford Foundation funded 40 medical schools to develop integrated geriatrics curriculum spanning over the course of the four years of undergraduate medical training. Among these is the senior mentoring program at the University of Missouri-Kansas City School of Medicine that conducts a six-year B.A./M.D. curriculum. Students are paired with an older person/mentor who lives independently in a retirement community. The students meet with their mentors regularly to determine how they manage their lives and health.

Louise Arnold, Ph.D., associate dean for medical education, has noticed a substantial improvement in the attitude of students toward the older population. Ohio State University College of Medicine has a program called From Aging to Saging that extends over the four years of the curriculum. The core medical school program matches a student with an elderly resident in the community where they learn about each other throughout the duration of medical school. This becomes a problem-based learning approach over the four years where the partners accumulate some health issues.

At the Medical College of Wisconsin, geriatric study is linked to a clinical case in which the patient ages through the four-year curriculum. It begins with a fit and functional fictional patient who ages over the course of the curriculum, developing serious medical issues. Students are provided with geriatric education within the context of existing courses. Bonnie Kantor, Sc.D., director of Ohio State University's Office of Geriatrics and Gerontology, feels that an integrated geriatrics curriculum has become a necessity, not a choice.