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11-15-2003

Medical Education Digest, Vol. 5 No. 6 (November 15, 2003)

Nova Southeastern University

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Biomedical science and technology related to medical practice, combined with dramatic changes in the health care delivery system, have resulted in the need for new models to educate the next generation of physicians. This led to the establishment of the Academy at Harvard Medical School in 2001. The academy was created on the idea that major innovation in medical education will require a fundamental restructuring of medical schools and a way that produces new means for supporting the most effective teachers among the faculty. The traditional department-based structure of the medical school limits the extent to which the school can advance quality and innovation in training medical students.

The Academy at Harvard creates a new entity with the sole aim of supporting the efforts of the most gifted and innovative teachers. It plans to improve the professional satisfaction and standing of the entire teaching faculty. The mission of the Academy at Harvard Medical School is for it to support the development and implementation of innovative curricula, educational resources, and educational scholarship at the medical school by

- facilitating excellence and innovation in teaching
- fostering the choice of a career path with teaching as a major component
- providing a locus for the exchange of ideas about teaching and a platform for enhanced interactions among basic, social, and clinical scientists
- acquiring new resources to support teaching

Criteria for membership includes

- excellence in direct teaching
- curriculum development innovation and creative thought
- educational leadership/administration
- faculty development and mentorship
- educational scholarship (e.g., educational grants/research, publications, and presentations)

Categories of membership included

- scholars - noted for excellence as teachers, educators, and mentors (five-year term)
- fellows - young faculty with demonstrated promise as educators (three-year term)
- distinguished scholars - faculty with longstanding commitments to education (three-year terms)
- associates - a small number of graduate trainees and students pursuing careers as teachers (one-year term)

(Thibault GE, Neill JM, Lowenstein DH. "The Academy at Harvard Medical School: Nurturing teaching and stimulating innovation." Academic Medicine. 78:673-681; 2003.)
The Future of Medical Education

There is unprecedented activity in medical education, remarks R.M. Harden, who is responsible for introducing objective structured clinical examinations to medical schools worldwide. Tensions have arisen, he states, that need to combine what appear to be opposites. This includes an emphasis on capability while preserving the scientific basis for the practice of medicine. It also includes the introduction of new themes into the medical curriculum such as communication skills and attitudes while not neglecting traditional topics.

He predicts that by 2015, there will be a significantly greater emphasis on student centered learning in curriculum planning. The curriculum will be designed to meet the needs of individual students, including fast tracking and the possibility of part-time training. There will be a continuing recognition of integrated teaching with more emphasis on interdisciplinary integration and interprofessional education. The community will be a major focus of the curriculum. There will be a further increase in time for electives and an exchange of students between schools for special study modules. Harden also predicts that there will be further development of simulation and virtual reality in learning.

(Harden HM. Evolution or revolution and the future of medical education: Replacing the oak tree. Medical Teacher. 22:No.5; 2000.)

Lectures: Harmful to Learning?

J. Willis Hurst, M.D., a former professor and chairman of medicine at Emory University, comments that the brain was simply not designed for a barrage of words, even if strung together by experts. He believes that lecturing, as commonly done, is not teaching. Hurst further comments that while lecturing is an easy way to dispense information to a large group of people, it does not accomplish what he refers to as the three steps involved in learning. These steps include remembering information, thinking (i.e., the rearrangement of information), and the use of information in a thought process until the person is fluent.

Hurst advocates that teachers should work with individuals and assist them in their efforts to learn how to learn. Information that sounded wonderful when heard is gradually forgotten, he maintains. True teaching does not occur unless there is a feedback system. Dr. Hurst believes, since this permits lecturers to determine whether their message was received by the listener, the content was used by the listener, and an acceptable degree of understanding of the subject was attained.


Cultural Competence and Medical Education

Faculty at the Ramsey Family and Community Medicine Residency Program adapted Bennett’s Developmental Model of International Sensitivity in their multicultural curriculum. They found it useful describing resident attitudes and behaviors and in guiding the faculty in assessing residents to provide optimal care to patients of all cultural backgrounds. They learned that people develop cultural competence at different paces. In addition, they found that they are influenced by their motivations, life experiences, and comfort levels. The learning experience in areas of cultural competence is facilitated when there are clear objectives, varied teaching methods, and applications to the clinical setting. Levels of cultural competence that they used in the education of their residents included the following:

- limited or no insights about influence of culture on medical care (Bennet Defense)
- minimal emphasis on culture in medical settings (Bennet Minimization)
- accepts roles of cultural beliefs, values, and behaviors on health, disease, and treatments (Bennet Acceptance)
- incorporates cultural awareness into daily practice of medical care
- integrates attention to culture into all areas of professional life

Curricular objectives and the use of the model that employs levels of cultural competence were found to be useful in designing the residency’s multicultural curriculum.

(Culhane-Pera KA, Reif C. “Ramsey’s five levels of cultural competence: Conceptualizing Bennett’s model into curricular objectives for multicultural medical education.” Annals of Behavioral Science and Medical Education. 9: 196-113; 2003.)
Both COMLEX and USMLE are implementing a clinical skills examination in 2004. It will be one of the components of the COMLEX Level 2 and USMLE Step 2. Medical students will be required to pass both the written component and clinical skills examination. This is the result of years of study regarding the concern that current national board examinations test only cognitive knowledge and analytical skills. However, clinical and communications skills are considered by medical educators and clinicians as being equally important. In addition, the clinical skills examination is purported to protect patient safety. Canada has been successfully using a clinical skills examination for several years as part of their medical licensing process, and it also has been used since 1998 by the Educational Commission for Foreign Medical Graduates (ECFMG) as part of the process used to assess foreign graduates for licensure.

It has been shown that poor communication skills and interpersonal and clinical skills are related to a higher incidence of malpractice suits, lower treatment compliance, and decreased patient satisfaction. A small but significant number of students who pass cognitive examinations lack the basic clinical and communication skills necessary to assume the responsibilities of a physician. The clinical skills examination will include trained “standardized” patients who are able to act like real patients. Candidates must demonstrate that they are able to establish a rapport with the standardized patients, obtain appropriate historical information, and perform a focused physical examination. This has been the rationale for establishing the new clinical skills examination as an integral part of the national licensing examinations for both the allopathic and osteopathic medical communities.

Studies conducted by USMLE with both residents and practicing physicians demonstrated that both groups were unable to differentiate standardized patients from real ones. Standardized patients are trained to simulate common problems ranging from those that are acute to those that are chronic. The sites for the initial examination for COMLEX will be Philadelphia and for USMLE both Philadelphia and Atlanta. Additional sites will be developed in the future.

The City University of New York Medical School (CUNYMS) reports on the use of the Group Objective Structured Clinical Examination (GOSCE). The Objective Structured Clinical Examination which was introduced in 1979 by Harden and Gleeson at the Ninewells University Hospital and Medical School in Scotland was an objective way to assess a student’s clinical competence that today typically includes trained standardized patients. It is organized so that in multiple stations communication skills as well as clinical competence can be assessed in an objective manner. OSCEs frequently employ standardized patients and use checklists designed to record and score a student’s performance and to serve to provide feedback. They allow groups led by different faculty at sites that are geographically separate to receive instruction that has negligible intergroup variation.

GOSCEs, while similar to OSCEs, employ multiple stations which involves small groups of students rather than individuals. One student may perform an assigned task while others observe, providing a critique and feedback. Students switch roles in subsequent stations. GOSCEs measure knowledge, skills, and attitudes. They can incorporate basic science content when appropriate (e.g., GOSCE on tuberculosis screening cross-references with the Microbiology and Immunology course). GOSCE stations in the CUNYMS first year of study includes the following stations:

- Interviewing patients with back pain
- Interviewing a patient with a positive TB skin test
- Obtaining a lifestyle history
- Conducting a focused adult chart review
- Conducting a child chart review

(Raggio TP, Nunes JV, Kachur EK. “Implementing group objective structured clinical examinations: Formative evaluation of medical communication skills of standardized patients.” Annals of Behavioral Science and Medical Education. 9: 71-76; 2003.)
Listening to Music and Medical Humanism

A course in humanism can be a useful tool for training in humanism. Humanism in medicine has been defined as those aspects of patient care that include meeting a patient’s needs with compassion and empathy. Since it can be listened to in a group setting, is very portable, and retains its impact even in small settings, music is a very easy tool to use for instructing students and residents. Faculty at Cooper Hospital/University Medical Center, University of Medicine and Dentistry of New Jersey Robert Wood Johnson Medical School developed an eight-session course. Music was played and then followed by a discussion led by the course director. The sessions included the following:

- What our patients listen to/controversies in music
- Songs about AIDS/politics in music
- World music/world medicine
- Interpretive music—lessons in listening
- How musicians and physicians learn
- The doctor as a metaphor in popular music
- Gender lessons from music
- The physician-musician interface

While the course did not help the course director to assess which residents had the best humanism skills, it did help to introduce general concepts of humanism in an informal group setting. The residents overwhelmingly embraced the course and it also helped them to understand each other better.


Combined and Accelerated Degrees

Students and parents see accelerated degree programs as a way to leverage their academic strengths and time spent in education. Such programs include those leading to a medical degree that can be achieved by completing three years of undergraduate school followed by four years of professional study. The undergraduate school typically accepts the first year of medical school to substitute for the fourth year of the curriculum leading to a bachelor’s degree. During times of financial stress, developing accelerated degree programs in which students can earn their bachelor’s degree and advanced degree in a shorter period of time can be attractive. It also stretches the academic walls of institutions without building additional structures.

Such programs should be featured more prominently in college literature, Internet sites, as well as at off campus college fairs and recruitment sessions. It provides a way for undergraduate institutions to expand their curriculum without having to build new curricula. Colleges that are more career-oriented can use combined degree programs by cooperating with graduate and professional schools in their own university or by affiliating with other professional schools. In addition, combined degree programs enhance the appeal of graduate and professional education by offering students the opportunity to achieve their goals in a more affordable manner.

(Greene H, Greene M. “Combined/accelerated degree programs-to attract motivated students, get an ‘edge,’ and help families fight soaring costs.” www.universitybusiness.com. October 2003:22-23.)

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