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Nova Southeastern University

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Study Focuses on Training Tomorrow's Doctors

A major study supported by the Commonwealth Foundation on the mission of the academic health center (AHCs) and what needs to be done to train tomorrow's physician was released in April by The Task Force on Academic Health Centers. Among the major findings and recommendations of the task force was that changes in the way medicine is taught constitute a challenge to the educational missions of AHCs. The task force indicated that consistent with the 1910 Flexner Report to the Carnegie Foundation, medical school students traditionally sat through hours of lectures on basic sciences and discussion took place in large groups with the whole class being present.

It is now suggested that such techniques may be suboptimal and new approaches need to be based on concepts of adult education, relying on active, situational learning that is self-directed, student-centered, and experiential. The task force advocates problem-based learning, medical simulators (e.g., mannequins), standardized patients, and the use of knowledge management technologies (e.g., e-curriculum). It is recommended that AHCs include continuous improvement of medical education among their highest priorities and develop new ways to measure the costs and quality of the educational mission. Faculty should expand and improve their teaching skills. AHCs need to increase efforts to recruit underrepresented minorities to prepare young physicians for an increasingly diverse population. In addition, accrediting bodies and medical professional organizations need to assist AHCs to develop methods to train physicians to be lifelong learners.


Bioethics Education at Osteopathic Medical Schools

No systematic review of bioethics education in osteopathic medical schools has been undertaken, but graduates need to be conversant in the many bioethics issues and to have bioethical values instilled in them. In addition, clinical bioethical reasoning skills improve empathy and diagnostic decision making. However, how these instructional processes are structured is not well defined.

A survey of the 19 osteopathic medical schools showed that no concerted effort has been done to define ethics in the osteopathic curriculum. Over the four years the average number of hours of instruction in bioethics in the osteopathic medical school was 20 hours, with 10 of the schools having full-time instructors in bioethics. Only a few instructors had formal training in bioethics and a small number were osteopathic physicians.

How bioethics was included in the curriculum varied greatly. It was a separate course in one school and contained in other courses in the others. Since medicine is a moral enterprise and ethical issues are confronted by physicians daily, instruction in the discipline of ethics is critical. The tradition of osteopathic medicine as set forth by the profession's founder, Andrew Taylor Still, requires support of in-depth scholarly investigation of bioethics.

Comparing Medical Humanism to Art

It is not what physicians say that makes them humanistic, but their precise timing, wording, tone, pacing, inflection of the voice, timing of the message, and their body language. Music and literature can be broken down into their component parts for analysis such as notes, chords, and rhythm. Literature similarly can be divided into words, sentences, and paragraphs. However, such analyses of these art forms provide little useful information when evaluating them by the sum of their parts. The same is true for the art of medicine. For example, the interview process consists of several steps or building blocks, somewhat analogous to the "notes" in music but they are not the "music."

It is not what physicians say that makes them humanistic but their precise timing, wording, tone, pacing, voice inflection, and body language. Furthermore, like the art critic, there is no single right answer since many different approaches have resulted in great works. Similarly, all humanistic physicians do not interview patients precisely the same way. In fact, it can be said that a rigid, mechanical style of conducting an interview is not highly humanistic. The same holds true for therapy in that the artistic (i.e., humanistic) physician senses the uniqueness of patients and treats them accordingly rather than by following a rigidly prescribed regimen. Teaching humanism and professionalism are the "heart" of the physician that accompanies his or her scientific mind. Such teaching and its assessment warrant the same careful implementation as any other part of the medical curriculum.

(Mish DA. "Evaluating physicians' professionalism and humanism: the case for humanism "connoisseurs". Academic Medicine. 77:489-495; June 2002.)

New Medical School Opens at Cleveland Clinic

The Cleveland Clinic together with Case Western Reserve Medical School announced the opening of a new medical school to train physician-researchers.

Scheduled to enroll 40 first-year students in the summer or fall of 2004, it complements rather than duplicates CWRU's existing medical school that has 145 students per class.

With fewer than two percent of the 700,000 physicians in the nation trained to do clinical research, the chief academic officer and chief of cardiovascular medicine at the Cleveland Clinic, Eric Topol, M.D., indicates that the new school curriculum marries basic science, patient care, and research.

The $52 million Cleveland Clinic's National Institutes of Health funding added to CWRU's $174 million NIH funding brings the university's national rank from 14th to about 6th.

(Solov D and Galbincea B. "A new medical school for Cleveland." The Plain Dealer. May 15, 2002.)

Training in Rural Aging

The majority of the world's aged population live in rural and remote areas (i.e., 60 percent). Most of the people providing a service to older people lack basic training, a trend which is more prevalent in rural and remote areas. However, little attention has been given to developing the necessary policies and programs. While a number of universities have postgraduate courses in geriatrics, these institutions are found in large cities and the professionals they train are not ready to go to rural and remote areas.

While it may be necessary to refer patients to specialist facilities and to those physicians with expertise in geriatrics, the main priority in geriatric training is to meet the needs of older rural populations. This is of particular importance in developing countries and should be in devising programs and training materials for use by primary health care givers. Emphasis needs to be on the fact that most older people are not ill, that most ill older people are not in hospitals, and that most care is given by people who are not physicians. New and emerging communications technologies can be used to facilitate and enhance these programs.

(Troisi J. "Training to provide for healthy rural aging." The Journal of Rural Health. 17: 336-340; Fall 2001.)
Residents Class Action Suit Over Salaries

A class action antitrust suit that claims to represent over 200,000 residents has been filed against seven medical organizations and more than 1,000 private hospitals challenging that the National Medical Resident Matching Program has kept residents' wages low and hours long. If successful, it would result in an enormous burden on the health care system and change the way future physicians will be trained.

The plaintiffs say that hospitals can force residents to accept below market wages for three to eight years depending on the specialty of the resident. Kevin J. William, M.D., professor of medicine at Thomas Jefferson University in Philadelphia, said that being a resident is not just a job but a continuation of a medical education. Resident salaries are low for the profession and uniform. They average $37,383 during the first year of residency, ranging from $39,060 in the Northeast to $35,552 in the South.

With 100-hour workweeks being common, residents often make less than $10 an hour. George L. Priest, a Yale law school professor who was consultant to the plaintiffs, said there is no good reason why doctors, after four years of graduate school, should make a quarter of what lawyers make. Alvin Roth, the matching program designer, said that people are willing to take the residency slots, referring to the most desirable positions. In the 1990's the Justice Department looked at the residency matching program and reached a settlement with an association administering family practice residencies but did not challenge the main matching program.

(Liptak A. "Medical students sue over residency system." The New York Times. May 7, 2002.)

Educating Health Professionals in Complementary and Alternative Medicine

Recommendations dealing with complementary and alternative medicine (CAM) at health professional schools and the need for research were the major thrust of a recent Josiah Macy Foundation-sponsored conference. It was pointed out that simply adding courses to the overcrowded medical school curriculum was not feasible or desirable. Instead, CAM should be integrated into the curriculum. Ambiguity in CAM terminology compromises education and research in the field.

In addition, efforts are needed to eliminate misunderstanding by CAM practitioners and practitioners of conventional medicine. At the conclusion of the conference, it was recommended that there was a need to recognize the importance of communicating risk/benefit and efficacy of common CAM procedures. Health professional schools should integrate awareness of knowledge of CAM theories and practices into the curricula. They need to collaborate in scientific research on the safety and efficacy and mechanisms of CAM.

Collection of data about the use of CAM therapies and approaches in diverse cultural and ethnic settings should be initiated by academic health centers. Health professional associations should make high quality, evidence-based CAM information widely available to practitioners and the public. Finally, professional licensure and credentialing bodies should include pertinent information about safety and efficacy regarding CAM procedures within their requirements.

Emphasizing Behavior Change in Health Professions Education

Abraham Flexner said in 1910, “The physician’s function is fast becoming social and preventive, rather than individual and curative.” The curative approach has had a profound approach on health care priorities, monopolizing the allocation of educational and health care resources. As far back as 1974, the U.S. Surgeon General’s Report estimated that the major causes of death were attributed to unhealthy behaviors (50 percent), environmental factors (20 percent), human biological factors (20 percent), and 10 percent to inadequacies in health care. In the United States, at least 50 percent of premature mortality is the result of behaviors such as smoking, excessive alcohol use, poor diet, obesity, lack of exercise, and unsafe sexual practices.

There is an urgent need to prepare a new kind of clinician committed to exerting constructive influences on people’s health behaviors. To do that, health professions educational programs must make this a high priority. To produce a new kind of graduate, their role models must be created whose values reflect these behaviors. We need to learn how to change our educational institutions and our professional roles before we will regularly produce new practitioners who are effective at helping people change their unhealthy behaviors.


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