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Study on Osteopathic Medical Education



A 20-month study of osteopathic medical education entitled "Osteopathic Medical Education in the United States—Improving the Future of Medicine" was recently published. Directed by Howard S. Teitlebaum, D.O., Ph.D., M.P.H., the study emphasizes the need to modify the continuum of osteopathic education to better prepare students, interns, and residents for the challenges of practice. It also expresses concern that more D.O. graduates are pursuing allopathic rather than osteopathic graduate medical education. In addition, it indicates that both students and interns do not have enough opportunities to observe and practice osteopathic manipulative medicine.

The study provides an opportunity for the osteopathic profession to discuss future planning efforts regarding the curriculum for future osteopathic medical students.

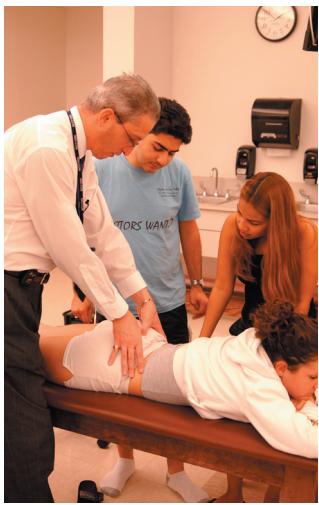
Beginning in 2003, the study surveyed 1,882 fourth-year osteopathic medical students, as well as second-year residents, residency program directors, and deans of osteopathic medical schools. Information obtained included age, sex, race, marital status, student and resident debt, current and expected income, and intended field of specialization. It also rated their satisfaction with osteopathic medicine as a career and the instruction they received in more than 40 content areas. Also requested was the confidence they had in a wide range of clinical examinations. Among the recommendations was the importance of educators exploring how to use available technologies to enhance learning. Another recommendation was that models of education other than traditional lectures should be considered. The study cautioned against just adding more courses into the already crowded curriculum.

Among the survey's findings was that D.O. students reported a range of debt between \$2,900 to \$327,000, with a median of \$150,000, which is an amount that was reported to require an average of 15 years to repay. The respondents indicated that 31 percent of students intended to enter primary care while 56 percent intended to select an allopathic residency-training program. Of those surveyed, 82 percent were satisfied with their choice of a career in osteopathic medicine. Regarding the residents, 60 percent were in allopathic programs, 13 percent of which were dually accredited by osteopathic and allopathic accrediting bodies. The study stressed the need for students to continue to get training in osteopathic principles and practice so that the strength and distinctiveness of the osteopathic medical profession is preserved.

(Schierhorn C. "Education Study Catalyzes Quest for Change-Charting a Course." *The DO*. 47(3): 32-43; 2006.)

"Medical Education Highlights for Primary Health Care"

Allopathic and Osteopathic Medical Student Enrollment Issues



With a near-zero increase in the number of graduates of allopathic medical schools in the last two decades, and even with a 300 percent increase in osteopathic enrollment in the past 25 years, the physician needs of the nation will not be met. So says the Association of American Medical Colleges in a 2005 survey of medical schools conducted by the AAMC Center for Workforce Studies.

The AAMC reports that there are five new allopathic medical schools anticipated in the next five years, which by 2015 will mean about 500 more students per year. For existing allopathic medical schools, the size of expected first-year enrollment by 2010-2011 is expected to increase by 919 or 5.4 percent more than 2005-2006. The AAMC is encouraged by this but is concerned that it is not likely to achieve the 15 percent increase in enrollment they are recommending. It also does not achieve the 3,000 graduates per year recommended by the Council on Graduate Medical Education (COGME) to meet the likely increase in demand for physician services.

Forty percent of the 125 allopathic medical schools reported that they definitely or probably would be increasing their first-year enrollment. This includes 55 percent of the schools in the South and 75 percent of those in the West. However, in the Northeast, only 16 percent of the allopathic medical schools indicated that they would definitely or probably be increasing first-year enrollment, while a 37 percent increase is definitely or probably anticipated in the Midwest. The AAMC report concludes that it is concerned that current plans do not even meet AAMC and COGME recommendations that are below the anticipated increased demand for physicians.

(Yamagata H, Grover A, Salsberg E. "An Analysis of Medical School Expansion Plans." *Analysis in Brief*. AAMC. 6(2); 1-2; 2006.)

Using Patient Partners to Train Students



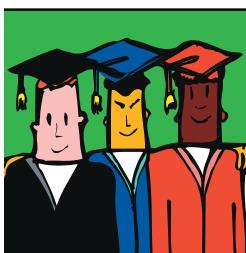
Students may not be getting adequate experience in managing patients with back pain. Training patients with nonspecific back pain, including those with inflammatory disease and sciatica, may solve this. Training includes two full and four half-day workshops at the Clinical Skills Center of Whittington Hospital, with content based on the undergraduate rheumatology curriculum of the Royal Free and University College of Medicine.

Patient partners (PPs) were provided with a seminar on back pain and learned the elements of history taking and the gait, arms, legs, spine (GALS) screen. PPs practiced this on each other and learned the communication skills needed for history taking and what the doctor was trying to achieve. They learned what the concept of feedback was and what they would be doing with students. This was followed by a five-minute presentation by the PPs on a covered topic. The investigators, who were rheumatologists, provided feedback. In subsequent sessions, PPs learned basic spinal anatomy and participated in a group discussion on non-drug therapy for back pain. The PPs also took part in a four-station objective structured clinical examination (OSCE) that included students in the current rheumatology system whose history taking and examination skills were assessed regarding back pain. PPs then provided their feedback.

Students received this form of teaching well, finding it an invaluable, non-threatening experience and receiving feedback they appreciated. They preferred that the sessions be given with the facilitation of a PP and the presence of a clinician to answer medical questions that were beyond the scope of the PP's knowledge. PPs enjoyed the experience as well, leading to a better understanding of their own condition and improved skills in communicating with medical professionals. The project also showed that it was feasible to train PPs with back pain to instruct medical students.

(Haq I, Fuller J, Dacre J. "The Use of Patient Partners with Back Pain to Teach Undergraduate Medical Students.) *Rheumatology*. 45(6): 430-434; 2006.)

Future Challenges to Medical Education



In giving the final speech before his retirement to the Association of American Medical Colleges (AAMC), Jordan Cohen, M.D., AAMC president, issued a series of challenges to medical education. They included:

- increasing the racial and ethnic diversity of the medical profession. This includes identifying more qualified minority applicants for the applicant pool and doing as much as possible to enhance their academic preparedness as well as increasing their interest in a career in medicine.
- leading the transformation of the health care system. The current system is outmoded and must be replaced.
- strengthening the continuum of medical education. In addition to undergraduate and graduate medical education, this includes continuing medical education that must become based on active, self-directed learning in a practice-based format.
- upholding the integrity of research and the safety of human subjects.
- enlarging the capacity of medical schools by at least 15 percent. Even that will add only 2,500 more graduates to the workforce each year.

He also cautioned physician educators who demean a nurse, disrespect a patient, harass a student, exploit a resident, overcharge for a service, fudge data to gain a favorable journal review, permit commercial interests to bias educational offerings, or shill for a pharmaceutical company.

(Cohen JJ. "What New Doctors Must Learn." Adapted from address at Association of American Medical Colleges annual meeting; November 6, 2005.)

Teaching Interviewing Skills to Residents



Because it is unable to support a large faculty and resident component, the University of Minnesota Medical School in Minneapolis developed a shorter, less time-intensive communication-skills curriculum. Recently, the Accreditation Council for Graduate Medical Education (ACGME) required all American residency programs to demonstrate that their residents were proficient in communication skills. As a result, the college developed four seminars, each three hours in duration. They were designed to assure that the residents are able to gather data to understand patients' problems, develop rapport, respond to patients' emotions, and educate and motivate patients. The goals of each seminar are to

- open a medical interview and set an agenda
- explore patients' concerns, gathering sufficient data to make an adequate diagnosis
- respond to patients' concerns and emotions empathetically
- close an interview, clearly stating diagnostic assessments and negotiating a plan for treatment and follow-up

Seminars are held with groups of four-to-six residents that are preceded by assigned readings and include didactic presentations, videotapes of actual patient interviews, role-playing, and a discussion. The seminar is organized with the following components:

<u>Component</u>	<u>Time in Minutes</u>
explore individual experiences and needs of learner	20
didactic presentation (theory/evidence)	30
videotape of interview behaviors and skills plus discussion	30
practice using role-playing	60
reflection on individual practices/learning needs	30

(Weissman PF. *Teaching Advanced Interviewing Skills in Residents: A Curriculum for Institutions with Limited Resources.*" Med Education Online (www.med-ed-online.org/) 11:3; 2006.)

Importance of Training Clinical Teachers



It is particularly important for clinical teachers to acquire an understanding of educational theory and principles. They must be able to plan and structure teaching in different clinical settings and for learners at different levels of their training. The clinical teacher needs to facilitate learning, make teaching activities learner-centered, active, and experiential as well as individualized. As the training of physicians becomes less didactic and more problem-based, this is particularly important.

It is proposed that this training begin in the undergraduate years of medical education and continue into internship and residency training. They should be able to use the wide range of teaching methods, including lectures, small-group discussion, and bedside teaching. Those who want to take on a more formal role of teacher of medical students or residents should commit to some form of structured training in clinical teaching. Physicians who teach should be selected from those who have a sense of teacher identity, enthusiasm for teaching, good two-way communication skills, and who are positive role models. They should learn teaching in different clinical settings.

It is important for them to learn the principles of adult learning and clinical approaches to teaching and planning. Skills they should acquire include the establishment of rapport with trainees, identifications of learning opportunities, setting goals, questioning, feedback, and reflection (i.e., transforming experience into knowledge, skills, and attributes). Teaching clinical teaching methods should include such activities as bedside teaching, ambulatory care teaching, communication skills, desk-side teaching, videotape recording skills, examination skills, and supervising skills.

(Molodovsky E, Sekelja N, Lee C. "Identifying and Training Effective Clinical Teachers: New Directions in Clinical Teacher Training." *Australian Family Physician*. 35(1/2): 53-55; 2006.)

Efficiency Negates Need for Physician Increase

ADartmouth Medical School study challenges the need to expand medical school enrollments. The school's Center for Evaluative Clinical Sciences concludes that more efficient use of the current physician workforce will allow it to be adequate through 2020. The study, funded by the National Institute on Aging and the Robert Wood Johnson Foundation, indicates that spending millions of dollars to increase the number of physicians will result in an oversupply. The study also indicates that such efforts will divert funds from patient care.

David Goodman, M.D., who headed the Dartmouth study team, recommends instead that efforts be expanded to increase the efficiency of medical practice and to direct resources to care that has been proven to be effective. He points to interdisciplinary group practice that has models of both efficiency and medical excellence such as that found at the Mayo Clinic. That institution uses fewer doctors and resources in managing patients compared to other academic medical centers. Data from Medicare files show that during the last six months of life there is a variance of between 6 full-time physicians per 1,000 chronically ill patients to almost 30 per 1,000.

On average, the Mayo Clinic uses 9 physicians per 1,000 patients compared to 28.3 physicians per 1,000 at New York University in the six months before death. Dr. Goodman states that quality of care rather than quantity is the critical factor. It was concluded in the study that instead of financing further growth in medical education, it would be better to reorganize health care delivery systems that can deliver good care at relatively low cost.

(Goodman D, Weinberg J, Chiang-hua C, Stukel T. "Efficiency, Not More Doctors, Is the Prescription for the Future." Dartmouth Medical School www.newswise.com/p/articles/view/518438/; March 1, 2006.)



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