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O&A is published five times a year by the OEA. We welcome your feedback and ideas for future articles. Please direct your comments to Ann Maderer, phone 617-636-2191, email [ann.maderer@tufts.edu](mailto:ann.maderer@tufts.edu).



Students studying brain model, 1968

UA136, Digital Collections and Archives, Tufts University

## The Scientific Foundations of Social and Behavioral Medicine: A Part of Flexner's New Century

By Richard Glickman-Simon, MD  
Scientific Foundations of Social and Behavioral Medicine Course Director

It has been exactly 100 years since Abraham Flexner delivered his now famous report on the status of North American medical schools. When first published by the Carnegie Foundation in 1910, the 155 schools in the United States and Canada constituted a mixed bag of trade schools with widely varying admission policies, instructional quality, clinical exposure and adherence to the mainstream scientific principles of the time. Most schools fell far short of acceptable scientific standards and half of them disappeared soon after the report was published. (As we all know Tufts survived.) It was Flexner who linked biomedical research with education, and who first introduced the four-year, two-by-two curriculum, which soon became the accreditation standard for undergraduate medical education.

The effect of Flexner's recommendations was nothing short of transformative for the profession and society. Science-based medicine was soon able to claim a monopoly on health care as the public turned toward mainstream medicine and away from competing practices such as homeopaths, osteopaths and chiropractors. Their confidence was further reinforced as these highly-skilled graduates emerged from prestigious institutions with spectacular achievements that only science could deliver – vaccinations, antibiotics, oral contraceptives, open-heart surgery, organ transplantation and digital imaging technology to name a few.

A century later, Flexner's legacy is alive and well in medical education. Research remains a primary mission of most medical institutions, in some cases eclipsing its educational mission. Variations are common, but most students still matriculate through the basic four-year undergraduate curriculum of didactic instruction preceding clinical training. But most significantly, the curriculum remains steadfastly fixed atop a deeply scientific foundation. If anything, the influence of science has only intensified, with a renewed interest in evidence-based practice and rapid advancements in molecular medicine.

However, despite its indisputable contribution to the advancement of the profession, it may be time to question our strict adherence to Flexner's recommendations. For one thing, they were intended for another century. While the two-by-two model's early emphasis on the basic science knowledge made sense at the time, it has proved *(continued on page two)*

**SFSBM** (continued from page one) to be insufficiently flexible to accommodate the thousand-fold increase in the volume of biomedical information that has accumulated since. Most medical schools (including Tufts) are just now adapting their curricula to the information age by emphasizing evidence-based decision-making skills over the acquisition and application of facts.

Another concern has to do with the interpretation of the term “scientific medicine”. At the time of the report’s publication, medical educators naturally responded by instituting curricula heavily emphasizing the *natural sciences* – anatomy, physiology, biochemistry, microbiology and the like – that we now refer to as the basic sciences. Anthropology, psychology, philosophy and other relevant behavioral and social sciences were either downplayed or excluded. Not only was this approach consistent with the reductionistic epistemology favored by prominent academicians, but it served to clearly distinguish mainstream medicine from its more humanistic competitors at the turn of the last century.

Notwithstanding its enormous contribution to medical progress, this historically narrow interpretation of scientific medicine has long been criticized for encouraging a disease-centered approach to patient care. As evidence documenting the benefits of patient-centered care has accumulated over the past 30 years, medical educators have tried to squeeze the social and behavioral sciences into their existing curricula without compromising their traditional commitment to the basic sciences. Although some schools have been more successful than others, an overly packed curriculum serves to compress any new content to the point of irrelevance. Compounding this problem is the exclusion of social science and humanities courses from premed requirements. Many students enter medical school unfamiliar with this kind of material or unaware of its relevance to their career.

Like all other medical schools, TUSM has employed a variety of strategies over the years to engage students in the social and behavioral sciences while maintaining its century-old tradition of rigorous basic science training. Though results have been mixed, three years ago we were given a rare opportunity to finally get it right. The Educational Strategic Plan has produced a progressive new curriculum designed to bring Flexnerian education into the 21<sup>st</sup> century. Scientific Foundations of Social and Behavioral Medicine (SFSBM), a new course to be introduced this month, is a major part of that effort.

The goals of SFSBM are to:

- Place the determinants of health and the management of disease in their proper genetic, environmental, developmental, behavioral and sociocultural contexts
- Draw connections between individual behavior, human systems and public health, emphasizing their relevance to the practice of medicine
- Explore the processes and challenges of human development through the life cycle, highlighting the influences of relationships, families, communities and the health care system
- Demonstrate how systems of care determine a population’s health status by affecting the behavior of consumers, providers, payers, suppliers and policymakers in the health care sector
- Show how physician-led community-based practices can directly enhance the health status of entire populations and the quality of life for its individual members

The course is divided into four sections: The Determinants of Health, Health Promotion and Disease Prevention, the US Health Care System, and Community-Based Practice. The latter section is further divided into two different perspectives: lifecycles and culture. Several innovations distinguish SFSMB from similar content taught in the past:

**Multidisciplinary.** The course is co-directed by faculty from two departments, Psychiatry and Public Health / Community Medicine. In addition, lecturers and small group facilitators represent a broad range of disciplines: acupuncture, behavioral medicine, biomedical ethics, chiropractic, energy medicine, epidemiology, family medicine, geriatrics, hypnotherapy, internal medicine, law, pain medicine, pediatrics and public health.

(continued on page three)



Richard Glickman-Simon, MD

## Faculty Medical Education Journal Club

Summaries of the following articles can be found at:

<http://www.tufts.edu/med/about/offices/oea/facultydevelopment/journalclub.html>.

### Twelve tips for doing effective Team-Based Learning (TBL)

*Medical Teacher* 2010, 32(2): 118-122.

Dean X. Parmelee and Larry K. Michaelsen

### Assessing the quality of clinical teaching: a preliminary study

Rosemarie L. Conigliaro & Terry D. Stratton

*Medical Education* 2010, (44): 379–386.

Please contact Ann.Maderer@tufts.edu if you would like to receive a copy of either article.

### SFSBM (continued from page three)

**Integrative.** SFSBM integrates content from other first-year courses and contributes to a number of longitudinal key themes in the curriculum, most notably: Epidemiology / Biostatistics, Evidence-Based Medicine / Information Mastery, Ethics and Professionalism, Foundations of Patient Care, Cultural Competency, Life Cycles (Pediatrics to Geriatrics), Patient Safety & Quality, and Population Medicine / Health Care Delivery Systems.

**Clinical.** A common challenge in any medical school curricula is to make material clinically relevant to students who have yet to experience patient care. This is true for both basic science and social science courses, though from opposite directions. All learning objectives in SFSBM have some relevance to clinical medicine, and the material is constantly and explicitly tied to clinical practice.

**Undistracted.** One of the key features distinguishing SFSBM from similar courses in the past is its unified placement in the curriculum. Rather than interspersing the material diffusely throughout a semester or two, for the first time the course is concentrated into a four-week block at the end of the first year. The content no longer must compete with the intimidating basic science behemoths that tend to consume students' entire attention. Finally, our students are right where we want them – front and center.

Medicine is a complicated business. Most of the problems our students will face as physicians represent a culmination of a lengthy and convoluted evolution extending well beyond the pathology presenting before them. In some respects the origins of these problems date back tens of thousands of years and are influenced by events thousands of miles away. By focusing their exclusive attention on a deficient gene product or malfunctioning cellular receptor they will miss the true breadth and complexity of the situation and poorly serve their patients. Viewing disease and illness exclusively as a series of biological events is familiar and expedient, but it's also simplistic, inadequate and second-rate. It may have been good enough 100, 50 or even 25 years ago, but in this day and age practicing world-class medicine demands a higher standard. Students should not expect to succeed in a globalized, 21<sup>st</sup> century world unless they have a sophisticated grasp of the environmental, social and behavioral context of the people they serve and the system they serve them in. This is the reason for this course.

## FACULTY DEVELOPMENT CALENDAR

Please save these dates. We will send a detailed description of the workshops as the date approaches. If you have questions, please contact [Maria Blanco, EdD](#) or [Sharon Freeman](#) at 617-636-0891.

### 12th Annual Practical Approaches to Precepting Conference

Friday, May 7, 2010  
9 am-5 pm, TUSM, Boston

### Competency-Based Medical Education: Are We Getting It Right?

Thursday, June 3, 2010  
9 am-12 pm, TUSM, Boston

## STUDENT SPOTLIGHT: MATTHEW NITZBERG, M'10

**Matt Nitzberg:** Born in Cambridge, MA. Majored in Chemical Engineering at Cornell University. Currently 4<sup>th</sup> year student going into Internal Medicine at Northwestern.

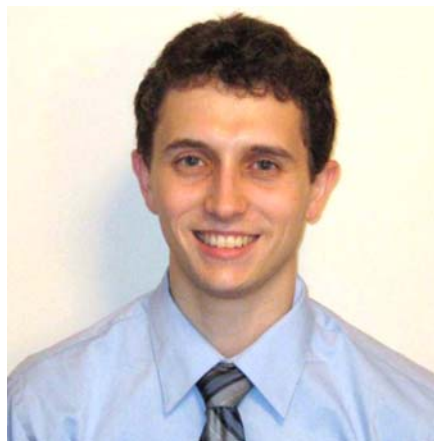
*Matt was interviewed by Maria Blanco, EdD. Here he discusses his recent experiences as a 4<sup>th</sup> year student Problem-Based Learning (PBL) facilitator.*

**How did you learn about this teaching opportunity?** I learned about this teaching opportunity from taking PBL as a first and second year. I remember thinking to myself how much fun it would be to facilitate a PBL group.

**What inspired you to teach in this program?** Simply put, I really love to teach. Teaching is a great way of enhancing my own knowledgebase as it requires me to understand material at a greater degree of depth than I would otherwise. It is also extremely rewarding when I've successfully caused a student to understand something because of my explanation.

**How would you describe your responsibilities/tasks as a PBL facilitator?** Aside from keeping everyone engaged and creating a comfortable learning environment for the group, my goal was to tease out as many quality learning points from each case as possible. It's easy to rush through cases at a superficial level. When I was in my first and second years of medical school, I didn't realize how much there was to know embedded within each case. I tried to generate meaningful discussions by asking a lot of "Wait, but why would this happen?" type questions. Sometimes the group would be able to reason out the answers together, and if not they would make these questions their learning questions for the next week.

**What did you enjoy the most while teaching in this program?** I really enjoyed creating a fun, relaxed learning environment that was still (I hope) educationally efficient. I've had two PBL groups, and though each had a different dynamic, I think the environment fostered great



relationships. I also enjoyed generating curiosity and excitement about the material. I tend to be very excited about most of the subject matter in medicine and it's great when a student says, "that's so cool!!" because they have just learned something that excites them.

**What did you find most challenging about being a 4<sup>th</sup> year student PBL facilitator?** One of the hardest parts about facilitating PBL is trying to remember where my students are in their medical education. I facilitated a first year group and a second year group. For each group, I had to try and put myself in their shoes and remember what I had learned at that point and what would be relevant / important to learn about.

**What lessons did you learn from teaching in this program?** I learned to never underestimate how much your students are capable of and how much they can teach you. I would sometimes ask questions that I thought were "above" their level and they would provide an even better explanation than I could have provided. Also, their learning question presentations were often outstanding and taught me more about their topic than I had originally known.

**How, if at all, are you planning to apply your experience with this program and / or the lessons you learned from teaching this course to your medical career?** Teaching PBL provided me with a lot of experience searching for  
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**Student Spotlight** (continued from page four)  
teaching points embedded in cases. I think this is very applicable for the style of teaching which we will all have to perform as interns and

residents. No matter how “routine” an admission to the hospital is, there’s likely always something that can be learned.

**What recommendations would you make to peers who might be interested in teaching in this program?** You don’t need to know the answers to questions - you just need to be able to identify areas where questions can be asked and make sure that those questions get asked.

## NEGEA Annual Retreat

The NorthEast Group on Educational Affairs (NEGEA) Annual Retreat was held at the University of Connecticut Health Center School of Medicine in Farmington, CT, from March 12-13, 2010. The following TUSM presentations were made:

### A GME Innovation Award was given to:

Laura K. Snyderman, MD<sup>1</sup>; Daniel Chandler, MD<sup>1</sup>; Yung-Chi Sung, PhD<sup>2</sup>; Joseph Rencic, MD<sup>1</sup>  
<sup>1</sup>Tufts Medical Center<sup>2</sup> TUSM  
*Peer Observation and Feedback of Resident Teaching During Work Rounds*

### Short Communications

Maria Blanco, EdD; Scott Epstein, MD; Ralph Aarons, MD, PhD; Yung-Chi Sung, PhD; Ann Maderer – TUSM  
*Anonymous vs. Face-To-Face Evaluation and Feedback Given by Medical Students to Problem-Based Learning Facilitators*

Laura K. Snyderman, MD; Daniel Chandler, MD – Tufts Medical Center  
*Peer Observation and Feedback of Resident Teaching: How to Create a Similar Program at Your Institution*

Laura K. Snyderman, MD – Tufts Medical Center ; Maria A. Blanco, EdD –TUSM  
*Medical Students as Teachers: Participant’s Perceptions of the Impact of a Fourth-Year Medical Education Elective on Their Current Teaching Practice as Residents*

Robert A. Kalish, MD – Tufts Medical Center; Maria A. Blanco, EdD –TUSM

*Integrating the Teaching and Learning of Compassionate Care into a Rheumatology Outpatient Clinical Skills Exercise*

### Workshops

Laura K. Snyderman, MD; Daniel Chandler, MD; Bethany Gentilesco – Tufts Medical Center  
*Direct Observation of Resident Teaching During Work Rounds: Practical Tips to Implementing Direct Observation at Your Institution*

Maria A. Blanco, EdD – TUSM; Mary Y. Lee, MD, MA, MS – Tufts University  
*Writing Effective Grant Proposals*

### Posters

Maria A. Blanco, EdD; Elizabeth Richardson, MLS, MEd; Jane Ichord, MLS; Gail Hendler, MLS, AHIP; Ann Maderer; Scott Epstein, MD – TUSM  
*Tufts University School of Medicine’s Medical Education Literature Alerts: A Faculty Development Initiative to Keep Faculty Up-to-Date with Educational Literature*

Kevin Hinchey, MD; Michael Picchioni, MD – Baystate  
*Competency Based Progression: the Learner-Manager-Teacher Model*

Gina Luciano, MD; Beth Carter, MD; Patricia McArdle, EdD; Kevin Hinchey, MD – Baystate  
*Rise and Shine: An Intervention to Promote Resident Teaching and Diagnostic Reasoning in Morning Report*

David Rosen, Medical Student-3; Dmitry Nepomnayshy, MD – Lahey Clinic  
*Perceptions of the Surgical Residency Interview*

Michael Rosenblum, MD, FACP; Sudeep Aulakh, MD; Lauren Meade, MD – Baystate  
*The Future is Now: Continuity as a Team-Based Concept in Radical Office Redesign*

Susan Albright, TUSM Director, was a co-author on the poster: *Exploring Issues Pertinent to Virtual Patients in Medical Education* with Marc Triola; J.B McGee; David Fleiszer; and, Nancy Posel.



## Mary Y. Lee, MD

# Medical Education Day

On March 31, 2010, the second biannual Mary Y. Lee, MD, Medical Education Day took place in Sackler with approximately 75 attendees participating in a day of presentations, posters and workshops.

The plenary lecture was given by John Mahoney, MD, Associate Dean for Medical Education and Associate Professor of Emergency Medicine at the University of Pittsburgh School of Medicine. He presented, "Why Do Generational Differences Pose a Challenge to Medical Educators?" which is now available on TUSK at <http://tusk.tufts.edu/view/content/M1891C/988764>.

Also on TUSK are four oral presentations, selected from over 25 submitted abstracts:

### **How Do Medical Students Ask Patients About Disability? An Examination of Interpersonal Communication Processes between Medical Students and Standardized Patient Educators with Disabilities**

Presented by: Ashley Duggan, PhD; Boston College; Adjunct Faculty, Tufts University School of Medicine

### **Conceptual Development of a Competency-Based Approach to Residency Education**

Presented by: Kristen Goodell, MD; Assistant Professor, Tufts University Family Medicine Residency at Cambridge Health Alliance

### **Rapid Resident Cycling: The Fourteen Day Mini Block**

Presented by: Michael Rosenblum, MD; Assistant Clinical Professor, Dept. of Medicine, Baystate Medical Center

### **Peer Observation and Feedback of Resident Teaching During Work Rounds**

Presented by: Laura K. Snyderman, MD; Assistant Professor, Dept. of Medicine, Tufts Medical Center

Workshops included **Life Long Learning** with presenter Allen Shaughnessy, PharmD, Professor, Public Health and Family Medicine, TUSM; **Survey Design** with presenter Dawn G. Terkla, MEd, Associate Provost for Institutional Research and Evaluation, Tufts University; and, **Teaching the Importance of Teamwork and Team-based Care** with presenters Robert Trowbridge, MD, Assistant Professor of Medicine, Maine Medical Center; Paula T. White, MS, RN, Director, Center for Clinical & Professional Development, Department of Nursing; Maine Medical Center; and, Doug Salvador, MD MPH, Patient Safety Officer/Associate Chief, Maine Medical Center.



The program booklet with complete abstracts will be available soon on TUSK.