University of Michigan
Medical School

Med Ed

at MICHIGAN

March 2006
Volume 2, Number 1

A publication of the Department of Medical Education
University of Michigan Medical School
http://www.med.umich.edu/meded/
734.936.1644

Welcome New Faculty Member!

Dr. Raymond G. De Vries

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Raymond G. De Vries, Ph.D.
Associate Professor

After a cold and snowy drive from Minnesota, Raymond De Vries joined the Department of Medical Education in January. For the past several years Dr. De Vries has been juggling appointments at three institutions. In 1988, he moved from California to Northfield, Minnesota where he was appointed Associate Professor of Sociology at St. Olaf College. In 1999, with support from a mid-career K award from NIH, he took an extended leave from his position there to consult and do research at the Center for Bioethics at the University of Minnesota. In 2000, a grant proposal he co-wrote with colleagues at the Minnesota Center for Health Care Ethics–a study of the ethics and policy implications of the use of deep-brain stimulation for the treatment of Parkinson's Disease–was funded by NIH. In academic year 2004-2005 he returned to teaching half-time at St. Olaf while working on research projects at both ethics centers.

His life in Ann Arbor is only slightly less complicated. True, he is working in one place, but he holds appointments in several departments: Medical Education, Bioethics, Obstetrics, and Sociology. No, he is not a renaissance man; it is just that he has a wide array of interests. His Ph.D. is in sociology and his work in medical sociology led to a request that he teach that subject to the bright undergraduate students at the University. One important dimension of his research has been in the social organization of maternity care, thus it seemed logical to seek an affiliation with obstetrics. Ray has studied the rise and fall and rise of midwifery in the United States and, over the past several years, he has turned his attention to comparison of maternity care here with obstetric systems elsewhere in the developed world.

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Faculty Members
Department of Medical Education

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Pamela B. Andreatta, EdD, MFA, Assistant Professor
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Mary Ellen A. Bozynski, MD, Professor
Wayne K. Davis, PhD, Professor Emeritus
Thomas J. Deegan, MD, Clinical Assistant Professor
Raymond G. De Vries, PhD, Associate Professo
Teddy E. Dielman, PhD, Professor Emeritus
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John G. Frohna, MD, Clinical Associate Professor
Paul G. Gauger, MD, Associate Professor
Thomas R. Gest, PhD, Associate Professor
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Maya M. Hammoud, MD, Assistant Professor
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David T. Stern, MD, Associate Professor
Tricia S. Tang, PhD, Assistant Professor
Casey B. White, PhD, Lecturer
Kimberlydawn Wisdom, MD, Assistant Professor
James O. Woolliscroft, MD, Professor

(Dr. Raymond G. De Vries, cont'd. from Page 1)

He is co-editor of *Birth by Design: Maternity Care in Europe and North America* (Routledge, 2001) and author of *A Pleasing Birth: Midwifery and Maternity Care in the Netherlands* (Temple University Press, 2005). The latter book is a product of a two year study in the Netherlands; funded by the Fogarty Center of the NIH, this project gave Ray the opportunity to return to the land of his ancestors and to learn the language he should have learned at home while growing up (his parents spoke Dutch, but, like many second generation immigrants, they used it as a "secret language").

Ray's research in bioethics includes study of the field itself and of the ways social science can contribute to ethics in the life sciences. He is working on a social history of bioethics, looking at the structural, political, and cultural factors associated with the appearance and success of bioethics. He is also working with colleagues on several research projects related to bioethics: 1) an ethnographic study of Institutional Review Boards in the United States, 2) an assessment of the export of research ethics to developing nations, 3) a study of the norms of conduct in science, and 4) a look at the unique ethical problems that surround the development and dissemination of new medical technologies, including gene therapy. He is co-editor of the forthcoming, *The View from Here: Social Science and Bioethics* (Blackwell, 2006).

Ray and his wife, Charlotte, are the parents of three children (Anna, age 27; Rocky, 25; and Jesse, 22). Charlotte comes to Ann Arbor from her job as a minister of worship and for at least a few months will enjoy a well-earned sabbatical. New to the city, Charlotte and Ray already feel like they own shares in Zingerman's–it is impossible to find a $10.99 sandwich in Northfield, MN, so they are assuming that sandwiches at the deli must come with stock options. Together, Ray and Charlotte have built two homes (and this means build, as in doing the framing and roofing and plumbing and wiring, not hiring a contractor to do this) and are looking for a prime lot or fixer-upper in the Ann Arbor area.

Department of Medical Education

http://www.med.umich.edu/meded/

Clinical Simulation Center (UMCSC)

Michael E. Marsh, B.S., M.A.
Manager, Clinical Simulation Center
Department of Medical Education

The Clinical Simulation Center applied for, and received, certification to be an American Heart Association Training Center for Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) training. The Training Center Faculty members are Steve Kronick, MD, Susan Housholder, RN MSN, Tom Deegan, MD, and the TC Coordinator is Michael Marsh. The importance of the certification process was critical to moving ACLS and PALS training for all house officers back to the university, rather than relying on external vendors. The Clinical Simulation Center invested in advanced computer-based mannequins, defibrillators, and airway management instruments to support hands-on diagnostic and application oriented instruction for certification and recertification courses. The results for 2005 included the certification of eight new UM instructors for ACLS and seven instructors for PALS, AHA certification as an approved course provider, ACLS training for 150 incoming house officers, PALS training for 80 incoming house officers, and ACLS recertification for 50 house officers and hospital personnel. ACLS courses are now offered on a monthly basis.

Teaching Medical Students to be Teaching Residents

Larry D. Gruppen, Ph.D.
Professor and Chair, Department of Medical Education

Among the many responsibilities of first-year residents is that of teaching medical students. As is true for most of their faculty, most residents do not receive any formal instruction on instructional methods or practice in teaching skills. In an effort to augment the teaching abilities of our graduates, Larry Gruppen has developed and implemented an intensive fourth-year elective, “The Resident as Teacher: Surviving Your First Year.”

This elective has been offered annually since 2000 for cohorts of a maximum of 15 students. These students participate in daily sessions and learn about a variety of topics through a wide range of instructional formats as a means of demonstrating “best practices.”

Activities include:

1. a written description of their personal philosophy of education (done at the beginning and end of the elective)
2. reflection on one’s best and worst educational experiences
3. analysis of theories of learning and their implications for medical education
4. a workshop on the one-minute preceptor model of clinical teaching
5. training and practice in techniques for facilitating small groups
6. an introduction to the use of educational technologies in education, especially the effective use of PowerPoint
7. development and practice of a 5-minute ‘chalk talk’
8. principle of providing effective education feedback
9. training and practice (with feedback) in techniques for large-group instruction (lecturing skills)
10. preparation and practice of a skills instruction session
11. a demonstration of the Brief Structured Observation technique of clinical evaluation and instruction
12. a discussion of methods and principles relevant to patient education
13. the design, development, and presentation of an educational module relevant to their chosen specialty, that each student could take with them and use in their teaching role in their residency program

The elective is frequently over-subscribed, demonstrating a widespread interest on the part of students in acquiring these skills and preparation. The students evaluate many of the components of the elective very positively, but are critical of the activities that failed to meet their standards for “quality education,” which requires us to make continuous evaluation and improvement to the elective. The students are often remarkably sophisticated about the educational process, clearly acknowledging the impact of poor teachers who they hope not to emulate and good teachers they saw as role models. They are enthusiastic about the small size of the group and the highly interactive nature of most of the sessions and argued strongly that the elective not grow in size but rather be offered more frequently.

Integrating a Sociocultural Medicine Curriculum in Pediatrics: Part II: Transforming the Curriculum into Clinical Practice

Mary Ellen A. Bozynski, M.D., M.S., Department of Pediatrics and Communicable Diseases
Tricia S. Tang, Ph.D., Department of Medical Education
Hilary M. Haftel, M.D., M.H.P.E., Department of Pediatrics and Communicable Diseases
Jennifer Laundy Meyers, M.D., Department of Pediatrics and Communicable Diseases

In 2003, the University of Michigan received a John Templeton Spirituality and Medicine Award to integrate a longitudinal and comprehensive **sociocultural medicine curriculum** into pediatric residency education. The curriculum involves a three-pronged approach targeting the multi-systemic levels of the individual physician, educational infrastructure, and the evolving culture of medical training.

Our newly funded course enhances our sociocultural medicine curriculum by intensifying spiritual care-focused training as it relates to end-of-life, medical ethics, and patient-physician communication.
Specific goals include:

- Train faculty to demonstrate and model spiritually/culturally responsive care
- Identify and monitor opportunities for residents to apply Sociocultural Medicine (SM)-focused knowledge and skills when working with patients/families
- Increase resident exposure to and participation in interdisciplinary efforts (e.g., pediatric ethics committee, transplant evaluation, psychosocial care)
- Strengthen residents' role and leadership in case-based teaching within the curriculum and in patient care settings.
- Design a portable system to track SM-focused experiences and document the achievement of SM-focused competencies

The course will utilize the previously developed framework targeting the individual physician, educational structure, and the evolving culture of clinical training. In contrast to the previous course, this course will be taught in the context of the daily care of patients and families.

To date, there have been no studies examining the baseline skills and knowledge of residents with regard to spiritual care. Furthermore, no research has critically examined the impact of spiritual care education on the development of residents' clinical skills. Given these gaps in the medical education literature, the purpose of the present study is to investigate factors associated with spiritual care proficiency among pediatric residents.

Our research study has three aims: 1) to implement a core curriculum on spiritual care in pediatric residency training at the University of Michigan, 2) to evaluate the impact of the training program on residents' spiritual care skills, and 3) to identify the best predictors of spiritual care proficiency.

Our study will follow a prospective, longitudinal, single cohort design over a period of three years recruiting interns entering the pediatric residency program in June 2005. We will collect baseline data on the resident cohort including demographic background, sociocultural-related education history, attitudes towards sociocultural issues and topics (including cultural awareness and spiritual awareness), and cross-cultural communication skills. We will also examine a number of predictor/intervening variables. The attainment of spiritual care focused communication skills will be measured via resident performance on the breaking bad news OSCE. We will also measure resident self-efficacy and patient satisfaction.

A successfully designed and implemented curriculum may be used as a model for other training programs, both at University of Michigan and elsewhere, in the future.

Medical Students for Cuba Program

Nick Boncher, B.S., Medical Student (M4)
University of Michigan Medical School

As the challenges of maintaining a successful health care system become ever more difficult, an understanding of the methods other countries use in their own health care systems becomes increasingly important. As future physicians, we thought it was important to explore the advantages and disadvantages of a health care system that is very different than that of our own country. For the last four years, a group of nearly 30 medical students and at least one physician have traveled to Cuba with this goal in mind. The group, which had originally been organized and run completely by medical students, was begun with the idea of creating a renewable option for medical students to be exposed to a different health care culture. "We hoped that our new knowledge would help us to be able to participate in the reformation and streamlining of our own health care system as we become physician leaders," said one participant.[1] With these goals in mind, their focus shifted 90 miles south, to the communist state of Cuba. The Cuban health system is regarded by many as the best system in the Caribbean and in much of Latin America. Cuba was able to achieve such fame despite multiple barriers, including an economic embargo from the United States and its economic partners. Since its inception, the group Medical Students For Cuba, has remained a student organization and an outlet for students' international health curiosity.

Different than the U.S., is the mindset that underlies the Cuban health care system. Instead of spending the bulk of their resources on the third tier hospitals, the Cubans put greater emphasis on those physicians operating at the bottom level. Here, physicians' efforts are based on preventative care, health promotion, basic curative care, and triage. In an article in the Journal of Family Medicine, the authors note, "These accomplishments involve organizational innovations such as neighborhood-based family medicine as the focus of primary care; regionalized systems of hospital services and professional training; innovative public health initiatives and epidemiologic surveillance; universal access to services without substantial barriers related to race, social class, gender, and age."[1] This primary care emphasis has also allowed Cuba to be successful, while spending only 7.2% of their GDP on health care, as compared to 13.9% in the United States (WHO). One should note here, that the Cuban system also does place importance on high technology interventions and advanced surgical procedures, such as transplant surgery, but that the emphasis of their system is at the primary care level.

As a result of this primary care emphasis, Cuba has some impressive statistics. The efficacy of their programs can be noted by reviewing health care indicators. For instance, the incidence of infectious diseases preventable by vaccines is lower in any other nation at Cuba's level of economic development; immunization rates have remained for many years between 99% and 100% of the target populations.[1] Also, despite the economic difficulties imposed by the United States led embargo, life expectancy has remained high, 77.04 years compared to 77.43 in the United States, and infant mortality low (6.46 and 6.63 per 1000, respectively). Although these statistics are surrogate markers of a health care system, they suggest that the Cuban health care system has been successful, and that this has been largely due to their ability to meet problems at the primary care level.

To be sure, a large reason behind the success of the Cuban system is due to the nature of physician education and training. This, too, reflects the different mindset of the Cuban population and government, which in its ideal form makes strong efforts toward equality among its citizens. In the United States the most promising and brightest minds in medicine often choose specialties in which reimbursement is high and work load is low, like dermatology, leaving primary care residencies unfilled and the primary care work force undermanned. In fact, in 2005, the National Residency Match Program's results show that pediatrics and family medicine were two of the residency categories with the lowest percentage of slots filled. On the other hand, categories like dermatology, radiation oncology, and ophthalmology had 100% fill rates. United States residents Cuban counterparts are mandated to spend their first three post-graduate years in primary care as part of the program "Medicina General Integral." During this time, the training includes rotations in each primary care specialty (internal medicine, pediatrics, and obstetrics and gynecology), as well as a longitudinal continuity experience based in a local neighborhood and supervised by family physicians. The residents live in the communities in which they work, often in an apartment above the clinic, allowing themselves to be available at all hours, if need be. Only after these three years can physicians think of further specialization. This ensures that there is a large and comprehensive primary care work force *(cont'd. on Page 6)*

(Medical Students for Cuba Program cont'd. from Page 5)

available at all times. Furthermore, during their first two post-graduate years, the best and brightest students are sent to work in the areas in which the health care is in the worst state. In particular, these include rural and mountainous areas. This is opposite to the decision of most American medical graduates who often seek the desirable destinations of high-powered academic hospitals in cosmopolitan cities over community hospitals or programs serving rural communities.

The Cuban system, though very different from our own system, has shown to be an effective health care provider. Their expertise in creating a self-sufficient and successful health care system has been an example to the rest of the Caribbean. The inefficiencies seen in our own system could be improved by instituting some of the changes found within the Cuban system, such as their dedication to primary care, education, and prevention.

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[1] Waitzkin H, Wald K, Kee R, Danielson R, Robinson L. Primary care in Cuba: low and high techology developments pertinent to family medicine. Journal of Family Practice, 1997; 45:250–259.

Upcoming Conferences

- GEA Northeast Region
  2006 Regional Meeting
  March 3-4, 2006; Philadelphia, PA
  http://www.aamc.org

- GEA Central Region
  2006 Regional Meeting
  March 9-12, 2006; Kansas City, MO
  http://www.aamc.org

- AERA 2006 Annual Meeting
  April 7-11, 2006; San Francisco, CA
  http://www.aera.net

- GME Leadership Development Course–Part I
  April 22-23, 2006; Austin, TX
  http://www.aamc.org

- GEA Western Region
  2006 Regional Meeting
  April 30-May 3, 2006; Asilomar, CA
  http://www.aamc.org

- GEA Southern Region
  2006 Regional Meeting
  May 4-6, 2006; Galveston, TX
  http://www.aamc.org

- AAMC Early Career Women Faculty
  Professional Development Seminar
  July 8-12, 2006; Washington, DC
  http://www.aamc.org/meetings

- AAMC 117th Annual Meeting
  October 27-November 1, 2006; Seattle, WA
  http://www.aamc.org/meeting

- Mid-Career Women Faculty Professional
  Development Seminar
  December 15-19, 2006; Scottsdale, AZ
  (URL for this seminar currently unavailable)