Member Report

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President's Message

James Campbell, Ph.D. - President.

Since our last communiqué, the call for papers has gone out and the submissions are in. Although we were in suspense until the last day of the deadline, judging from the subsequent flurry of submissions Santa Fe is going to be a banner meeting. Of course, Ken Wolf, Jose Calderon, and the members of the Planning Committee deserve a lot of credit for getting things off to a great start. They are putting together an excellent program for our Annual Meeting with something for everyone. They've also added a few new features such as starting on a Thursday and ending on Sunday plus having a Gala Ball on Saturday night with tie rentals! I'm not going to steal all their thunder, however, so I will let them tell you what's happening when they get the chance. All in all, our Annual Meeting promises to be another ABSAME don't miss event. "So don't be square, be there!"

"Santa Fe is going to be a banner meeting"

On other fronts Mark Vogel, our Administrator, continues to provide us with superb organization skills. Just take a look at our web site at www.absame.org. Mark, along with Ken Wolf, our treasurer, recently put in some long hours to help keep the organization updated with the IRS. While I know that as behavioral scientists we are known sometimes for embroidered and fervid use of the native tongue, nothing compares to wading through the IRS bureaucracy. So, hats off to a job well done!

After the October meeting I will be handing over the reins of President and placing them in the very competent hands of Alicia Monroe. During my tenure as President, ABSAME has gone through some transitions, yet it continues to prosper thanks to the dedication and hard work of its devoted members. For many of us, ABSAME represents our professional home. Besides, where else could you get the opportunity to be part of a multidisciplinary, scholarly and just plain friendly organization of like-minded, talented associates?

As a reminder, keep in mind that we need articles for our journal, the Annals of Behavioral Science and Medical Education. See you in Santa Fe!

Annals Appoints New Editor

Jim Campbell, Ph.D. has been approved by the Board of Directors of ABSAME as the new Editor-in-Chief of the Association's journal the *Annals of Behavioral Science and Medical Education.*

The journal was first published in Spring 1994 under the direction of Linda Garcia-Shelton, Ph.D., the inaugural Editor-in-Chief with Lars Larsen, M.D. serving as Associate Editor. The journal is distributed to all ABSAME members and contains both original peer-reviewed articles and regular sections (Behavioral Science Teaching Rounds, Abstracts, Journal Watch, and Book Reviews). The mission of the journal has been to provide a continuous forum for the discussion and presentation of behavioral science and medical education topics.

Jim wishes to express his gratitude to the Board and to Linda Garcia-Shelton, He realizes it will be a challenge to follow in her proficient and masterful footsteps.

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Association for the
Behavioral Sciences
and Medical Education

30th Annual ABSAME Meeting

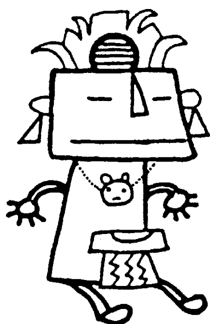
Integrating Culture and Complimentary Medicine: Challenges to the Biomedical Paradigm

October 12-15, 2000

Hotel Santa Fe

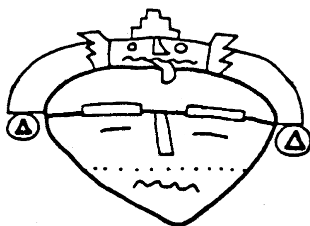
Santa Fe, New Mexico

The 2000 ABSAME conference will highlight how health care education and delivery systems are developing integrated and complementary approaches to managing and encouraging diversity as they attempt to meet one of the greatest challenges of the early 21st Century.



Santa Fe, New Mexico

Unmatched in its wealth of culture and history, Santa Fe's mountaninous surroundings and pleasant climate make it an ideal destination. A city of four cultures (Indian, Spanish, Mexican, and Anglo), you can tour and explore everything from pueblos and historic petroglyphs to live theater and art galleries along Canyon Road.



Featured Speakers Include:

Bonnie O'Connor Ph.D.
Rhode Island Hospital/Brown University

Marguerite Evans M.S., R.D.
National Center for Complementary and Alternative Medicine (NCCAM)

Thomas E. Perez
Dept of Health and Human Services, U.S. Office for Civil Rights

Gladys T. McGarey M.D., M.D.(H)
Gladys Taylor McGarey Medical Foundation

M. Brownell Anderson
Associate Vice President AAMC
Deputy Director, Division of Medical Education

Edward Eckensfeld
International Consultants and Communications

Victor LaCerva MD
Family Health Bureau,
Medical Director for the NM Department of Health.
Author: Pathways to Peace

Program registration and information available online
www.absame.org

Experiencing Curricular Reform at Rochester

Laurence Guttmacher, M.D., The University of Rochester Medical School

Joao asked for a brief and wise piece. I feel more comfortable with brevity than wisdom, but let me pass on some thoughts about our experience in Rochester: We are in the midst of a massive curricular overhaul, an experience that I expect many share.

Our new curriculum, dubbed the Double Helix, contains a number of significant changes. All courses are now interdisciplinary. For example, anatomy, histology, and physiology were folded together to form the Human Structure and Function course. The first year begins with "Mastering Medical Information," which includes medical infomatics, epidemiology, biostatistics, and clinical decision making. The second year ends with a series of weeklong courses, some of them reprises of earlier materials, and some unique, such as a week devoted to trauma and violence. Students begin their clinical exposure during orientation week. Thus, Introduction to Clinical Medicine occurs during the first semester. This is followed by a year-and-a-half-long Ambulatory Clerkship. All of the clinical clerkships will do their ambulatory teaching during the first two years. Students are assigned to community based preceptors and have very specific learning objectives established. Our third year will consist of three core clerkships—adult medicine, which combines medicine and surgery, one which combines ob-gyn and pediatrics, and mind brain behavior, combining neurology and psychiatry. Each of the core clerkships will end with a two-week basic science block.

There will be a comprehensive assessment largely in an OSCE format at the end of the second and third years. The identification of relative deficits will lead to an individualized learning plan hammered out with each student and his/her advisory dean.

In addition to the courses, we have identified five themes: prevention, cultural diversity, health care economics, law and ethics, and nutrition. Every PBL must include at least one theme. Theme directors are responsible for consulting with Course Directors to make sure that their area is being attended to.

Is this wonderful? Absolutely! There is an air of excitement around the place that is terrific. We are getting top drawer applicants who are drawn by the curriculum. Is it frightening? Absolutely! We suddenly need 200 high quality community based preceptors in primary care and a goodly number of specialty-based preceptors.

What are the major lessons that I have learned from this experience?

1. The curriculum belongs to those who put in the sweat. Grousing from the sidelines is remarkably ineffective. The Departments and individuals who have "won" have been those who attended the countless committee meetings and put in the work.

2. The fate of behavioral science is interesting in this paradigm. There is not a separate behavioral science course. Much of the material that we ordinarily teach in behavioral science has now been relegated to the theme groups. **The content is there, but it must be taught within the context of, say, a PBL whose primary focus is elsewhere**. This puts the onus on those of us with interest in this area, to maintain an ongoing work relationship with course faculty and to write really good tutor guides since they are more likely to be subject experts in, say, genetics than in, say, sociology. The students very much want to pursue behavioral science content. For example, the ethical issues raised in a case of lead poisoning will always attract their attention. The major work is in getting the faculty up-to-speed, and in overseeing the curriculum in order to make sure that everything is covered. It is quite easy to lose track of behavioral science learning objectives. That means that one must oversee the curriculum with an unblinking watchful eye. Yet if the plan works, it is incredibly effective since the students see the immense clinical relevance of behavioral science.

See: **Curricular Reform**; Page 5

Editors Note

Larry Guttmacher, ABSAME's past president, wrote a far-reaching piece. Read on. It is really thought provoking. Is this one more example of the "only in Rochester" phenomenon? Judge for yourself, and whatever your verdict, contribute your own experience as Larry challenges you to do. Send e-mails to jolen2000@aol.com and they will eventually be shared with our membership.

Finding a Shoe that Fits

O.J. Sahler, MD
Professor of Pediatrics, Psychiatry, Medical Humanities, and Oncology, University of Rochester School of Medicine and Dentistry

Immovable obstacles have always fascinated me. I used to butt my head up against them just to see if they were truly immovable. My head ("bloodied, but unbowed") was clearly the loser in these encounters. And, unfortunately, being blessed with a strong protective cranium, the contents and connections that characterize my particular brain were wholly unperturbed: not one neuronal pathway deviated in the slightest from its usual course and not even one synapse misfired. Meaning that I learned nothing from these painful experiences.

"So, what's music therapy? I don't have to sing, do I?"

While others may have different perceptions of those enormous, lumbering, elephant stampede-like monstrosities known as university medical centers, I have always found them to be looming obstacles just waiting for the right butting. The temptation to provide that butting has always been so overpowering that no amount of thoughtful —indeed, prescient— advice has ever succeeded in overcoming my need to give it one more go.

There are, I understand, some people who actually believe that it's never too late for an old dog to learn new tricks. My need to butt heads with obstacles is closely matched by my need to prove optimists wrong — again. Here, then, is a story about new paradigms, about surmounting external (and internal) obstacles, and, having already had bunion surgery because of vanity and poor judgment, about the eureka experience of finding a shoe that fits — again.

About 3 years ago my office doorway in pediatric hematology/oncology was darkened by Bryan Hunter, Ph.D., MT-BC (Music Therapy-Board Certified), coordinator of music therapy programs at Nazareth College of Rochester. He was, so he was quick to inform me before my scowl totally solidified on my brow, at his wit's end, forlorn, beaten down, at a loss (although not for words), and ready to throw in (up? out?) the towel. I was, he told me, his last hope.

With the pressure on, I rummaged for my triplicate prescription pad. Should it be alprazolam to decrease his (or my) anxiety? Or, might a selective serotonin reuptake inhibitor be called for to mitigate the impending sense of eternal gloom even the spectacular view of the parking lot decorating my window couldn't dispel? Was that bottle of wine from a colleague last Christmas still there in my desk drawer? Ahhhhh. I felt myself beginning to think about relaxing as my fingers curved around the protruding cork. Thank goodness for panaceas. No need to addle my brain trying to distinguish between anxiety and depression, his or mine, after all. One cure fits all.

"Last hope for what?"

"Music Therapy and Medicine, of course" (you klunk, he was kind enough NOT to say).

"Hmmmm. Can't imagine wanting to think about that, but Medicine and Music Therapy might be a possibility."

"Whatever…..," he countered, sounding like my young adult daughter when her conversation with me is becoming just too dumb for any other word.

"So, what's music therapy? I don't have to sing, do I?" (Chortle, chortle)

"I hope not," he said, with an awfully straight face, and he didn't even *know* me!

Well, to make an extremely long story fit into this newsletter, which the editor absolutely refuses to enlarge to 16 pages, that afternoon was the start of one of those once (or twice)-in-a-lifetime experiences that always make you wonder what would have happened if you had had strep throat that day and were home in bed watching *As the World Turns* instead of sitting at your desk twirling your hair.

It's been a *(fortissimo)* blast. Thus far, among other things, we've provided music therapy to 22 bone marrow transplant patients and, not surprisingly, reduced their sensation of nausea and their pain. I know, my (or your) grandmother could have predicted that. But, my grandmother didn't know about GABA receptors, entrainment of nerve impulses, or the reduction in circulating cortisol associated with decreased firing in the thalamus, and then the amygdala, and then the hypothalamus and pituitary, and then the adrenal that enhances immune function because cortisol is a glucocorticoid that we *know* (like for years)

inhibits production of some pretty critical cytokine precursors of cell-mediated immunity. And all of this happens when you listen to music!

Let me tell you what a trip it was to show that patients in our study who received music therapy reconstituted their bone marrow faster than those who didn't and to be able to explain the phenomenon (not perfectly, but then we don't really know what makes some of our best-accepted therapies — like chicken soup — work either) in the conventional physiologic terms that define Western Medicine. Such terms are neither good nor bad, ladies and gentlemen, they just happen to be the language spoken in the world of the NIH. And, as we all know, it helps to be able to communicate with the thingamijigs who live at the NIH if you have finally stopped butting your head against formidable walls (mentioned above) and, instead, just let yourself relax and be fully permeated by the essential oil of understanding that good, reliable, valid research costs lots of $$$$.

Let me also tell you what a trip it is to collaborate with music therapists (and acupuncturists, massage therapists, Qi-gong instructors, aroma therapists, and humorists —did you know that one *really good* belly laugh can reduce your secretion of cortisol, that nasty glucocorticoid, for up to 24 hours. Count 'em, folks, *24!*) How wonderful to interact with people who have time as one of their major gifts to give you. And whose whole premise about how we make people better is to truly understand why, how, and in what way, they're feeling bad.

It was my good fortune that Dr. Hunter stood outside my door feigning desperation that fateful day (actually, I learned later that it was the last day of a year-long sabbatical during which he was supposed to have set up a hospital-based music therapy program, so maybe he wasn't feigning after all. Certainly, at 5:30 p.m. on a summer day, I probably really was his last hope!).

The idea he had to sell and the view of the world (forget that measly parking lot taking up all the space in my office window) that has emerged for me since then, have rejuvenated my life and practice. I am amazed everyday by what I don't know, excited about the possibilities of new connections, and challenged to translate chi into something that will have meaning in *Dorland's Medical Dictionary*, even without being squared.

Now I think about *important* stuff, like, are there enough acupressure wristbands for our teenagers who are getting chemo? Do we have biodots for our radiation therapy patients who need to relax and let the good rays do their thing? Must we give this patient benadryl to go to sleep on her first night in the hospital when she just told us that she can't sleep because she forgot to bring her walkman? Why are we having this mother spend 48 hours in the hospital after delivery and not using that time to show her how to stroke her baby? Is there a law that you can't forgo versed for your gum surgery just because you're in the hospital? After all, dentists have been offering Bach, Vivaldi, and you name it instead in their offices for decades? Why do we do the things we do, even when we know that some things just don't make sense?

Oh-oh. I can feel my head suffusing, my mood ring turning to fire, and my center listing, listing, listing…..

Rats! Despite my best intentions and greatest efforts in writing this piece, I've just discovered — again — which shoe, inescapably, fits me best: the shoe of a butter.

Oh, well. Perhaps I can be something else (less painful) in the next life.

To look on the bright side, at least I'm enamored of the cause and I just know those obstacles aren't really and truly immovable……..Here goes! Just watch! ■

Continued from Page 3

Curricular Reform

3. The most effective advocates are those who can remove themselves from their narrow point of interest. Johnny-one-notes do not succeed, so it is important to keep a broad perspective and to argue from the students' perspective.

4. Curriculum reform works much more easily if it is centralized. This underscores the importance of getting behavioral scientists in positions of influence.

It would be interesting to hear from others who have gone through a similar process. ■

Reflections on Bringing the Medical Humanities into Behavioral Science Teaching

Ann Randolph Flipse, M.D., University of Miami Medical School

In this viewpoint piece, I take the liberty of sharing my thoughts with you, anadorned, as I face a challenge of my own making, one which would be easier to implement, were it imposed by institutional powers. The challenge is to integrate the medical humanities into the teaching of the behavioral sciences.

It seems to me that teaching behavioral science with the integrated medical humanities is a natural. Who better than we, "softer ones" within the faculty, to help students reflect on literature, art, music, medical history, and anthropology?

"literature and medicine share an inherently enduring relationship"

I must confess to great elation in reading in ***Academic Medicine*** of an orthopedic residency with a quarterly book club discussion about assigned reading. And it was reported in the same issue in which Jane Austin was mentioned.

Two years ago a book titled "Empathy and the Practice of Medicine," prepared under the auspices of Yale's Program for Humanities in Medicine, arrived with instructions to distribute the book to all incoming first year students. I wish it had been also sent to every faculty member of the medical schools. The contributors make a very good case for the premise that the study of literature makes physicians more empathic.

In the May 2000 issue of the ***American Journal of the Medical Sciences***, there are several articles that we can cite on the subject. Rita Charon writes that "literature and medicine share an inherently enduring relationship." She also reports that third year students at Columbia keep a Parallel Chart about "clinical and personal considerations that are critical to their care of the patient but do not belong in the hospital chart." What a great way for the students—and for us—to know about what they are experiencing!

Some of our students, who took mostly science courses as undergraduates, have virtually choked on the idea that history of medicine could possibly be important to them. At a time when professionalism is at the forefront of so many of our educational meetings, what better way is there to place the students in the continuum of an ancient profession? What better way is there to teach students about the changing nature of our scientific knowledge and about uncertainty and humility than to point out the mistakes and accomplishments of the past?

Barron Lerner delineates three reasons for teaching history: we can learn from the past; we can remember that history is a "profoundly social enterprise," which encompasses not only knowledge but also influences of culture, politics, etc.; we can realize that the medical encounter is always a human interaction.

In supporting a role for the visual arts in medical education, Boisaubin and Winkler observe that the practice of medicine has always been a visual science. The visual arts can help students hone observational skills, something we can support through utilizing painting, photography, movies, and students' television personal favorites like ER and Chicago Hope, folded into teaching-learning techniques.

From my own experience including the humanities, the first time is the hardest. The trick is to be—and remain—energized, not enervated by the resistance of some of our students.

There is a lot of secondary gain in this for us, educators. The perk is all that we can learn while preparing for this endeavor and from sharing opinions and insights with the students.

If you have some experience including the medical humanities, please share your ways of doing things. ■

Editor's Note

This article by Ann Flipse, closes with a golden key, another issue of our newsletter. The articles featured past and present in this publication stand out on their own, and constitute, together, a remarkable collection of wisdom and insight. Ann's "Reflections" are candid and open and bound to get your creative juices flowing. Read on.

Association for the Behavioral Sciences and Medical Education

ABSAME Info & News

Dr. Carr Announces Retirement

John ("Jack") Carr, Ph.D. Professor of Psychiatry and Behavioral Sciences at the University of Washington, has announced his retirement, effective September 1, 2000. Jack and his wife Danie came to Seattle and the UW in 1963, both just out of graduate school at Syracuse University. Planning to stay on the west coast only a few years, they are still there, mortgage paid off, 4 kids and one grandchild later. Three of their four children live in Seattle, the fourth is in Vancouver, Washington, across the Columbia from Portland. After 37 years in the Department of Psychiatry, four of those years as Acting Chair, Jack is ready to concentrate on writing, travel with Danie, continued teaching, governance, skiing, and his granddaughter, Lili. "Actually, I'm cutting back to 40% time, still doing much the same as before, just a little less of each so I have more time to enjoy family". There are still many projects involving ABSAME Jack will continue to be involved in, chief among them the joint World Health Organization/ABSAME/AMSP collaboration for Behavioral Science modules. Jack and Jim Campbell will be reporting on that project at the Santa Fe conference.

Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Support

The NIH Office of Science Policy and Planning has posted the updated revision of the report "Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Support" on its web page at http://www1.od.nih.gov/osp/ospp/ecostudies/COIreportweb.htm

The NIH prepared the report to comply with a congressional request that the NIH combine and update two previous reports: "Disease-Specific Estimates of Direct and Indirect Costs of Illness and NIH Support" and "HHS and National Costs for 13 Diseases and Conditions." The NIH submitted the first version of the report in 1995 and updated the figures in 1997 and in early 1998. For the current revision, all of the NIH support figures have been updated to reflect FY 1999 funding levels. Several, but not all, of the cost estimates have been revised since the initial report. Cost estimates were revised for alcohol abuse, allergic rhinitis, Alzheimer's disease and other dementia, asthma, atherosclerosis, dental disease, peptic ulcer, heart diseases, coronary heart disease, HIV/AIDS, lead poisoning, end-stage renal disease, mental disorders, neonatal respiratory distress syndrome, acute respiratory distress syndrome, smoking, and urinary incontinence. The main web page of the NIH Office of Science Policy and Planning is www1.od.nih.gov/osp/ospp/

Hans Mauksch Fund

When you renew your dues, please consider a donation to the H Mauksch Fund, which was named after, and honors, the founding president of ABSAME. An important purpose of the fund is to subsidize, on a merit basis, student attendance to the ABSAME annual meeting and to recognize student presentations.

Norman Cousins Award

The Fetzer Institute (http://www.fetzer.org) established the $25,000 Norman Cousins Award to acknowledge the vision, creativity, and leadership of those who work in the health professions. For the 2000 award, the Institute invites applications from teams working in health care (including health professionals, nurses, administrators, doctors, support staff, educators, and others) who have implemented a health care project that focuses significantly on relationships. The 2000 award will recognize an exemplary relationship-centered project in health care that was implemented by a group of three or more key collaborators. Projects can include policies, procedures, initiatives, and programs. Eligible applicants include groups representing public or private health care organizations such as hospitals, universities, community groups, etc. Applicants may not be staff, board members, current fellows or scholars, senior advisors of the Fetzer Institute, or Cousins Award selection committee members. Application guidelines are available online. Contact: The Fetzer Institute (616) 375-2000 ext. 269 E-mail: cousins@fetzer.org RFP Link: http://www.fetzer.org/announcements/NormanCousins2000.html For additional RFPs in Health, visit: http://www.fdncenter.org/pnd/rfp/health.html

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