

Member Report

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Association for the Behavioral Sciences and Medical Education

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One Genesys

Parkway
Grand Blanc, MI
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Tel: 810 762-8042
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Executive Director

Mark Vogel, Ph.D.

New Directions In Multicultural Education

Presidents Message - Alicia Monroe, M.D.

As my first year as president of ABSAME draws to a close, I am more excited than ever about the intellectual synergy and opportunities for creative collaboration that are kindled within this organization. The ABSAME Board and its members can take pride in the numerous accomplishments this year. In a year that many Americans chose to limit their travel, the 2001 ABSAME annual meeting was very successful, and well received by the participants. ABSAME members including Ann Flipsie, Julia Frank, Lynn Epstein, and myself facilitated an intellectually stimulating group discussion entitled, "Empathy, Equity, and Patient-Centered Care" at the Association of American Medical Colleges (AAMC) annual meeting in Washington, D.C. We are pleased to have

Fred Hafferty on board as our new representative on the Council of Academic Societies (CAS) of the AAMC. In addition, we are pleased that Liva Jacoby will serve as the ABSAME Liaison to the Women in Medicine Group of the AAMC.

The program committee for the 2002 annual meeting is already hard at work developing a groundbreaking program for next year's meeting, "Reducing Health Disparities: What is the Role of Medical Education?" The conference will showcase innovative, cutting edge multicultural educational interventions that seek to assess a variety of outcomes including learners' knowledge, skills, attitudes, patient satisfaction, and health outcomes.

Increasing diversity in the U.S. population, and persistent disparities in health status have motivated governmental agencies to provide resources to assist health care professionals in delivering quality, culturally appropriate health care. In ad-

dition, medical educators are creating a variety of multicultural training opportunities for medical students, housestaff, and practicing physicians to enhance general cultural awareness, knowledge, and particular clinical skills. Educators are utilizing existing models of cultural competence to

guide their program development, or creating new models that emphasize skills deemed to be particularly relevant for a certain specialty or clinical setting. One approach to multicultural skills training emphasizes a commitment to active engagement with patients, communities, and colleagues. This process stresses humility, self-reflection, lifelong learning, patient-centered care, dynamic partnerships and advocacy.¹ Strategies for operationalizing this skills training approach and incorporating

meaningful, developmentally appropriate educational methods and assessment tools are underway.

During the fall semester of 2001, I implemented a new elective for first year and second year medical students at Brown Medical School. This course focused on the knowledge, skills, and attitudes required for effective patient advocacy with an emphasis on the role of culture in developing advocacy partnerships with patients, families, peers, and community service providers. The course primarily focused on advocacy at the interpersonal level—between patient/family/community agency and the student. Advocacy opportunities are often linked to illness and suffering among vulnerable members of society who are disproportionately impacted by environmental pollution, poor health, and lack of information

"One approach to multicultural skills training emphasizes a commitment to active engagement with patients, communities, and colleagues"

See: **President's Message**; Page 3

Voice of a Prophet

Joao V. Nunes, M.D.

September 11, 2001, 1:20 p.m. By that time the regular person on the street had already comprehended the enormous magnitude of the tragedy that had befallen America in the early business hours. By 1:20 p.m. the Twin Towers of the World Trade Center in New York City had collapsed into a pile of smoldering rubble and adjacent buildings were also at risk of collapsing. The New York skyline, which had always provided constancy, remaining easily recognizable while we changed, had lost major landmarks. By 1:20 p.m. one fifth of the Pentagon, the symbol of America's military might, had been severely damaged. Four American jetliners had been hijacked by terrorists and flown on a suicide mission, three of which produced the damage. The fourth plane crashed in rural Pennsylvania. The death toll estimates ran in the thousands on the ground and included the hundreds of jetliners' passengers and crew.

By 1:20 p.m., radio and television newspeople had substituted a somber tone for an earlier one of disbelief. Yes. America had been cowardly violated. Innocent lives were lost and the psychological consequences could only be imagined.

At 1:20 p.m., buses rolling on Amsterdam were taking passengers for free. With many others I took the "M101" going south on Amsterdam. We had to switch to another bus going east on 125th Street. We joined in West Harlem people coming from Washington Heights and from downtown Manhattan going everywhere. These were the anonymous people one hears nothing about. Some had made their way from the business where they worked at the towers and their vicinity, bearing the weight of the disaster on their shoulders and reflecting their still raw fear in the gleam of their eyes. They had run and walked great distances before 1:20 p.m. Others were coming from other points in the city. The driver broke the non-descript noise to announce he had been instructed to make the intersection of Lexington Avenue and 125th Street the last stop. There one could take Metro North commuter trains that were running toward Westchester County and Connecticut on an emer-

gency schedule. That was good news for some. Others were left wondering what they would have to do to reach their final destination, since the subway was not running.

The bus soon became extremely crowded. The ridership constituted of a racially and ethnically diverse group, a representative slice of New York, I thought, who had set aside their differences and were orderly doing their part. Because the city needed to attend to the emergency unencumbered, non-essential personnel had been instructed to go home, if possible. If not, there were private and public temporary shelters set up to accommodate people. It dawned on me that going home, such a simple act that we do daily with hardly a thought, had become so important under the circumstances, for all those bus passengers and for the city. Everybody wanted to help the city.

On that bus the spirit of solidarity was everywhere. People banded together courteously helping each other, controlling their frustrations, and talking about the trag-

edy. Talking about something that grieves us is very important and beneficial indeed. Flashes of "The Sound of Silence," a Simon and Garfunkel song came to mind, especially the verse that says, "The words of the prophets are written on the subway wall." On the bus the prophets were saying — or shouting — their words. There was certainly the usual doom and gloom, but also pure gems. At one point a strong woman's voice seemed to unite the sentiments of the entire ridership. She said, "After today this country will never be the same, we'll never forget this. But I'm sure we will work together as a country as never happened before."

As a person who studies and teaches the science of human behavior and its applications to the practice of medicine I was pleased to hear somebody state so concisely and elegantly two very important points that underscore our humanity. First this tragedy will likely become an organizer of our memories. The same way many people still remember where they were, what they were doing when President Kennedy was assas-

*"...work together
as a country as
never happened
before"*

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President's Message

and limited access to culturally appropriate health care services. The course sought to deepen the students' understanding of the relationships among race, ethnicity, social factors, economic factors and health status indicators. Presentations from physicians, anthropologists, public health researchers, health educators, community service providers, patients, and family members were included to provide multiple perspectives on complex health and social problems and to share expertise in developing community partnerships.

Readings were drawn from several sources including the medical literature, government publications, the social sciences, and periodicals. The course utilized reflection as a strategy to build self-awareness, to develop greater insight into the social and community context of health care and patient advocacy, to generate hypotheses about patient behavior to reduce the likelihood of stereotyping, and to refine physician-patient communication skills. Skills training focused on gathering clinically relevant cultural information, patient education, and honing skills in self-assessment and peer assessment.

As anticipated, a group of highly motivated students with an affinity for cross-cultural issues elected to take the course. Students responded well to the active learning format that emphasized interactive large group presentations, followed by small group discussions. The patient advocacy emphasis provided immediate opportunities for pre-clinical students to connect the sociocultural content of the course to their past and present community service activities. Students tended to perceive that they had a high level of awareness of their own cultural perspectives and

the cultural perspectives of their classmates. Students' reflective responses and course evaluations suggest that students appreciated the "big picture" focus many of the speakers employed. This approach included a brief biomedical overview of a health problem followed by a discussion of the racial, ethnic, social, cultural, economic, and contextual aspects of the problem. Information

was well received about health disparities, what is known about their etiology, opportunities for advocacy, and strategies for reducing health disparities. Revisions of the course are in process. The course was educationally valuable for me as a teacher and has served to further clarify my notions about "developmentally appropriate multicultural education." Over the next several months leading up to next year's annual meeting, I look

forward to learning more about the multicultural educational activities of ABSAME members. Please e-mail me at Alicia_Monroe@brown.edu if you are interested in sharing thoughts and ideas.

Reference

1. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care for Poor and Underserved*. 1998; 9(2): 117-125. ■

"Students' reflective responses and course evaluations suggest that students appreciated the 'big picture' focus"

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Voice of a Prophet

sinated, for many people, today's events will be an organizer of memories. And naturally, emotions accompany the memories. Second, we, this country's collective, were passive recipients of a cowardly act of terrorism, that is, victims. If we

are to leave crippling victimhood behind, individually and collectively, we must transform our passivity into activity. Working "together as a country as never happened before," seems quite appropriate. ■

Beyond Competence: Altruism, Advocacy, and Public Health

Report on the 31st Annual ABSAME Meeting

Kenneth E. Wolf, Ph.D.

The horrific events of September 11, 2001 were foremost in our thoughts and conversations when the 31st annual ABSAME meeting — October 13-16, 2001— was convened at the Sea Crest Oceanfront Resort & Conference Center in North Falmouth, on Cape Cod Massachusetts. Sixty-eight members, new members, and guests participated in **Beyond Competence: Altruism, Advocacy, and Public Health**, in part to honor those who were affected by the tragic events, and also in an effort to move forward. Once again, a combination of plenary sessions, workshops, interactive seminars, common interest breakfasts, and poster sessions provided a diverse format to maximize learning and collegial interaction. This year we also saw the addition of Brief Paper Presentation sessions.

The conference opened on Saturday after-

noon with the first plenary by Terrance G. Cooper, Ph.D., Louise Arnold, Ph.D. and M. Brownell Anderson asking the fundamental question, “Professionalism – What Is It and Why Does It Matter?” This was followed by an afternoon of seminars and workshops. The day was ended with our traditional ABSAME Dinner (New England style), highlighted by a stimulating and entertain-



ing address from Michael Stein, M.D., “Why Doctors Write.” Dr. Stein, the author of three novels, an Associate Professor of Medicine and active researcher, shared his personal views and experiences as an accomplished writer and academic physician to the delight of all who attended.

Sunday morning saw the return of the Breakfast Plenary, featuring a wonderful presentation from Leah Dickstein, M.D., “The Health Awareness Programs: A Prescription for Living Better.” This early morning, yet well attended session made us grateful that Dr. Dickstein decided to follow her initial career as schoolteacher with a distinguished career in medicine and medical education. (And I am sure that following her presentation, several of us are drinking less coffee and more orange juice, as well as savoring the rewards of dark chocolate.) In the next plenary session DeWitt Baldwin, Jr., M.D. reminded us of where and why the issues of professionalism in medicine had emerged in his excellent presentation, “Professionalism, Humanism and Moral-

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ity: What Do They Have to Do With Medicine?" In the second half of the session, Beverley Rowley, Ph.D., discussed the "Professionalism, Ethics and Conflict of Interest." These were followed by a lively interactive discussion. Concurrent seminars filled the balance of the morning. The afternoon started with a successful Poster Lunch, which gave poster presenters access to all conference participants.

A special session organized by Dr. Julia Frank was held in the afternoon, "Responding To The National Tragedy: What Do We As Educators Have To Offer?" The session was well attended, with many sharing their experiences, reactions and feelings, both personally and as educators, following the terrorist attacks on September 11, 2001.

Monday morning brought the return of the popular Common Interest Breakfasts followed by the last in the series of superb plenary sessions. Lynn Eckhert, M.D., Dr.P.H., addressed cultural competence as a public safety issue in her session, "Culturally Appropriate Health Care" and reviewed what has, and is being done, by our professional organizations to address this critical issue. She specifically mentioned the excellent work that has been presented at this and previous ABSAME meetings. The remainder of the day offered a variety of concurrent sessions, interrupted only by a lunch business meeting. Alicia Monroe, M.D., President, called for increased volunteerism, and specifically invited all new members of ABSAME to get involved. The schedule for Tuesday was compressed, with sessions being moved earlier so that attendees could leave with enough time to comply with newly required airport security measures.

One other new activity occurred throughout the meeting. Mark Vogel prepared an ABSAME Exhibit, providing a wonderful, professional stand-alone presentation of what ABSAME is and how to join. The exhibit travels easily and will be used at the AAMC meeting later in the Fall. This meeting also served as the venue for the debut of the new-look of our journal, *Annals of Behavioral Science and Medical Education*. But, do not let the attractiveness of the journal's exterior fool you; the quality is still first rate!

Cape Cod again proved to be a great environment for a stimulating and educational conference. And in spite of the somber mood of the times, professional medical educators committed to the behavioral sciences came together in numbers similar to previous meetings to share ideas and experiences with new and familiar colleagues. The collegiality, camaraderie, and friendship always found at ABSAME proved once more to be undeniable and unstoppable. I pray that we see each other under better circumstances next year in Squaw Valley, California. ■



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Innovations in Medical Education

Innovations at Drew

Shobita Rajagopalan, M.D.

Editor's Note

As we reported in the Business Meeting at the Annual ABSAME Meeting, this new section of the *Member Report*, Shobita Rajagopalan's idea, is a forum for the exploration of curricular innovations in medical education. As such this is the place for letting our creative pedagogic juices flow while positioning ourselves to get valuable comments and opinions from the ABSAME community. Send your creative Work-in-Progress to me as an e-mail message (jolen2000@aol.com). Fittingly, Shobita is the first to contribute. Enjoy.

Association for the Behavioral Sciences and Medical Education

Until the year 2000, the UCLA and Drew-UCLA Medical Education programs followed the conventional medical school curricular pattern. Reform has since been instituted, which emphasizes small-group faculty-student interaction, mentorship, educational activities across class lines, problem and evidence based learning and multidisciplinary training, and medical informatics. The unique clinical curriculum at Drew consists of a third year Core Clerkship Phase and a fourth year College Phase. A Primary Care longitudinal clinical experience and a mandatory research project are integrated into the core clerkship phase and college phase respectively. The college phase at Drew has been appropriately entitled the Urban and Underserved College, reflecting the University's mission. The fourth year required Primary Care research project is a novel curricular initiative characteristic of the Drew program. Students initiate and develop creative primary care research projects, which include the human rights approval process, with close faculty mentorship and guidance. An innovative thesis initiative that requires individual students to present an abstract at a scientific forum and eventually provide a directed scholarly publication has recently been approved. ■

Shobita Rajagopalan is Assistant Dean for Medical Student Curricula and Chair of the Educational Policy and Curriculum Committee at Charles R. Drew University of Medicine and Science, King-Drew Medical Center, Los Angeles, CA

Annals Plans Fall 2002 Issue

Jim Campbell, Ph.D.

Memories of the Cape Cod and the 2001 ABSAME meeting are starting to fade, but as a participant at this event (or those interested in the issues presented) we invite you to rekindle these memories and solicit your submission of a paper for publication.

The peer reviewed *Annals of Behavioral Sciences and Medical Education*, is now planning its Fall 2002 issue and we are looking for your contribution to this endeavor. If you presented at the last meeting, we would appreciate the submission of a written version of your presentation. If you did not present, but have a paper that you would like to be considered, please consider sending it for review.

The *Annals* is a peer-reviewed journal, so we cannot guarantee acceptance, but we can guarantee an enthusiastic reading with honest feedback. Manuscripts should conform to the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals," (N Eng J Med, 1991; 324-8) and information for submissions to the *Annals* is available online at www.absame.org.

A submission deadline for this issue is **March 1, 2002**. If you have questions or ideas, please contact Dr. Campbell, the editor, at CampbellJ@health.missouri.edu. We hope that you will accept this invitation to make a contribution to this next issue of the *Annals*. ■

ABSAME Info & News

ABSAME Textbook Behavioral Sciences in Medicine

It is a pleasure to report that O.J. Sahler and Jack Carr have signed a contract on behalf of ABSAME with Hogrefe and Huber, Publishing Co. of Gottingen, Germany to produce our long-awaited behavioral sciences textbook.

The goal of the textbook is to serve as an authoritative reference for medical students, residents, and other healthcare trainees regarding the contribution of basic behavioral principles and research findings to human behavior as it affects health and illness.

To this end, the many contributors to the text are currently updating the manuscript to meet the following objectives:

- (1) Provide accurate, current, substantive information in a succinct but readable format
- (2) Engage the reader by highlighting and clearly defining key ideas and terms
- (3) Provide clinical correlations that promote understanding and aid recall
- (4) Test knowledge and understanding through questions that guide study
- (5) Provide direction for further reading and study.

The text will be 300-400 pages in length. This will include a glossary, end-of-chapter study questions, and a 200-300 question USMLE-type practice exam on the behavioral sciences.

The instructor's guide, a unique feature of this project designed to provide suggestions for active learning experiences, will appear on-line at the ABSAME site. The guide will be interactive, allowing instructors to both download information and add their own suggestions for activities and resources.

The text is scheduled for publication during the second quarter of 2003. This should allow fall course directors time to review the work for possible adoption immediately after it comes to market. The cost to students will be approximately \$30.00.

JCAHO and Graduate Medical Education

On Aug. 6, the Joint Commission on Accreditation of Healthcare Organizations posted on its Web site revised standards related to resident supervision. Developed in consultation with the Accreditation Council on Graduate Medical Education, the new standards make a hospital's medical staff responsible for the supervision of residents delivering care to their patients. They also add graduate medical education (GME) as an explicit responsibility of a hospital's governing body, requiring periodic communication between that body and the hospital's GME committee. The new standards go into effect Jan. 1, 2002, and can be viewed at http://www.jcaho.org/trkhco_frm.html. Click on "Standards" and then "Standards Revisions for 2002."

New Members

ABSAME welcomes the following new members who have joined the Association in the past six months (including those from the annual meeting).

Jill Carty Psy.D., Flint, MI
Rebecca Daniel M.D., Marquette, MI
Bezalel Dantz MD, Chicago, IL
Theresa Drewniak Ph.D., Flint, MI
Carol Elam Ed.D., Lexington, KY
Alyce A. Getler Psy.D., Boston, MA
James Graham M.D., Little Rock, AR
Larry Gruppen Ph.D., Ann Arbor, MI
Karl Johnson M.D., Los Angeles, CA
Ruth Margalit M.D., Baltimore, MD
Rene J. McGovern Ph.D., Kirksville, MO
Linda H. Pololi M.D., Greenville, NC
Michael Rainey, Stony Brook, NY
Shobita Rajagopalan M.D., Los Angeles, CA
Virginia Reed PhD, Hanover, NH
Edwin S. Rogers Ph. D., Knoxville, TN
Seema Singh M.D., Rochester, NY
Kimberly N. Sutton Ph.D., Atlanta, GA
Tricia Tang Ph.D., Ann Arbor, MI
Nancy Testerman MS, Loma Linda, CA
Christine Wade, New York, NY
Casey White B.A., Ann Arbor, MI

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ABSAME Annual Meeting 2002

Charlotte Kennedy

The theme for the 2002 ABSAME Annual Meeting is "Reducing Health Disparities: What Is The Role Of Medical Education? Ethnic, gender, and socioeconomic disparities exist in health status in the U.S. These disparities have been attributed to differences in health behaviors and biologic predisposition, as well as differences in health care system access, diagnosis, and treatment.

While understanding of the biologic and psychosocial bases of disease and illness has increased in recent decades, much less discussion has centered on sociocultural factors as determinants of illness. The challenge of preparing medical students to treat an increasingly diverse patient population demands a focus on the influence of cultural and sociocultural factors on health.

The conference goals are to examine methods for integrating knowledge on sociocultural factors and health disparities in medical education; highlight educational methods for integrating epidemiologic data on ethnic, gender, and socioeconomic disparities in health status; and to highlight related knowledge concerning sociocultural influences on health in the following areas:

- Health Behaviors (eating, activity level, substance abuse, violence)
- Health Conditions (illnesses, such as Type II Diabetes, Cancer, HIV-AIDS)
- Health Care System Factors (access, diagnosis, treatment).

Presentations will focus on the contribution of sociocultural factors to illness but also to optimum health, as well as on current information and trends from multiple specialties and disciplines within the medical school setting.

Reducing Health Disparities: What Is The Role Of Medical Education?.

October 10 - 13, 2002
Resort at Squaw Creek
Squaw Valley USA, Lake Tahoe, CA



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Joao Nunes, M.D.

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48439-8066
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