

11. The elusive content of the medical school curriculum: a method to the madness. D'Eon M, Crawford R. *Medical Teacher* 2005; 27:699-703
-how do we cope with the information explosion? how do we decide what to include in our curriculum in the spirit of economy of time and information? The authors propose a model for determining curriculum content which includes input from a wide variety of stakeholders including the general public. Interestingly, they state that they “found no evidence in the literature that the general public was consulted on the specific details of the content for undergraduate medical education”. A good read for anyone wanting to understand the principle challenges we face in reviewing and assessing our curriculum.
12. Spirituality and Health Care Education in Family Medicine Residency Programs. King DE, Crisp J. *Family Medicine* 2005; 37:399-403
-we often struggle with the challenge of where and how to include curriculum content related to spirituality in health care. The authors state that increasing interest in spirituality has begun to affect medical education and this paper is basically a review of spirituality as it occurs in 138 family medicine residency programs. Spirituality as a curriculum component is essentially present in all family residency programs. Certainly this may imply a challenge to us to first define spirituality as it pertains to chiropractic care and then determine where and how to integrate this into our curriculum.
13. How we developed a core curriculum in clinical skills. Syme-Grant J *et al.* *Medical Teacher* 2005; 27:103-106
-I think that this is a very useful little paper, showing the procedure followed by one medical school to determine a core curriculum in clinical skills. It underscores the principle that the determination of curriculum content is not to be taken lightly (as it often is, unfortunately). The creation of a Clinical Skills Program included four stages which are applicable to our own course review process here at Northwestern. One of the features that I like is the fact that assessment of the program is built right into the planning process (as opposed to a later add-on). All course managers or designers should review this one.
14. Computer Animation and Improved Student Comprehension of Basic Science Concepts. Thatcher JD. *JAOA* 2006; 106:9-14
-literally the first paper published in JAOA in 2006, this article not only describes the role and importance of enriched presentation of material (in this case, computer-assisted instruction, or CAI), but, and this is the important part, it also includes an assessment of the role of CAI in the learning process. It's a great example of “project-based assessment” which I discussed at the recent Brown-Bag Seminar. By the way, the results demonstrated that “CAI can be an effective tool for relating basic science to medical students by improving comprehension and eliciting interest in the lessons.”
15. Educating for Professionalism: Creating a Culture of Humanism in Medical Education. Wear D, Bickel J. University of Iowa Press, Iowa City, 2000

(this item is a selection of pages from a 200 page textbook)

-This selection is from a textbook on the philosophy of medical education. I have chosen pages 60-69 and 124-127 for this reading. The authors discuss the evolution of a culture of humanism in medicine and medical education. They feel that there is a trend towards greater degrees of humanism in medical graduates and they offer ideas to explain this trend (such as the increasing percentage of female medical students, and the introduction of medical humanities courses). They suggest that “medical education stands at the doorstep of profound change”, and cite the same societal forces that concern chiropractors, such as managed care. Bottom line: “doctoring”, that old-fashioned concept of the humane “Marcus Welby”-style of medicine is coming back into fashion and medicine, aware of the trends, is trying to understand what this means to medical education. For example, suggestions are made for redesigning the pre-clinical curriculum in medical schools “to include socially relevant *doing* as well as *studying*”. A good read to get a handle on an important medical trend and to think about what it means for our program, and for chiropractic in general.

16. Cost-effective Osteopathic Manipulative Medicine: A literature review of cost-effectiveness analyses for osteopathic manipulative treatment. Gamber R *et al.* JAOA 2005; 105:357-360

-sooner or later, the “powers that be” have got to catch on to the fact that study after study after study demonstrate the cost-effectiveness of manipulative therapies, whether delivered by DCs or DOs (hopefully in our lifetime). Here’s *another* review of studies (19, in this case) supporting the fact that manipulative care has economic benefits ranging from less time lost from work to fewer days in hospital. It’s a great review of the osteopathic perspective on the value of “OMT” (osteopathic manipulative treatment). As an example, check out the paper by Radjieski (in 2000) who studied the role of OMT in patients hospitalized for pancreatitis. Their conclusion: “length of hospital stay is *significantly* shorter in the OMT group than in the study group receiving standard care”. Hello...is anybody listening?

17. Climate studies: can students’ perceptions of the ideal educational environment be of use for institutional planning and resource utilization? Till H. Medical Teacher 2005; 27:332-337

-another example of project-based assessment, this time by Hettie Till from CMCC. It’s based on the data obtained by a 50-item questionnaire called DREEM (Dundee Ready Educational Environment Measure). This simple-to-administer instrument collects data in 5 domains, such as “students’ perceptions of learning” and “students’ perception of atmosphere”. There have been many studies published using the DREEM instrument and comparative data from institutions around the world are now available. It’s something I’d like to implement in the near future here at NWHSU.

18. From best evidence to best practice: effective implementation of change in patients’ care. Grol R, Grimshaw J. Lancet 2003; 362-1225-1230

-a good read if you think that “Best Practices” and “Evidence-based Care” is only a chiropractic concern. The medical profession is struggling with these issues, too. The challenge is to *apply* the findings of EBC to the practice of medicine (or chiropractic). The authors describe some of the barriers to this process and they aren’t all related to the care-giving practitioner. These barriers include the political environment, leadership, patient care organizations, and even patients themselves. This paper may help you put our own Best Practices initiative in perspective and give you a fuller appreciation of the task ahead.

19. The role of basic sciences in a problem-based learning clinical curriculum. O’Neill PA. *Med Education* 2000; 34:608-613 (Abstract only)

-I know that this is an older paper (6 years old) but it is a good example of the importance of integration of basic and clinical science in medical education. This study (another good example of project-based assessment), investigated the presence of basic science objectives in third year clinical modules (in other words, if it were our program, the presence of basic science objectives in courses from T7-10). Their findings suggested that students are still capable of increasing their basic science knowledge at this level and that this is facilitated by having basic science content in their clinical courses. An interesting idea for educational research in our DCP (anyone interested in doing it?).

20. Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine. Benzing J. *Patient Education and Counseling* 2000; 39:17-25

-again, an older paper, but forgive me because this is a classic. This provides an excellent review of the history, structure and function of the two paradigms of medical care: evidence-based and patient-centered. Essentially these “separate worlds” may be thought to represent the art and science of chiropractic. “Bridging the gap” is suggested as an essential step in providing complete medical care. To give you a flavor of the content, read this quoted paragraph:

“Thus, we have got the paradox that evidence-based medicine is extremely important, since it offers patients only high quality care and protects them from all kinds of unhelpful and unnecessary medical interventions, while at the same time it could become a threat to patient-centered medicine, when patients’ own opinions are bypassed or even frustrated. Yet, without patient-centeredness, medicine can lose its humane face and leave the patient alone amidst the medical technology, paper guidelines and statistical figures”

Sound familiar? It’s the same issue that the CCGPP is grappling with, and incidentally, a reason why the “Pyradigm” model (by Tom Milus, DC) is a valuable structural metaphor that links the art, science and philosophy of chiropractic to best practices. This reference is very highly recommended to all faculty.