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<p>G-1</p>	<p><b>SUSTAINABLE DEVELOPMENT IN MEDICAL CURRICULUM FOR SUSTAINABLE HEALTH</b>  <i>Lakshiram Murmu, M.B.B.S, M.S., L.L.B., L.L.M., Department of Emergency Services, All-India Institute of Medical Sciences, New Delhi 110029, INDIA</i></p> <p>The Rio Declaration, which introduced the concept of sustainable development (development which meets the needs of the present without compromising the ability of future generation to meet their own needs), has affirmed in its' very first principle that human beings are entitled to a healthy life. From developmental perspective health is a matter of concern for every sector in society and not just the "health sector". Hence, health sector has an advocacy role to play when future policies are developed and actions planned. In fact Agenda 21 of sustainable development, presents a golden opportunity for health professionals to increase their influence on national planning to reverse the trend of health threatening development, and lead the way towards sustainable development. This assumes significance because process of globalization has increased conflict between the economic imperatives of development and the health and environment protection needs of people. So much so that some nations or communities can be said to live in the "worst of both worlds". (hazards of modern development and poverty) Thus making 21<sup>st</sup> century health sector problems more complex and multidisciplinary in nature. The patient centric medical curriculum with emphasis on biology over ecology is not apt to adequately deal with assessment and management of local and global health risks. These new challenges demand reform and reorientation in the medical curriculum to incorporate the idea of sustainable future. There is a need for an integrated framework of biological and ecological paradigm, which is people partnership oriented and proactive rather than reactive. The medical curriculum, therefore, must integrate the objectives, concepts and learning experiences of education for a sustainable future. This will help to comprehend the public health implications of global trade, overconsumption, pollution, biotechnology, and climate change. However, this can't be achieved by adding sustainable health as a new subject in the medical curriculum. Rather, it is the dimension of sustainable development to be emphasized in every aspect of medical education. The nature, scope and purpose of teaching about sustainability is to encourage a meeting of disciplines and emphasize creative thinking, problem solving, co-operative learning and community participation locally and globally, and in turn to open up new horizon for justice and equity in health.</p>
<p>G-2</p>	<p><b>ACADEMIC SUPPORT FOR BASIC SCIENCE COURSES: THE COGNITIVE SKILLS PROGRAM</b>  <i>Norma S. Saks, Ed.D., Office of Education, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, Piscataway, NJ 08854-5635 U.S.A.</i></p> <p>Medical schools have an immediate interest in fostering student academic success to facilitate timely progression through basic science courses, and over the long term, to increase graduation rates. Equally important is the goal to promote skills needed for self-directed lifelong learning. Medical students have been highly successful in academic pursuits prior to medical school. However, medical school requires the assimilation of large amounts of information, often presented at a rapid pace. The need to reach out for academic support is not always apparent to these previously successful students, and many medical students feel uncomfortable asking for assistance. For over 20 years, the Cognitive Skills Program (CSP), a comprehensive program of academic support, has been available to students at Robert Wood Johnson Medical School. CSP services and the concept of academic support are introduced during the first year orientation program, and basic science course directors include information about academic support in course materials. Students are encouraged to schedule appointments for individual consultation with CSP faculty to discuss study and test taking strategies, and time management issues. CSP faculty have expertise in principles of learning and memory, and are also familiar with course content, course materials, and proficiency demands. CSP support for first year students also includes small group content review sessions, and individual tutoring; second year students have access to individual tutoring. More than half of first and second year students access CSP services, and student satisfaction surveys have been consistently positive. It is believed that the strong achievement of our students, both in courses and on the USMLE Step 1, attests to the success of the basic science curriculum and of the CSP.</p>

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G-3	<p><b>COLLEGE-BASED MEDICAL EDUCATION AT THE UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE</b> <i>Craig S. Scott, Ph.D.*</i>, <i>Tserendulam Dashsuren, M.D., MSc.</i>, <i>Department of Medical Education and Biomedical Informatics, University of Washington School of Medicine, Seattle, WA 98195 U.S.A.</i></p> <p>The University of Washington School of Medicine (UWSOM) has successfully begun implementation of the first two years of its recently adopted, highly innovative College-Based Medical Education (CBME) for enhancing clinical information gathering, professionalism and clinical reasoning skills. The current academic year will witness the school's first class to complete the CBMEs second year. The cornerstone of the CBME is a groundbreaking new college structure that seamlessly and permanently joins a highly select group college faculty with manageably sized groups of students. The new UWSOM college structure consists of five colleges, each with six faculty, one of whom serves as the head of the college. The new college faculty serve not only as mentors, but they are actively involved in the educational process including teaching the entire second year. This structure provides the school with an invaluable core group of clinical faculty who will oversee student's clinical skills and professional development, in permanent one-on-one clinical transition and professionalism skill development/teaching relationships.</p> <p>As a result of this series of UWSOM enhancements, clearly communicated expectations are now in place for Yrs I and II, fully developed by the college faculty, which describe what they should teach and how they should evaluate students' performance. Performance benchmarks for the clinical transition and for professionalism are nearing completion for Yrs III and IV. The benchmarks describe what students should be learning, the level to which they will be held accountable in the Objectively Structured Clinical Examinations (OSCEs) are and how they will be expected to demonstrate competence on two new high stakes OSCEs; one at the end of Yr II which must be passed satisfactorily prior to beginning clinical rotations, and a second at the beginning of the senior year which must be completed satisfactorily prior graduation. The expectation is that at each phase in the CBME Curriculum, clinical skills benchmarks must be mastered before students proceed to the next phase.</p>
G-4	<p><b>CHANGES IN STUDENTS' EMOTIONAL STATES DURING LEARNING AFTER THEIR FIRST SEMESTER IN MEDICAL SCHOOL</b> <i>John L. Szarek, Ph.D.*</i> and <i>Sarah McCarty, M.D.</i>, <i>Department of Pharmacology, Ross University School of Medicine, Dominica, WI, and Department of Internal Medicine, Joan C. Edwards School of Medicine at Marshall University, Huntington, WV 25701 U.S.A.</i></p> <p>The purpose of our study was to determine whether changes occurred in students' emotions during learning in a traditional curriculum after their first semester of medical school and to examine possible reasons for the changes. Students completed the Emotional States Assessment Technique (Szarek et al, 2002 and Walker, 2001) three weeks after the start of their first semester (n = 46) and again on the last day of the semester (n = 39). The Technique assesses the percentage of time students experienced emotions associated with anxiety, enthusiasm, dejection, and contentment and the specific events in their learning that caused their emotion(s). Frequency counts of the emotions were made and expressed as a percentage of the total number of comments; the specific events reported by the students were coded using themes identified in their comments and expressed as a percentage of the total number of comments. There were no changes in the percentages of time that students reported experiencing emotions associated with anxiety, enthusiasm, dejection, and contentment. However, there were differences observed within each category with respect to specific emotions and the events that caused the emotions. Although there were no major changes in the frequency count of emotions associated with anxiety, there was an increase in the number of student experiences related to performance in medical school (75% at end of semester vs. 52% at the start of the semester) as a cause of their anxiety. Pertaining to emotions related to enthusiasm, students reported being less excited at the end of the semester (20% vs. 31%) which was accompanied by a shift in experiences from excitement of the new environment and achieving a life-long goal (7% vs. 20%) to passing tests (38% vs. 8%). Students reported being more dejected (15% vs. 9%) and apathetic (23% vs. 9%) at the end of the semester which was related to an increase in reporting of experiences related to poor performance on examinations (35% vs. 15%). There were no changes in emotions or experiences related to contentment. We conclude that the shift in students' emotions during learning over their first semester in medical school was related to examinations and their performance on them. Using these data we can consider changes in the curriculum which will enhance the students' enthusiasm for learning independent of examinations.</p>

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G-5	<p><b>THE BASIC SCIENCE CONSERVATORY: REAL AND VIRTUAL</b> <i>Esther Maria Corrigan, M.D., M.Ed.* and Gilbert Edward Corrigan, M.S., M.D., Ph.D., St. Johns Medical Center of Detroit, Michigan and the American University of the Caribbean School of Medicine</i></p> <p>The past century has seen the identification, definition, maturation, and employment of great intellectual domains in the medical sciences. Each of these disciplines - known as the basic medical sciences - has had a significant period of initiation, development, and maturation of the both the intellectual boundaries of the discipline and of the procedural scientific techniques unique to the discipline. The amount of data, instrumentation, and intellectual properties of each of the disciplines has reached a point of autonomy - with each discipline providing a complete microcosm of human inventiveness allowing for singular identification.</p> <p>Each discipline is able now to provide an intellectual center of activity in its defined domain. A conservatory will include a library, museum, photographic gallery with a self defined hall of fame, an information center for members, an informative section for those considering a career in the topic area (scholarship center), a room of assembly with support of committee activities, teaching areas for continuing education and technical instruction, worker safety surveillance records, and business related functions (think tank and press).</p> <p>The conservatory is necessary as the employers of the basic sciences vary in their support and shuffle disciplinary boundaries leading to discontinuities and uncertainties. This is coupled with declining library capacities and a loss of interest in archival activities in all of academia. The increased demands for updated professional credentialing adds to the need for these learned centers. A virtual conservatory with locked access is very available enterprise on the internet; it may be less demanding of resources and more responsive than the real one. Real and virtual conservatories are present marginally in some medical disciplines; no strong basic science sponsorship is present.</p>
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