Wood Named Dean of COM

Douglas L. Wood, associate dean of COM, will serve as the new dean of the college starting July 1. Wood will replace Myron S. Magen, the college's only dean since its founding in 1969. Magen, who will retire as dean in July, will join the COM Department of Community Health Science where he will continue his leading efforts in health policy analysis.

A national expert on kidney function, Wood said that stepping into the dean's position will bring new challenges. Among them are maintaining the college's record of training excellent primary care physicians and continuing the leading COM legacy to provide outstanding opportunities for women and minorities.

"Dr. Wood is an outstanding physician educator," said Harvey V. Sparks, MSU vice provost for human health programs. "I'm confident he will lead the College of Osteopathic Medicine to a new level in the education of primary care physicians."

Sparks added that Wood brings his vision for a strong, positive future for the college at a time when medical education, health care and medical research are all changing rapidly. David K. Scott, provost for the university, commented that Wood's appointment, combined with recent appointments of deans for the Colleges of Nursing and Human Medicine, brings together an impressive management team.

Each brings a vision, a track record and a spirit of cooperation and teamwork that I am confident will create a new era in the dynamically evolving arena of human health in our society," Scott said. "They build upon the pioneering efforts of their predecessors in creating a distinctive model at Michigan State."

The COM dean's search committee named Wood to the position after reviewing a nationwide pool of qualified candidates. The MSU Board of Trustees approved the appointment at its meeting April 5.

Magen Appointed to National Health Education Reform Panel

MSU-COM Dean Myron S. Magen will serve as a national representative of the views and goals of the osteopathic profession as a newly-appointed member of the prestigious Pew Health Professions Commission.

The Commission, the first of its kind, engages representatives from the spectrum of health professions in a public dialogue on the future of the U.S. health care system. Through communication and action, the Commission will assist the nation's health professional schools and colleges to understand the changing nature of health care and the role that they have in its reform and in creating a vision of its future.

Magen brings to the discussion his extensive and diversified perspective as an osteopathic physician, a pediatrician, an educator and an administrator.

"This is an exceedingly important initiative," said Magen, who joins MSU President John A. DiBaglio on the commission. "It's imperative that we find ways to streamline health education to make it more responsive to the needs of society."

"It's important that we launch this effort now because we are not meeting the public's needs at this time," he added.

The Commission will complete the first of its five objectives, establishing an Agenda for Action, by the end of April. Under discussion are 18 ambitious reform recommendations that include a redefinition of the core science curriculum; a reorientation of the teacher-learning process; a shift in the patient-care-training setting; a dissolution of the boundaries among health professions; a redirection of faculty incentives; the creation of new governance and organizational arrangements; and a change in the orientation of the health professions from illness to health.

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Plotting the Future Course of Medical Education
By Douglas L. Wood, D.O.

American medicine has experienced a continuous evolution throughout this century. However, the most dynamic changes to the medical field, and indeed to the medical education system that supports it, have occurred in recent decades.

While some of these changes have brought progress to the field of medicine, others have mounted new and difficult challenges that must be faced in the coming years. These changes, both good and bad, bring medical education to a juncture, an intersection. Past actions must be evaluated and new directions must be chosen.

Where Have We Been?
As medical schools have evolved over the past 20 to 30 years, we have seen the emergence of two basic types of institutions: those which train their students primarily in large, university-owned tertiary care facilities and those which train their students in various community hospitals. Within these institutions, four types of curriculum have evolved in North American medical schools to educate preclinical students.

The first is the disciplinary pattern, taken in 56 percent of schools, which uses the classic two-plus-two approach, namely, two years of preclinical instruction and two years of clinical instruction. Twenty-five percent of schools use the second approach, called the "disciplinary with a core course" approach, where major interdiscipliary courses are used to provide correlations between basic science concepts and principles and the manifestations of disease. A third instruction pattern, employed in nine percent of schools, uses the systems approach with a curriculum organized around body organ systems. The final approach to medical education instruction used in only a few select schools is the problem-based approach.

Each of these approaches is efficacious to some degree. Each has also made evident some of the problems in medical education that will require revision and change. For example:

- **Information overload:** Medical knowledge has increased exponentially over the past few years. It is estimated that by the year 2000, the half-life of medical information will be two years. The amount of information which a medical student can consume in a four-year period is limited. We are obligated, therefore, to carefully select that information which is essential in an attempt to reduce the volume to a manageable and digestible level.

- **Problem-solving abilities:** The essence of medical practice can be distilled to problem-solving. Patients present with problems and physicians are expected to facilitate solutions. Medical educators are regularly criticized for the lack of problem-solving ability seen in medical students. This accusation deserves astute investigation by the medical education community.

- **Thinking abilities of medical students:** Contemporary medical education is generally viewed as a process wherein rote memorization occupies the majority of the student's efforts to the detriment of thinking and problem-solving.

"Osteopathic physicians and medical educators must vigorously address the issues of our place in medical education and the practice of medicine."

Medical education is under attack for not developing and encouraging thinking in its medical students. Certainly, memorization of factual matter is important since thinking requires reflection and memory. Students must be encouraged to reflect upon medical problems rather than simply function as facts-in-facts-out machinery.

- **Training versus education:** It has been said that an overwhelming majority of medical schools within this country bear a striking resemblance to trade schools in that students are trained rather than educated. Students are merely fed facts rather than challenged with questions. Because few patients present as containers full of facts but, rather as challenging medical questions, physicians must be able to effectively approach these questions.

- **Not a continuum:** The path from undergraduate education through specialty training can hardly be viewed as an educational continuum. Rather, it is segmented to a significant degree with most of the segments having little connection to the elements which precede or follow. Even to the educationally uninhibited person, this lack of a continuum would not appear to be the most prudent design for a medical education curriculum.

Some medical educators contend that changes in medical education will not address these issues. To a minor degree these educators may be correct. However, I, for one, believe that major reform is needed in medical education and that these alterations can and will address the majority of the issues.

The goal of medical education reform will be to create a system that will graduate more effective and efficient physicians who project compassion by being fully aware of the psychosocial dimensions of a patient's illness. These physicians will be trained in an ambulatory environment. They will not substitute the most modern technological diagnostic device for thinking and problem-solving.

How Do We Get There From Here?
Producing physicians with these qualities will require changes in the structure of medical education.

Deciding the most effective way to change the system continues to be a matter of careful and extensive consideration. The following is my own practical approach to medical education reform.

- **Medical school admission requirements** must be carefully analyzed to determine their relevance to medical education and also the future practice of medicine. Students admitted should have an adequate foundation in the social and behavioral sciences. It is probable that some select students could be admitted with fewer than 90 undergraduate credits.

- **Once in medical school, the student must not be deluged with factual matter.** This basic premise must be addressed throughout the curriculum. Students must be encouraged to think and to solve problems rather than becoming large memory devices. Computer data banks can better serve this purpose. Use of small group instruction and computer-assisted instruction will assist in addressing this issue.

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• Medical education must be a continu-
  uum. If this is to happen, a very close-
  bonding must exist between medical
  school and clinical training facilities.

• Material presented in the preclinical
  years must represent modern thinking
  in these areas. The traditional bound-
  aries in the "basic sciences" are break-
  ing down and new interdisciplinary
  alliances are being formed. At
  Michigan State University, the neuro-
  science and molecular biology areas
  are excellent examples of this phe-
  nomenon.

• A more integrated preclinical curricu-
  lum will facilitate the coupling of the
  preclinical and the clinical years. Like
  the preclinical area, the clinical years
  will become more integrated. The
  merging of family medicine, general
  internal medicine, and general pedi-
  atrics into a primary medicine depart-
  ment needs to be considered. This
  combination will benefit
  students by providing them with an
  opportunity to serve clinical clerkships
  where a comprehensive approach to
  medical care is taken.

Osteopathic physicians and medical
educators must vigorously address the
issues of our place in medical education
and the practice of medicine. Questions
concerning the future of the osteopathic
profession and therefore, osteopathic medi-
cal education, are of utmost concern to the
majority of us within the profession. We
continue to have a unique and important
perspective that is needed in today's medi-
cal field. The areas of osteopathic holism,
the spectrum of manual medicine to
include palpatory diagnosis and manipula-
tive therapy and our belief in health promo-
tion and disease prevention all truly make
us unique. Our practices and beliefs
deserve preservation.

Osteopathic medicine has a strong tradi-
tion in the area of primary care medicine.
It indeed appears to be our niche in the
spectrum of medical practice. A logical
step for the profession appears to be a reori-
entation of both its medical education sys-
tem and its practice system toward the pri-
mary care medicine area.

We have a golden opportunity to lead
medical education and medical practice in
this arena. To succeed, our excellence in
this primary care must become more evi-
dent. The public must become more aware
of the high quality care and services that
the osteopathic profession provides. I feel
strongly that we will attract premiere medi-
cal students and subsequent practitioners
because of our excellence. When we as a
profession, and particularly those of us in
osteopathic medical education, are able
to effectively address the major problems in
medical education, we truly will have
seized this opportunity.

Medical education is at a crossroad. It
can continue, as it has throughout this cen-
tury, and react to changes in medical prac-
tice. Following this path might lead medi-
cal education into another dynamic era,
similar to the one in which medicine exists
today. Or medical education could carve
its own path - it could be proactive and
mold its own future.

The osteopathic profession and oste-
opathic medical education is likewise at a
crossroad. We can continue to "go along
with the crowd" or we can seize the oppor-
tunity and truly become a leader in medical
education. As has been said many times,
the future is up to us. Let us be proactive
and mold our own destiny.

Douglas L. Wood, D.O.

Born: Muskegon, Michigan

Education:
B.S. in Zoology from
University of Michigan
D.O. from Kansas City College of
Osteopathic Medicine, Kansas City, Missouri
Internal Medicine Residency at
Mount Clemens General Hospital
Nephrology Fellow at
Henry Ford Hospital
Ph.D. in Medical Education in the
area of Educational Evaluation and
Research, Wayne State University

Professional Career Highlights:

Wood joined MSU-COM in 1972
as an associate clinical professor. He
was named associate dean of the
college and full professor in 1987.

Wood has served as director of
medical education and medical
affairs at Mount Clemens General
Hospital. He also chaired the hospi-
tal's Division of Cardio-
Pulmonary Medicine and
Respiratory Therapy for nearly a
decade. During that time, Wood
was also director of the hospital's
hemodialysis unit, the internal
medicine training program, contin-
uing ambulatory peritoneal dialy-
sis unit and the comprehensive
health educational systems.

Wood is a Fellow of the American
College of Osteopathic Internists.
He is a recipient of the
"Outstanding Educator" award from
the College of Osteopathic
Medicine and Surgery, Des
Moines, Iowa. Wood has also
been honored by the Michigan
Kidney Foundation as
"Outstanding Nephrologist" and
by the Michigan Senate for his
contributions to the diagnosis and
treatment of citizens with kidney
disease.

He is certified in internal medicine
and in nephrology by the
American Osteopathic Board of
Internal Medicine.

Myron S. Magen, D.O.

Magen Appointed
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Magen said he is particularly interested
in these recommendations that shift patient
care training to ambulatory/community-
based settings and those that emphasize a
team approach in training health care
providers. Coming from a profession of
largely primary care providers that are
community-based, Magen said an osteo-
pathic physician he could, perhaps, repre-
sent a different approach to these issues.

"I believe," Magen said, "that by the end
of this decade, [health professionals]
will recognize the important tenets that osteo-
pathic medicine has held throughout its
history. These include the role of primary
care and patient-centered medicine, the
need for health promotion and prevention
of disease and the recognition that medical
care must encompass the whole person —
their social, psychological, environmental
and lifestyle concerns."

Along with carrying out their Agenda for
Action, Magen and the other Commission
members will pursue four other objectives:
- develop appropriate policy recommen-
dations for federal, state, professional and
institutional agencies which will support
the implementation of the agenda; to
communicate the agenda; to provide
resources for institutional change; and to
explore and fund demonstration projects at
health professional schools across the
nation.

The Pew Health Professions Commission
is an outgrowth of Duke University's Future
of the Health Professions project of the Pew
Charitable Trusts. The Trusts, the nation's
second largest philanthropy, support pro-
grams in six broad areas — health and
human services, conservation and the envi-
ronment, culture, education, public policy
and religion.

Dear Communiqué Readers:

Our interest in quickly relaying
information about the announcement
of the new COM dean required us to
issue an abbreviated Communiqué
this month.

Please look next month for our
special issue on MSU efforts in can-
cer research, treatment and preven-
tion. And, of course, look for all our
regular faculty, alumni and student
news features.

Patty Shea, editor
Plan a Grand Summer!

Mark your calendars now for upcoming summer conferences planned at the Grand Traverse Resort Village:


Grand Traverse Resort Village offers the very best in luxurious accommodations and conference facilities. Nestled in the beauty of northern Michigan, it is located six miles north of Traverse City on U.S. 31. Featured are a half mile of prime beach front on East Grand Traverse Bay, two 18-hole championship golf courses, including Jack Nicklaus' "The Bear," an indoor sports complex with five tennis courts, four racquetball courts, an exercise/weight room, tanning booth, indoor and outdoor swimming pools and whirlpools and many other attractions.

Watch for conference brochures sent to you in the months ahead!

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Tutorial on Level I Functional Indirect Techniques

A three day intensive tutorial in the diagnostic and therapeutic application of functional (indirect) technique. This system uses the principles of motion testing for ease and bind, inherent tissue motion, and motion away from the resistant barrier, and is applied to the vertebral axis, rib cage, and extremities. Faculty includes Edward G. Stiles, D.O., F.A.A.O., chairperson, Harriet Shaw, D.O. Previous training in Principles of Manual Medicine, Level I Muscle Energy; Level I Craniosacral Technique; Level I Myofascial Release is recommended but not mandatory. 24 hours Category I credit. Sponsored by MSU College of Osteopathic Medicine and College of Human Medicine. Cost is $600; physicians in training: $300. Includes continental breakfast and lunch, plus course materials.

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Tutorial on Level III Myofascial Release Techniques
May 31-June 2, 1991

Myofascial Release, Level 3 is a three day continuation of levels one and two. Day one reviews previous course materials and develops a series of goals generated by participants based on their clinical experience with all levels of manipulative care. Special emphasis is placed on relationships among functional anatomy, biomechanics, neural events and patients' responses to their disabilities. Using vision and palpation, functionally related myofascial units are assessed statically and dynamically. Combinations of myofascial, functional, craniosacral, muscle energy, unwinding and "craniofascial" release techniques are demonstrated with ample laboratory practice time provided. Faculty includes Robert Ward, D.O., F.A.A.O. chairperson. Prequisite training in Principles of Manual Medicine, Levels I and II Myofascial Release Techniques is required. 24 hours Category I credit. Cost is $600; physicians in training: $300. Includes continental breakfast, lunch, and course materials.