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The Role of the Non—Medical Curriculum Specialist in Working with Geriatricians

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Before describing my role, I think it will be helpful to describe the way I see the job that the Jewish Institute for Geriatric Care is trying to do in developing a new curriculum.

When any group undertakes the development of a new curriculum they are usually inspired by one or more of the following circumstances:

1. They may wish to introduce to their students a new subject matter, or a new way of organizing a subject matter.

2. They may wish to teach their students a new clinical approach.

3. They may wish to establish a new method of teaching their students what may or may not be a new subject matter.

4. They may wish to make a teaching program developed by their institution available to other institutions.

As I see it, JIGC's curriculum project has been inspired by all four circumstances: They wish to convey new information and perspectives in the subject matter of geriatrics and to teach a particular approach that is problem-oriented, whole-person-oriented, rather than disease-oriented. The new subject matter and approach require new teaching methods that develop in the student certain attitudes, self-awareness, and interpersonal skills as well as knowledge and technical skills. Finally, they wish to make the "JIGC educational experience for students" available at many other institutions. In short, JIGC has undertaken a very large job.

Traditionally, attitudes and interaction skills have been passed on by apprenticeship. If, however, you want to reach more students than that number who can have direct contact with you, you have to do something else, and JIGC has chosen to do a curriculum.

What is a curriculum? A curriculum is a specified set of

experiences that we view as educational and design so that they will result in the students having new knowledge, skills, attitudes, awareness, or whatever. Many teachers and institutions develop curriculum for their own students, and this involves specifying in some way that can be referred to from year to year the set of topics, readings, lecturers, guest lecturers, grand rounds, clinical assignments and other experiences that go into a student's education.

A curriculum that will be used beyond one's own institution, by people other than those who have taught and developed it, must consist of a set of experiences that replicate for other students your institution's educational experience. Since major parts of that education are the professionals, resources, and patients with whom a student comes in contact, the trick is to design a set of experiences that will provide a similar education, although the experiences may be quite different.

My role is to help JIGC make the educational experience of their students "exportable". A major task in this role involves helping the project staff to become self—conscious and aware of exactly what the educational experience they provide is.

My role as a non—medical curriculum advisor has had a number of aspects. First, I try to help the JIGC staff define the body of information, attitudes, skills, awareness they wish to teach. What part of it is new or different from what others know or do already? Answering this involves deciding whether the curriculum should be comprehensive-- because if it is not, where can one find the total contents of a geriatric curriculum? -- or selective, conveying only and conveying well that which JIGC has added to the state of the art.

If 5omething is new, in what way is it new? New because it is a process people have not yet learned? Or new because it is a way of combining personnel and/or resources? If the latter, should J1GC teach it? What if other institutions cannot put it into practice? In an indirect way curriculum frequently brings about institutional change. consider, for example, a curriculum in which many learning activities ask a medical student to interact with other health care professionals at his institution, an institution which turns out not to have a "team" approach. The communication fostered by faculty interaction with the students and around implementation of the new curriculum may itself be the beginning of a team approach. Or, as a simpler example, a curriculum which consists of a good deal of worthwhile audiovisual material may persuade an institution that does not

have much audiovisual equipment to acquire some, which in turn can lead to that institution's hiring of an audiovisual staff person, which can lead to an increased use by the institution of audiovisual material for communication and education. This potential for gradual institutional change is why curriculum is sometimes half—jokingly described as a "subversive activity". However, if your curriculum requires too much change to implement, more change than another institution is willing to accommodate, the whole curriculum can get thrown out. So "How much is new?" is an important question in determining the basic contents of what you wish to teach.

A second aspect of my role is helping the JIGC staff to articulate their goals for students in a way that is measurable. How will you know if your students have learned what you want to teach? Describe what you want them to learn in some way so that you can first tell if your curriculum is addressing it, and so that you can later tell if you have succeeded. For example, a goal such as, "to convey information concerning hearing problems in the elderly" would he hard to measure since it is so broad that different teachers would have quite different interpretations of what type of information is important. Goals have to be stated concretely enough so that teachers would agree when they are achieved.

A third aspect of my role has been to help design the set of educational experiences that bring about achievement of the goals. Most medical teaching seems to rely on readings, rounds, lecture, case study discussion, and clinical internship. JIGC is similar to other institutions in their repertoire of educational techniques.

What JIGC adds to the traditional educational resources, by virtue of being a major and pioneering institution for geriatric care, is: a staff with in-depth knowledge of the field and perspectives acquired from wide experience; team meetings on cases that bring together a broad range of health care professionals; a wide range of patients; and many of the most current medical techniques. What is different about the JIGC educational experience is, then, not the teaching methods per se, but the knowledge and perspectives of the staff and the resources of the institution. So how do they design a curriculum that allows other institutions to provide a "JIGC educational experience" for their students? (I am not saying that the experience must be a carbon copy -- clearly each institution will have their own resources that will shape the program in positive ways, but there are some things that JIGC wants to pass on

reliably.)

The answer is that JIGC methods must be richly supplemented for export.

How can the experience of interacting with and observing teachers with certain attitudes, perspectives, styles of patient—doctor interaction be replicated for students at other institutions? How can the experiences of team meetings, the sharing of information, the process of decision making by health care professionals (ranging from nurses, to physical therapists, to psychiatrists) be replicated? How can the experience of interacting with patients with a broad range ot problems be replicated? How can the experience of seeing a wide range of recent medical techniques in practice be replicated?

What supplements do we use? The most traditional supplement to develop is readings -- to convey the knowledge, attitudes, or skills embodied in JIGC staff members or guest lecturers who are a part of the "JIGC educational experience". As an early step, staff members have written papers articulating the body of knowledge they pass on to students.

A second useful type of supplement is audio—visual material. Documentary filming of some of the actual experiences at JIGO can provide for students elsewhere:

A.A range of techniques. If not actually a "hands—on" experience at least a chance to see what the techniques look like. For example, techniques of passive exercise to prevent contractures, or ways to help patients learn the use of walkers.

B.A range of patients .As a simple example, an audio—tape can provide a range of: common patterns of speech difficulties for students to use in practicing diagnosis and setting treatment objectives. A tape of interviews with several patients can show the range of attitudes that exist around, say, the problem of living at home alone.

C.The course of a medical problem and the treatment program over time. For example, what are the stages that occur with a healing hip? what things is a patient able to do at each stage? What daily activities present difficulties?

D.Team meetings -- the interactions that take place, the type of resources and perspectives each team member brings, the way decisions are made.

E.Doctor-patient interviews -- content, style, tone, pace of doctor—patient interaction, hew a doctor draws out a withdrawn patient, deals with an angry or confused patient, handles sensitive issues, such as sex history or views on death and religion.

A third type of supplement is class seminar activities that foster active participation on the part of the student. Active participation enhances learning and retention in any case, but it is especially important for students outside JIGC where certain components of the real experience may not he available - Examples of such activities are role playing doctor—patient interactions, or debating two sides of a controversial medical approach, or working through a case study by each student taking on the role of a different member of the health care team and making recommendations from that point of view, or sharing experiences after the viewing of a provocative film or after clinical work (if available).

The fourth aspect of my role is to help in the designing of ways to measure student learning, for both "formative feedback" to help in the development of the curriculum, and "summative feedback" to evaluate the completed version and to give other teachers to use in evaluating their own students' use of the curriculum. Since what we hope students will learn is ultimately evidenced in their care of patients, it is best to evaluate behaviors that are as close to that end-point as possible. The furthest away is probably responses to written tests, but since this is such an efficient way to measure at least information learned, such tests are used as one technique. It is quite difficult to measure attitude change over a brief period of time by paper and pencil tests. Other methods of evaluation, particularly for skill development and attitudes, use behavior closer to the real behavior -- i.e. role-playing, case study performance, and clinical performance if possible.

The fifth aspect of my role is to make recommendations on format and organization of material. What material does the teacher get, what do students get? Many booklets -- one per module -- or one for the whole curriculum? Should audio-visual material come in film, video—tape, film-strip, slide-tape, or audio-tape. Many of these questions have to do with what other institutions are accustomed to using. While I can advise on what is pedagogically effective, what people are accustomed to is an important consideration. We also have to consider what will be commonly available several years in the future in contrast to

now, and, as with ideas, resources, teaching techniques -- how much will other institutions be willing to stretch to meet the educational conditions we see as the most effective?

Curriculum development is as yet much more of an art than a science. To use a simplistic medical analogy, think for a moment of developing a medication —— you hope it will have reliable, definable effects for the range of patients who are likely to use it. However, compared to the understanding of cause and effect in biochemistry, the understanding of cause and effect in education is in its infancy. In addition, once you have developed the proper mix of ingredients of the medication in the lab, you have to find substitutes for the ingredients, because the original ingredients do not exist anywhere else, and no two labs have the same ingredients. Finally, imagine that each physician prescribing the medication must add his/her own ingredient before dispensing it, and there is no formula for what is to be added, This last condition has been given much attention in the curriculum development field as the issue of "teacher proofing". Self-instructional booklets may be "teacher- proof", but no curriculum delivered by a live person can be. Even so, there is still much disagreement in education over the extent to which curricula should be "teacher-proof". Those who view teachers as spoiling a curriculum want it to be teacher-proof. Those who view the teacher as giving it life do not use the phrase "teacher-proof" to describe a very structured curriculum —— they call it "canned".

The art of curriculum development involves deciding just how much structure to provide other teachers and where: where the teachers' own resources and skills will enrich and add life and wisdom, where they will blur what is being taught. It also involves much intuition about what supplementary experiences will replicate the experience of the student of the master teacher at the master institution.

Whether you have done a good job does not become clear until pilot testing, when the curriculum is outside the "incubator", actually being implemented at other institutions. *A* later aspect of my role as a curriculum specialist will be to help analyze the pilot test and ask which parts of the curriculum work, which parts have to go back to the drawing board.