TRADITIONALLY, the medical faculty plans the medical school curriculum to prepare physicians to serve those health care needs perceived by the faculty to be important. Gaps may develop or persist in areas of the curriculum that are important to the public-at-large, in part because of failure of the faculty to assign high priority to them. Society has limited access to the means of promoting changes in medical school curricula, even when such changes could produce physicians better prepared to meet the health care needs of the community as a whole.

One of the authors (BJT) suggested to leaders at the University of Pennsylvania School of Medicine that a non-medical group be invited to comment on medical education. The suggestion to develop a conference to elicit non-medical ideas about the medical school curriculum came at a time when the University of Pennsylvania School of Medicine was renewing its efforts to review and revise the medical curriculum. This paper describes the development and proceedings of the conference and some of the problems encountered. A summary of curricular initiatives begun following this conference demonstrates efforts made by the School of Medicine to address the concerns of the participants.

PARTICIPANTS

The conference was held in the winter of 1984. The design of the conference had taken shape gradually over the preceding six months in a series of meetings with the dean, associate dean, several faculty members, and other clinical scholars. After the conference was approved by the Dean’s Office and the Curriculum Committee, 14 faculty members agreed to participate; most were full professors and members of the Curriculum Committee.

The non-medical conference participants were found through a complicated set of “networks” of medical and non-medical acquaintances. Potential participants were interviewed in person or by telephone. The interviewer described the rationale for the conference and asked whether the non-medical contact felt prepared to contribute. Thirty-five such interviews were conducted; 25 of the 35 people interviewed were selected and agreed to participate. Because of conflicting commitments, only 17 of the 25 non-medical members attended the conference. All had had occasion, because of their occupations or personal contacts, to think about the role of the physician in delivering medical care and about the health care system. The participants included corporate managers, union and government officials, consumer advocates, theologians, lawyers, faculty members in health professions and liberal arts, and health care researchers. Five of the participants were women and four were members of minority groups.

Before the meeting, all non-medical participants were asked to consider ways in which physicians could be better trained to meet the needs of society. The non-medical group also received background readings on medical education, excerpted from the medical school catalog and from material published by the American Medical Association, the Association of American Medical Colleges, and the Institute of Medicine.
CONFERENCe FORMAT:
NOMINAL GROUP TECHNIQUE

The conference consisted of two sessions. In the morning, the non-medical group met alone to formulate, compare and consolidate their concerns about the training of physicians. In the afternoon, they were joined by the medical educators to examine and clarify the concerns given highest priority.

The quality of ideas generated by any group depends largely on meeting techniques that can increase rationality, creativity and participation. Therefore, attention was paid to the selection of the group processes to be used in the conference. Several strategies for group participation were considered for the morning component of the conference: interacting or unstructured groups, “brainstorming,” the Delphi technique, and the nominal group technique.

All of these options except the nominal group technique were believed to have disadvantages in accomplishing the goals of the morning meeting. An interacting group risks limiting contributions to only the most vocal or high-status members of the group. Also, the group often focuses on a single train of thought for extended periods of time. As a result, often relatively few ideas are raised and discussed. “Brainstorming” elicits many ideas in a short period of time. But this strategy does not include a procedure for clarifying and ranking ideas.

The Delphi technique, pioneered at the Rand Corporation in the 1960s, has been used successfully by diverse health care groups. The technique consists of a series of questionnaires used to solicit and collate judgments on a topic. Each succeeding questionnaire summarizes and gives feedback on the information derived from earlier responses. It has been estimated that a minimum of 45 days are required to complete a Delphi process involving two iterations of questionnaires. The Delphi technique would have been a good alternative if there had been more time to develop the meeting. We might have examined two lists of concerns about the medical curriculum, generated by separate Delphi processes by the non-medical and medical educator groups.

The nominal group technique was used in this meeting. It is a modification of the “brainstorming” technique and has been widely used by health care groups. It was developed as a group-process method for business management to promote equal participation in eliciting ideas and establishing a priority list. The developers of the nominal group technique have suggested that it is a useful tool to draw upon consumer ideas. It involves six steps: 1) generation of ideas in writing, without discussion, 2) recorded round-robin listing of ideas on a chart, 3) discussion and clarification of each idea on the chart, 4) preliminary vote on priorities, 5) discussion of the preliminary vote, and 6) final vote on priorities.

Because the nominal group technique performs best in groups smaller than ten, the 17 members of the non-medical group were divided into two groups. A plenary session, held after these groups had completed their task, enabled the non-medical participants to compare the two lists of concerns and to vote on a composite priority list. These concerns were grouped into three subject areas, to facilitate the afternoon discussion with the medical educators.

NON-MEDICAL GROUP’S CONCERNS

The final list of concerns produced by the non-medical group is summarized below, in decreasing order of priority:

1. Improve the physician-patient relationship. Treat the patient as a whole by providing empathetic care for both medical and non-medical problems. Include the patient and family in decision-making.
2. Teach a systems approach to health care. Promote an understanding of the physician’s role in the system, the resources and structure of the system.
3. Teach about health care economics and the interplay of ethics and economics from both a patient’s and society’s standpoints.
4. Develop skills to facilitate communication with patients and allied health professions. Teach basic counseling and listening skills.
5. Include instruction in underemphasized aspects of medical care: preventive medicine, geriatrics, medical ethics, epidemiology.
6. Sustain the physician’s own mental health.
7. Maintain professional credibility. Provide rigorous medical training in order to earn patients’ respect by demonstrating competence and professional behavior.
8. Train educators to serve as role models who put into practice the above recommendations.

MEDICAL AND NON-MEDICAL GROUP DISCUSSION

The afternoon meeting between the non-medical and medical educator groups was organized as an interacting group. The purpose of this phase of the meeting was to promote discussion and clarification of the three major areas of concern raised earlier by the non-medical group. Although limited in its ability to promote decision-making, the in-