Present Situation of Educational Reform and PBL in Japan

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My Background

- Chairman of PBL curriculum at Saga University Medical School
- Former Associate Director, Department of General Medicine, Saga University Hospital
- Advisor, Program for Medical Education in East Asia, JABSOM
- Member of Research Development Committee for Medical Education, Japanese Society of Medical Education

Contents of this presentation

- Trend in educational reform in Japan
- Present situation and issues regarding PBL
- Supplement
  - New PBL plan of Saga University

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Rapid change in Japanese medical education

- National guideline “Model Core Curriculum”, 2001
  - Careful selection of learning contents
  - Recommend of Clinical Clerkship (CCS) and PBL
- Common Achievement Test (CAT), 2002
  - To assure student’s quality before clerkship
- Mandatory postgraduate clinical training, 2004

Recent social need; Quantity over Quality?

- Collapse of medical service providing system
  - Serious shortage of doctors
  - Not rare doctor’s death from overwork
  - Close down of community hospital
- The needs for medical education has been changing
  - Shorten and revise the PG training
  - Increase medical students/graduates up to 1.5 times present
  - 4+4 system?

Could be a incentive to go back to traditional teaching?
Back to starting point of medical education reform

- The clinical competence of medical school graduates is low.
  - One of the reasons of confusion in PG training
  - Need to improve in both quality and quantity
- More haste, less speed
  - Undergraduate education should be more effective
  - True clerkship after pre-clerkship education integrated by PBL is the key of improvement.

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<tr>
<th>MS1</th>
<th>MS2</th>
<th>MS3</th>
<th>MS4</th>
<th>MS5</th>
<th>MS6</th>
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<tr>
<td></td>
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<td>Pre-Clerkship Curriculum</td>
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<td>Clinical Clerkship</td>
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<td>PBL</td>
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Today’s contents

- Trend in educational reform in Japan
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PBL

- Self-directed learning (SDL) based on small group discussion (SGD) using case scenario under facilitation by tutor.

- PBL in Japan

AJMC

- Association of Japanese Medical College
- “Present Situation of Medical Education Curriculum”
  - Surveys using questionnaire for medical school curriculum
  - Reports every 2 years.

Background

- Leadership of educators
- Strong influence of MEXT
  - Policy of university reform by MEXT, 2001
  - Drastic scrap-and-build reform of national university
  - Competitive principle backing financial support
  - Introduction of third party evaluation
  - National University Corporation Low, 2003
  - COE (Center of Excellent) policy, 2004
  - GP (Good Practice) series, 2005

Rapid spread of PBL

Number of Medical Schools with PBL curriculum

<table>
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<tr>
<th>Year</th>
<th>(%)</th>
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<td>1995</td>
<td>4%</td>
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<tr>
<td>1999</td>
<td>49% (30/80)</td>
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<tr>
<td>2003</td>
<td>81% (65/80)</td>
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<tr>
<td>2007</td>
<td>94% (75/80)</td>
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Quality

Variety

Variety; Total hours for tutorial session
A total of “Core time” of 6 year’s curriculum

Variety;
Course with PBL

Variety;
Styles of PBL in Japan

Variety;
Difference of class schedule

Example of TBL and CBL
So what?

Variety itself is natural, but...
- Each medical school has its own goal.
  - PBL should be set for their goal.
  - Curriculum management should be done by their resource.
- But,

Reflection
- Is PBL working as we expected?
  - Do students learn actively with their self-direction?
- Can we show a prospective / next step to improve PBL in our school?
- How do we evaluate PBL?
  - Student's competence
  - Curriculum
- Any problem in managing with limited resources?
  - Human resources in Saga is 1/3-1/5 of JABSOM

Mysteries in PBL
- For effective SGD
  - Should tutor be quiet in SGD?
  - How non-field specialist can be a good tutor?
  - Scenario and tutor guide
- Planning & Managing
  - How to balance between tutorial and lecture.
  - How to bridge between pre-CCS and CCS
  - How can we show the evidence of PBL effectiveness

Variety itself is OK, but...
- One of the reasons of difficulty in curriculum development
  - Good practice in medical school A is not true in B.
  - Each faculty has different understanding/ background with PBL
- An example...
  - Unpublished research in Saga
    - Should tutor be quiet in SGD?

Survey in 2006
- Subject: 95 MS3s of Saga Medical School
- After tentative introduction of Hawaii-style active tutoring for 8 weeks in GI unit.
- Most tutors were field specialist.
  - GI physician & surgeon, GIM, GI radiologist
- Tutoring skills
  - Let students think aloud, share the thinking process
  - Ask "why" to students
  - Facilitate patho-physiological thinking
  - Give one point feedback on their presentation and advice for further learning
Did tutor facilitate tutorial active?

- Strongly agree (4%)
- Disagree (5%)
- So-so (19%)
- Agree (68%)
- No answer (4%)
- Strongly disagree (0%)

Do you want active tutoring in future, too?

- Strongly agree (18%)
- So-so (19%)
- Agree (62%)
- No answer (0%)
- Strongly disagree (0%)
- Disagree (1%)

Should field specialist be tutor?

- Strongly agree (42%)
- So-so (6%)
- Disagree (2%)
- Strongly disagree (2%)
- Agree (48%)
- No answer (0%)

Conclusion; Back to Basics

- PBL is SDL based on SGD using case scenario under facilitation by tutor.
- It is true, indeed, but not enough
  - Need many elements for successful PBL.
  - I’ve learned it in my scholarship days in JABSOM
  - Deepen, widen, activate and share the basic understanding of PBL in this workshop.
  - Then, make use of your curriculum development.

Supplement

- New Saga PBL plan
  - developed through 2 years discussion with JABSOM staff.
  - Selected as a Good Practice in “Promoting High-Quality University Education Program 2008” sponsored by MEXT
- Development of PBL curriculum to train active doctor in community;
  - by introducing continuous clinical training through 6 years and hybrid curriculum of PBL and CBL
  - Details are in attached paper.