



MAKING A DIFFERENCE

An Interview with Professor Henk Schmidt



From 1974 to 1992 Henk Schmidt, PhD, played a vital role in evaluating and developing Maastricht's medical school's problem-based curriculum. From 1992 to 1995 he was Dean of the Faculty of Health Sciences at the same university. From its beginnings, Professor Schmidt was also a key member of the Network, serving as its Associate Secretary General until 1995. In January 2001 Professor Schmidt became the founding dean of a new psychology programme at Erasmus University, Rotterdam, the Netherlands. In January 2001 I interviewed Professor Schmidt in Maastricht. The interview, which was conducted in Dutch, was translated, edited, and abridged.

Jan van Dalen
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How did you, as a psychologist, become interested in innovative medical education?

Before I came to Maastricht I was an assistant in the Faculty of Psychology at the University of Utrecht in the Netherlands. There I happily lectured about statistics to large classes of psychology students. In 1974 Winand Wijnen, one of the founding fathers of the prospective faculty of medicine in Maastricht, asked me to join him at the University of Limburg in Maastricht. At that time I was quite willing to return to this pretty part of the country where I was born.

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At Maastricht I was surprised that teaching was organised differently. To tell the truth, I was quite sceptical about PBL. However, when I conducted my first tutorship I noticed that it actually worked. I was intrigued. I wanted to find out how and why it worked.

Now PBL is one of the most critically evaluated educational approaches. Research, conducted in particular by my own group in Maastricht, but also by others, has revealed that there are two key elements that are crucial to the success of PBL: the nature of the expertise of tutors and the quality of problems used in problem-based curricula.

In a number of studies, published mainly in the US medical education journal *Academic Medicine*, my collaborators and I have shown that in a problem-based curriculum, novice students look for cues that may help them make sense out of what they perceive as an unstructured learning environment. They want some guidance regarding what they should do and how they should proceed. These cues may be produced internally, that is, through their own prior knowledge of the subject matter to be studied, or through the learning materials provided to them. If both are lacking, students turn to their tutor for help. In such cases it is important that the tutor has subject-matter expertise. Otherwise he or she will fail to help them, and learning will suffer.

The importance of the problems used in PBL to the quality of student learning was generally underestimated until we began studying their effects. I was quite excited when, at the end of the 1980s, my colleague, Wim Gijsselaers, and I were able to show that good problems contribute more to learning than any other element of the problem-based educational set-up.

In general, we now know more about the strengths and pitfalls of PBL than we do about most other educational approaches, including conventional lecturing. Did you know that there are hardly any published studies in the literature demonstrating the effects of lecturing?

Maastricht University was the second problem-based medical school in the world, after McMaster University, Hamilton, Canada. You participated in its development from the beginning, in 1974. Can you explain why Maastricht became part of the international movement for improving health professions education?

One of the Dutch medical educators with international recognition at that time was Harmen Tiddens, a pediatrician and a professor of medical education. Harmen had been impressed with the experiences at McMaster. He was invited to guide the development of the new medical school in Maastricht as its founding Dean. Harmen was a friend of Tamas Fülöp, the Director of Health Manpower Development of the World Health Organisation. Even back then, Tamas was a true visionary, a man who was very inspiring, and immensely supportive of changes in medical education. Until that time many of the medical curricula in developing countries had been exact copies of curricula in the Western world. Students in developing countries were not prepared by

these curricula to face local health care needs. Tamas was looking for medical educational models that would prepare students for the needs of their local population. Harmen and Tamas realised that PBL would be ideally suited to confront students with current, local health care problems. Community orientation could thus be integrated in a new curriculum.

As part of developing this new curriculum, worldwide experts in medical education were invited to visit Maastricht. (I met many of them.) Delegations from Maastricht also visited other schools where innovative education was taking place. I was lucky to participate in some of these visits. In 1979, Peter Bouhuijs and I met Zohair Nooman and Esmat Ezzat, who were in the process of establishing an innovative medical curriculum at Suez Canal University, Ismailia, Egypt. They asked us to assist them with its development. It was the beginning of a friendship that has lasted to this day. Zohair and Esmat, Winand Wijnen, Vic Neufeld of McMaster University, and Tamas Fülöp of WHO are the colleagues I consider my intellectual fathers and mother in medical education. It is with tremendous pleasure that I think back on that period. I remember that, as early as 1976, Vic Neufeld and I founded the First International Hiking Association in Medical Education. While hiking we plotted for a revolution in medical education. Now and again I miss that exciting period.

Why didn't you continue in this work?

Around 1995 I had the strong feeling that I had already seen much of what was happening in the Network. One develops new interests, and it is easy to grow apart. In addition, I felt that I had run out of new ideas, and I thought it was a proper time to say goodbye to the Network.

But before that, you were the first Associate Secretary General of the Network. Can you explain how that came about?

Maastricht was chosen as the site of the Network Secretariat in 1979. The coordinating secretary of the Network, Ine Kuppen, was increasingly confronted with organisational issues with which she wanted help. I became the educational advisor to the Network. Eventually it was decided to formalise that role.

During the time that I was Associate Secretary General, the Network increased from 20 to 150 schools. Much of the organisation, such as communication channels and management procedures, needed to be created. Together with Ine, and later with Pauline Vluggen, I was responsible for the day-to-day affairs facing the secretariat. We assisted the Executive Committee in preparing meetings, and we attempted to increase the scientific focus of the Network. While I was involved in the Network's operation, we organised 12 annual scientific conferences and numerous smaller workshops. I also established the Network's journal, originally the *Annals of Community-oriented Education*, now *Education for Health*. It turned out that these activities

provided opportunities for people who often worked in isolated educational experiments to get acquainted, to be each others' sounding boards, to share ideas and experiments, and to become part of a broader movement of like-minded schools.

One of the things that I liked to do was to experiment with new conference formats. The "Thematic Poster Session" was one of my pets. I also have fond memories of the "Fireside Chats." We actually dragged a couch and palm trees onto a stage and engaged experts in in-depth conversations.

Soon it became clear that there was a worldwide trend towards improving medical education. This trend was beneficial for our initiatives. The GPEP report *Physicians for the 21st Century*¹ and *The Edinburgh Declaration*² were published at that time, promoting change in medical education. In the 1980s in the Scandinavian countries and in the 1990s in the United Kingdom good work was done in medical education. These developments could clearly be recognised in the presentations at the Network conferences. In the early years most presentations addressed "this is what we do and how we do it". Nowadays most of the presentations deal with some kind of empirical study. That is progress, in my view, and an excellent development.

In October 2000, after an absence of 5 years you were invited to the Network conference in Bahrain. How did that feel?

Like a welcome hot bath! I still know so many people.

If you were asked to suggest new issues for the Network to focus on, which would those be?

Two issues that are a cause for concern are, I think, the Network's inability to demonstrate whether community-based education has had any effect on the practice of health care and the fact that the Network is not involved in some of the forums on PBL and other innovations in medical education. Community-based education is a wonderful idea, and its effect on students' competencies has been amply demonstrated. So far, however, its demonstrated effects on the quality of primary health care are only marginal, and tertiary care still is very attractive to many graduates, certainly in developing countries. Clearly, in general, students are more aware of the direct needs of the local population, but that was not the only intended goal. Our goal was to have a direct impact on the quality of health care provision. I don't think we have had this impact. Maybe we should widen our scope and look at other issues that influence students' career choices. You would not expect medical schools to go beyond educating their students as well as possible, but an organisation like the Network could try to address the political issues involved in changing the structure of healthy care delivery.

The other role I think the Network should definitely try to keep is providing an international forum for innovators in medical education in the broadest sense. I notice that conferences on PBL or other medical educational

innovations are being held without the involvement of the Network. I regard this as a sign that the Network is losing some of its attractiveness for a wider audience of medical teachers and researchers in this area. These colleagues have much knowledge to share that is important for Network schools as well. We don't want to lose them! We have always felt free to raise new issues in the Network, because friendship and mutual respect have always characterised the meetings. That feeling—the “hot bath”—is too precious to be lost!

Notes

1. Association of American Medical Colleges (1984). *Physicians for the Twenty-First Century. The GPEP Report: Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine*. Washington DC: AAMC.
2. World Federation for Medical Education (1993). *Proceedings of the World Summit on Medical Education*, (H. J. Walton, Ed.), 28, supplement 1, pp. 140–9.