

STINT Stiftelsen för internationalisering av högre utbildning och forskning The Swedish Foundation for International Cooperation in Research and Higher Education









Teaching Sabbatical

Fall 2019

Lars Henningsohn



10 pages

Preparation and planning

Already 2017 I applied to STINT for a teaching sabbatical after recommendations from a former STINT fellow at my University, Karolinska Institutet. For that application I had done some research finding out about Active Teaching and Learning methods at UCLA, UC Berkeley and University of Texas at Austin. It was a nervous time until I knew I was not going to get it that time.

Next summer of 2018 I decided to apply once again but this time include all the Universities in USA. I felt that would increase my chances of getting this very fine scholarship. The fall of 2018 was an eventful semester for me. Karolinska Intitutet (KI) nominated me to become the Vice chair of education for all educational programs at KI. And later that semester, after hearings, I got the appointment after an employee-election. The new position started January 1 2019 and was planned to use 50% of my working hours. The rest of the time I do teaching and clinic as a urologist.

Just before Christmas 2018 I got a letter from STINT saying that I was appointed/elected to goto the department of Urology at the University of California Los Angeles (UCLA) during the fall 2019 for 5 months. An intensive period of valuing pros and cons for me, Karolinska Institutet as well as my family started. It resulted in that this was a "once in a lifetime opportunity" impossible to turn down. However lots of work had to be done to find someone that could temporarily take over my assignments' at home. Fortunately the former vice chair of education was also a former STINT fellow saying he could help me with parts of my work as the vice chair. The rest was fixed with kind work from Karolinska Institutets president Ole Petter Ottersen and the vice president of education Annika Östman-Wernerson through a rearrangement in the Educational Committee. Without their positive attitude this would not have been possible.

The easiest part to fix was my clinical duties and even though I am one of few doing some urological surgical procedures in Sweden a nice letter explaining to my patients the reason for my absence took care of this side of my Swedish duties. The third part was to get someone to replace me being the MD program surgical course director. One of my colleagues at the course said he could do my job here for a semester. Now all problems were solved?

My family consists of 5 persons including me, my wife and three children, 23, 21 and 12 years old. Who would want to join me in California? It turned out that my oldest son would not want to go due to his studies at another Swedish University. Things were going well for him so he decided to stay and take care of our house in Huddinge in Sweden. The other two and my wife wanted to join the visit to California. The 21 year old had just gotten out of high school in Sweden and wanted a sabbatical himself. The 12 year old was planned to go to a nearby public school in Los Angeles. Everything seemed perfect.

The two most important actions now was to start up the application process for VISAs for us all and plan for a planning trip to UCLA to set everything up.

As my 21 year old son turned 21 during the spring semester of 2019 he could not be included in my application for a J-1 VISA as my wife and 12-year old could. They were so called dependents of mine and could therefore apply for J-2 VISAs together with my J-1 VISA. As the ESTA tourist VISA only is 90 days and cannot be extended beyond that without leaving USA, only to come back immediately after (not allowed to leave to Mexico or Canada) we saw a problem arising. He found out though that there was a so called extended tourist VISA called B-2 and he started an application himself. A B-2 VISA is good for up to 6 months stay and would cover this sabbatical perfectly if he was approved.

After about 40 web pages of information to apply for VISAs we were ready. However, these applications could not be finished (sent in for evaluation) until the DS-2019 came from UCLA. My 21 year old sons application got fast into the system and he could immediately book an interview at the US embassy in Stockholm. The waiting time to get an interview there was about 20 days. At the interview he immediately got to know he was approved, they took his passport to incorporate the VISA and he got it back within just a few days – very efficient. Now he was ready!

The paperwork from UCLA needed to continue our application was delayed. We felt like we were terrorizing our contact at UCLA with all the mails about this and the closer we got to our planned trip we got more and more stressed and started to think about changing our flight plans to a later date. With the J-1 and J-2 VISAs we were allowed to get into USA up to one month before the start of the STINT-fellowship August 1st. Two weeks into July!! the paperwork from UCLA finally arrived and we could finish and send in our application to the US department of State. There were now only 3 weeks left for our departure but fortunately the waiting time to get an interview was shortened during the summer to only about 2 weeks. We got our interview one week before the trip and as with my 21 year old sons application the return of the passports was very efficient and it took only a few days for them to be returned. Another problem arose when we were going to get our 12 year old sons passport with the VISA from the Post Office. In order to get it we had to present a Swedish legitimation of him and the only legitimation he had (12 y old) was his passport, the passport that was on the other side of the post office desk in a mail from the US embassy. Fortunately after contact with the police and the Swedish Tax agency we needed only to present the "personbevis" (which we already got for the interview) to get his passport back. Now we were ready for the trip, about one week before departure.

Now we have to go back in time again to the planning trip. I and my wife decided to do this trip in April/May. For this trip we had to have the ESTA visa waiver approval which is really easy to get. The educational team at the department of urology, UCLA, had made a schedule for us for this trip thoroughly and the week was booked with important informational meetings in order to plan for the fall-semester. We were even invited to an honor-dinner for me and my wife which we appreciated a lot and afterwards we felt very welcome. During this trip our plan was to visit as many interesting places to live as possible and by the end of the week know where we were going to live during the 5 months. It turned out to be impossible and we didn't have a place to stay in, at the return to Sweden. We had to fix this from home instead. On the day we were supposed to return to Sweden our flight company SAS pilots went into strike so we got 1,5 extra days in Los Angeles. We didn't mind!

Tasks and responsibilities

As the medical program is a fixed program concerning the courses and learning activities I was not offered to make a course of my own like many of my STINT fellows. Instead the plan was for me to teach within the already made courses within the program. In a clinical department like the department of Urology the plan was to co-teach and teach the third-year medical students on their 3rd year clerkship in urology and also the Sub-Interns (4th year medical students specially interested in urology) on their 4-week clerkship here. The teaching was planned for a 2 hour session every week on Wednesdays after the Urology Grand Rounds. All students got 2 of these sessions during their 2-week clerkship. The program at DGSOM is further explain below.

The MD program at David Geffen School of Medicine at UCLA

Before entering the MD program all applying students have passed their pre-med studies at a college or university somewhere in the US. Formerly the premed studies consisted mainly of courses in biology, chemistry, biochemistry etc in order to prepare the students for their medical studies but today that is not necessary. The students can major in any subject, however, the ones having a science major will most likely experience an easier MD study start with their knowledge in preclinical subjects.

Out of the 14.000 students applying to the MD program at David Geffen School of Medicine at UCLA (DGSOM), 600 will be called to an interview, a so called MMI, where-after 175 will be admitted to the school. MMI interviews are a number of short stations where the interviewed (=tested) student are supposed to answer and reply to very difficult assignments' and questions like "Do you always have to tell the truth to your patients?" or "please describe what you see on the table" (kind of like a Rorschach test). This way of testing the applicants is common nowadays but takes lots of resources to accomplish. The admitted 175 students then will enter a 4 year program where the first 2 years are preclinical and the last 2 years are clinical. The program is however going through a change in order to let the students get out into clinic and meet patients earlier, new program will start in a couple of years.

MD program year 1-2

After a first week of introduction to the profession ending with the "White Coat Ceremony" the students start their journey to become doctors. During the first 2 years at DGSOM, the students pass through 9 blocks of preclinical studies.

Year 1

- 1. Foundations in medicine I 8 weeks
- 2. Cardiovascular, renal and respiratory medicine I 9 weeks
- 3. GI, endocrine and reproductive medicine I 8 weeks
- 4. Musculoskeletal medicine 5 weeks
- 5. Medical neurosciences I

Summer vacation 2 months.

Year 2

- 6. Foundations in medicine II 9 weeks
- 7. Medical neurosciences II 5 weeks
- 8. GI, endocrine and reproductive medicine II 5+3 weeks
- 9. Cardiovascular, renal and respiratory medicine II 8 weeks

USMLE preparation and exam 6 weeks from March to May. First 6 weeks of rotation/clerkship starts May to end of June. No vacation

Next semester (with clinical rotations/clerkships) starts July 1st (see below MD program year 3-4).

These blocks are built in a similar way with "theoretical" parts and "laboratory" parts mixed. During Block 2 where I taught PBL (see below) a typical week looked as follows. Monday morning a new PBL case was presented, learning issues chosen by students and the case solution (part II) was on Friday morning, 2 hours each. Besides PBL all am-sessions where theoretical, lectures and the afternoons more practical, including cadaver dissections corresponding to the subject taught this week, seminars, labs etc. During these afternoon sessions the students also practiced becoming a real doctor in something called "doctoring". Al lectures were recorded for the students to go back to whenever they would like to but could also be seen streamed at the same time as they were going on. This resulted in a decreasing student crowd in the lecture hall where most students attended the first semester in contrast to the last semester where only few attended. This led to almost empty large lecture halls at the 4th semester and excellent lecturing for almost an empty hall. I cannot see how this can continue in the long run. Most likely good/excellent lectures will be recorded once and for all and then re-used until the material is outdated. I think this is unfortunate but inevitable in a modern way of teaching. Unfortunate because the active on-site interaction between students and a good teacher leads to "strong" learning. The students' interest in becoming good physicians are also clearly seen already at the first semester where they often told me they were on evening or night "on-calls" in specialties they wanted to try out. Fantastic opportunities to learn for those who did this. The DGSOM has its own learning management system called GRYPHON. In Sweden I had mostly worked with PingPong and most recently Canvas. They all have their special characteristics but I must admit that I feel Gryphon is quite easy to understand. I worked out well for me.

Doctoring

During doctoring the students practiced A. History taking, B. Physical examination, C. Patient interaction and D. Planning and treatment using standardized patients (=actors) both in groups settings as well as individually at the special SP-center down in Westwood. It is my strong opinion that this way of teaching is one of the best ways to go, producing good physicians in the end. The reason for this is the slow/fast change of health care into a highly efficient and high-producing care resembling a factory/an industry where students risk to slow down the "production". The drawback is however the cost of this way of teaching and learning to become a doctor.

Examination of blocks

All blocks ended with an integrated examination often including theoretical knowledge test using MCQ/SBA q's, skills test using OSCEs or lab-test using cadavers or radiology.

MD program year 3-4

Already before the summer after year two the mandatory clerkship rotation period begins.

Year 3

There are two 24-week long blocks of required clerkships. All 175 students were then divided into 2 tracks where one track included three 8-week blocks (Medicine, Family medicine, Psychiatry, Neurology) and the other track four 6-week blocks (Surgery, Ob/Gyn and Pediatrics).

Year 4

Even if some of the clerkships above were electives this 4th year is when the students really start to try out interesting specialties or primary care medicine. Primary care includes family medicine, internal medicine, pediatrics and Ob/Gyn. The students now often travel around the US to find out the best places for them to go to and become residents. Even though they aren't interns yet, they are now called sub-interns (Sub-I's) meaning they are seriously interested in the specialty where they are at the moment. These students do all they can to show the best sides of themselves during their sub-I elective. Based on their performance at their clerkships, their recommendations letters, interviews at different departments, and the USMLE test results all students in the US are ranked and matched in a central system (Nobel prize 2012, for the National Resident Matching Program) they will all get a notice on where to go and which specialty the got matched into on Match Day in March. Under great celebration the student exits UCLA after a Hippocratic Oath Ceremony and a Diploma Day.

Residency

During the first year of residency (PGY-1, postgraduate year 1) the newly become physician is called an Intern while doing their internship. Besides doing rotations and work within their actual specialty (urology) they do basic work in surgery and the emergency ward. To become a specialist in Urology at UCLA they then have to follow a track from PGY 2-6 where PGY4 is a year to do research at the department. During the PGY6 year of residency the resident is called a chief resident and get more responsibilities.

Fellowship

After residency the colleague specially interested in an area within Urology could apply for a fellowship. This would then mean that he/she would get an opportunity to be a close fortunate colleague to one of the senior specialists usually among the best in the world in his/her area. This appointment is usually for 1 year and by doing it in this way secures the continuation of experience and knowledge from the older generation to the younger generation.

Tasks and Responsibilities continued

In order to understand and see where I did most of my pedagogical work during the STINT teaching sabbatical the above description of the "Road to becoming a specialist in Urology at David Geffen School of Medicine had to be explained. At UCLA Health the rules were not to engage in clinical activities more than 20% of my working hours. At first when I got this information I was surprised and felt controlled by others. I knew that performing practical clinical activities on patients in the USA is highly controlled and subject to constant lawyers interested in suing health care personnel they feel did something wrong, but not letting me assist is harder to understand. However, this was not a big problem for me as I was here mainly to see the UCLA way of teaching new becoming colleagues to become good colleagues of ours, from student to specialist.

Activities during the sabbatical

AUA curriculum for medical students, the Urology Fundamentals

This curriculum was taught to all MS3 students on their 2-week urology clerkship which was a part of their surgical clerkship rotation. Once every week on Wednesdays between 10-11.30 am we met in the Belt library in CHS (Centre for Health Sciences = old hospital before Ronald Reagan Medical Center) and went through this specific premade curriculum from the AUA (American Urology Association). It included both theoretical PowerPoint slides and case-slides usable for discussions. The material was much too extensive for two 1,5 hours sessions and some parts felt slightly outdated but just having a curriculum for medical students is something I have been trying to implement in Europe through our large EAU (European Association of Urology) for years without reaching a consensus of what every single newly become physician should know within urology. Furthermore, it has been an honor to participate in the senior colleagues Artur Shapiro and David Leff's sessions within this program. They are truly fantastic and experienced colleagues and teachers transferring their knowledge to the next generation.

Urology mysteries revealed, at the Urological Ward

On the 8th floor in the Ronald Reagan UCLA Medical Center (=new hospital building) I taught urological mysteries to the staff, the nurse practitioner, the Sub-I, the residents on the ward and the students. This activity happened once very week on Tuesday at noon. My goal with this activity was to teach the learners to think "one more time" before starting a treatment that could lead to sideeffects or possible QoL reduction in our urological patients. I felt that this activity was very appreciated among the staff and I was happy to give some of my experiences from urology (experiential learning).

PBL teaching sessions on Block 2

PBL (Problem Based Learning) is just one out of many different active as well as problem-based teaching and learning methods we could use within our pedagogical tool box. At the UCLA DGSOM this method is used within all 9 blocks above. The PBL method will make the students understand that teaching and learning can be done with high efficiency without lectures. The teacher is supposed to be a facilitator helping the students to gain this knowledge without interfering too much. These sessions were done in group sessions of 10 students and 1-2 tutors. The tutors were either retired

experienced physicians or MS4 students with high interest in medical education. Every Monday a new tricky patient case was brought up, made for the students to become curious to find out more. The cases corresponded to whatever was taught during this week in Block 2. At the end of the Monday session all students should have a so called "LI=Learning Issue" of their own. A learning issue was something concerning the case they wanted to find out more about. On the Friday session the students then taught each other on their findings within their own LI where after the case progressed to the "solution". My job as a facilitator was to keep them on track as well as teaching them my experiences with cases just like these, if needed. PBL is in my opinion a method resembling real life learning but expensive and quite inefficient. All students are however seen and heard and individual grading can be applied.

Another student active teaching method used here at DGSOM is the TBL method (Team Based Learning). I have been an observer in a couple of these sessions where all 175 students are doing the session together in groups of 7-9. These sessions are between 2-3 hours and consists of 1. iRAT testing the individual's knowledge (material was flipped) and then the tRAT where they all helped each other to solve the first questions in the iRAT. This led to that all students went from many wrong answers to all correct answers. A fantastic development during just an hour. After a short break the session continued with more difficult clinical reasoning questions from a real case where the student groups answered and debated as well as defended their answer. All groups got it right in the end. The students seem to prefer this method because things are going faster and more activity can be felt. In my opinion this method is more efficient (2-3 teachers, 1 technician, 1 room, all students at once) where more material can be gone through in a shorter time. It is however still possible for a student to slip through without doing too much.

Teaching and learning activities at the department of urology

The department of urology has numerous teaching and learning activities going on almost all the time. The most regular and attended are the Grand Rounds every Wednesday at 7.15 to 8.15. All students, residents and physicians gather these mornings including a very nice breakfast with juice, coffee, tea, sandwiches, fresh fruit, egg, oatmeal, bacon and ham etc. No one, specially a Swede, can resist something like this. The Urology Grand Rounds covers urological topics and discussions as well as M and M's (morbidity and mortality) in order to increase knowledge and quality among all colleagues. About once a month the Sub-I's (MS4 with special interest in urology) doing their elective clerkship also got to present a subject of theirs in order for the department to get to know them a little more, hopefully also to increase their chances of getting a residency here after the graduation. All Sub-I's dress up nicely for this presentation to look as good as possible. At 6.30 every Wednesday there is a teaching session for the residents until Grand Rounds starts. These sessions are designed for the residents to go through the Campbell urology to help the residents pass the Board exam in the future.

Besides the Urology Grand Rounds, it is often possible to attend the Grand Rounds in the Ronald Reagan Medical Center, also going on every week with general subjects of interest for most physicians.

Another arena for teaching and learning urology is every second week when there are Tumor boards. This is a truly interprofessional activity where the most difficult tumor cases are discussed. The meeting draws beside urologists also oncologists of different kinds, radiologists, interventional radiologists, pathologists and other interested. During the meeting a small nice lunch sandwich is served to stimulate the discussions and attendance. Besides these activities the department offers pathology rounds, radiology rounds, FPMRS (Female Pelvic Medicine and Reconstructive Surgery) conferences, journal clubs once a month at one seniors home, oncology teaching sessions and more...

Clinical activities

Being a urologist, I am always interested in seeing how colleagues do their urology. Special areas of interest for me are of course in "my areas" of urology – external genital cases and surgery, andrological urology, reconstructive urology, fertility etc. However, I was kindly informed that I could only spend 20% of my time in clinic. The rest, 80% had to be somewhere else. My slight disappointment of not being able to decide this by myself was fast overcome by all the learning activities going on all the time. Being used to work a lot at home, much too much probably, this opportunity made me choose the most interesting clinical activities to observe. Despite the willingness to help out and do things I had to stay back instead. During these months I have seen the procedures of my highest interest, so I am not disappointed at all.

It is a very strange feeling being a bystander or observer in the same room as an experienced colleague. We should probably do this regularly in order to learn from each other and improve our performance in communication and message transmitting to our patients. It would be great having a peer-colleague giving positive and negative feedback. However, this is a situation we are not used to wherefore my main learning here was to see "how things" were done here. Basically, the answer is pretty much like in Sweden but some things differ dramatically. One of these things is that some patients do not have insurance covering enough of investigations and treatments. They have to say no unless they have a lot of money to pay "out of pocket" if not included in their personal health insurance. The insurance system is complex and hard for me to understand, specially since there is a law saying that every citizen in California has to have an insurance for Health. My level of knowledge has come to see that there are mainly 2 different ways of being insured, one called the PPO which means that the individual can meet any which doctor he would like to meet and get the investigations and treatments he would like to, BUT has to pay a certain proportion of the total sum, e.g. 20%. Twenty percent could be a lot of money in todays health care systems and patients might then turn down important investigations (e.g. hematuria investigations to exclude cancer). The other main insurance type is through the HMO system where the insured will get everything payed that is approved by the insurance company. In reality this means that even if I together with the patient come up with an individually perfect treatment plan, this plan might not be included in the insurance companies' reimbursements for a specific condition. The patient and doctor might then have to say no due to cost and (at least in me) raises a slight feeling of helplessness while on I and the patient knows all the facts in this individual situation, not the health insurance company. This leads to another difference in health care which deals with guidelines. Guidelines are hare to help us and should be followed as often as possible. They are of great help, specially when you are new in a field (e.g. resident). Being an experienced physician leads to seeing things in a patient situation that are deeply individually unique for that patient which in turn might lead to treatment plans outside of "the box" (=guidelines). I feel that colleagues here have their "hands tied" here due to this insurance system, and that individualized therapy is harder to reach due to this.

The learning environment for the residents and the students are excellent at this department. They are not only participating but are entrusted to actually perform and do things within urology. It is may strong feeling that the residents here get to practice more urological skills than my residents in Sweden. During out patient clinics they are a part of one of the senior doctors' teams and often see the patients before the senior where after a learning situation appears when this resident/student consults the senior about the case. Then they both see the patient who then will meet the "specialist in the field" to get his/her opinion and recommendations. The resident/scribe/student then takes

care of the journal chart and all practical work around the case. In this way the specialist can see large number of patients in a day and increase efficiency.

New clinical positions and roles to me are for example

- Nurse practitioner, NP. The nurse practitioner is an unusually well-educated nurse with possibilities to prescribe medicine, start and order investigations, interpret investigations, treat and investigate.
- Scribe. A scribe is very often a specially interested (in medicine) young person who works very close to a senior colleague fixing all journal notes, etc to increase the senior's efficiency in working with the patient instead of doing administrative work.
- Fellow. Not new to me but now I understand the real advantage of getting a fellowship in order to concentrate learning from a senior colleague with special knowledge and skills.
- Clinical professor, assistant clinical professor, assistant professor. These titles mean they are excellent clinically working physicians with no mandatory PhD-degree.

The staff with these positions, together with the students, residents and fellows, makes it possible for highly efficient clinical work together with an optimal learning environment. This is something I would like to consider in Sweden.

Out of all students wanting to become urologists at UCLA Health about 30 were called to interviews as well as all Sub-Interns. And out of these only 4 could be offered this position. The applicants come from all over the country, and USA is large, meaning that some have to travel really far for these interviews which cost a lot. But it is an important investment in their own future. All were interviewed by the department chair and a couple of others in the faculty. After this process the students were ranked where after the ranking was sent into the Nobel prized winning matching system common for the whole USA. In march the system has made the matching decisions and it is first then the department knows who will be their next 4 residents here.

Important lessons and comparisons (bold italic text below)

Active teaching and learning

I came here with a wish to see how UCLA David Geffen School of Medicine uses active teaching and learning methods in their new learning environments at the DGSOM. I have been a co-teacher at block 2 for the medical students in their PBL sessions. Problem based learning is a pedagogical method used to stimulate learning, like in real life. *It is in my opinion that despite being a fantastic pedagogical method, it is a resource demanding and inefficient way of teaching in today's "fast world".*

I have participated and observed the medical students TBL sessions in the new large high- and lowtech learning environments at David Geffen School of Medicine. Team Based Learning is more appreciated by the students than PBL and an inspiring and joyful way of teaching for not only students but also the teachers. **TBL is much more efficient than PBL but doesn't train the students in the same way as PBL with "Learning Issues". It is also possible for the students to be anonymous which is impossible in PBL.**

Using standardized patients is an area we need to build further on in Sweden. The MD students here at UCLA DGSOM practice from their first weeks of studies and continuously and regularly on standardized patients *which I believe is one of the best ways to practice being a real physician without being in the real hectic health environment.* It is however very costly and resource-demanding. *But this is an investment in the future for the future.*

Medical program

The MD students at UCLA DGSOM are slightly more mature than Swedish colleagues, perhaps due to the fact that they have already passed by 4 years of college studies before entering the MD program. Another reason could also be that these students have passed a number of difficult tests leading to a very strong feeling of being "one of the few chosen ones". All students I have met her transmit that feeling to me while I very seldom see/feel that feeling with Swedish students. The pride of being a student here is enormous. I would like to increase the pride in our Swedish students at home. The students here furthermore work very hard. During clerkships they start before 5 AM in the morning to prepare for rounds which take place at 6 AM where after the work until early evening. There are rules about working hours for medical students during their clerkships though saying that they are not allowed to be scheduled more than 80 hours per week during clinical clerkships. I would like my Swedish students to understand their much better working hours and feel their appreciation for this fact. The UCLA DGSOM students further more do not have summer vacations after their second year. This probably means they are actually studying more than 5 years (Swedish hours) within their 4-year program.

The MD program at UCLA DGSOM is currently under review in order for the students to earlier get clinical contact as well as increased number of clinical clerkships. *My opinion here is that in order to understand what is going on "out there" in the clinic with the patients one has to have a certain amount of theory, and therefore I am not sure the clerkship teachers will be overwhelmed with the younger students.*

Department of Urology

The department of urology has a vast number of teaching and learning activities regularly and continuously scheduled leading to a great learning atmosphere. The department furthermore seems not to be in a "splitting into pieces" (more subspecialized into specific diagnoses) mode like my and many other urology departments (and other specialist departments) in Sweden *and I believe (in contrast to many colleagues, politicians and consulting companies) this is of great benefit for the patients. It is my opinion that this department will continue to produce absolute top-quality urologists for the future due to the collaboration among the departments faculty.*

Los Angeles and California

Los Angeles is one of the largest cities in the USA and despite the traffic situation and the homeless both me and my family loves it. The reasons for this are many, the weather, the friendly people, the polite people, the proud people, the beautiful, spectacular and varied nature, the 2400-year-old trees, the vegetables and the fruit in the grocery stores, the road routes, the hiking routes and the wild animals on land and in the sea, all contribute to our opinion here. (see the added pictures)

Comparisons between UCLA and KI

It is my opinion that the end result of our education in Sweden is about the same as here at UCLA. One difference could be that Swedish physicians become more generalizers through our system while the UCLA/USA system produces more specialists. Pedagogically we are both using newer techniques and tools in our struggle to faster produce better doctors for the future. The MDcurriculum here is as locked down (schedule) as the Swedish curriculum and there is not much room for experimentation and small courses. Therefore, my job here was to work within the already existing curriculum. The forms of examination are the same here as at Karolinska Institutet and we are both revising and modernizing our MD-programs. From what I hear, the merit situation for teachers versus researchers are about the same as in Sweden. However, a professor here is definitively a teacher. A professor here cannot choose to not teach. The market here for physicians is really good and the salary for a senior about 4 times higher than for a Swedish colleague. Taxes in California are quite high and reaches close to 50% for those with high incomes just like in Sweden but here one has to pay for many of the things we get for "free" in Sweden so in the end there is not so much difference as one can think. The housing situation here in LA, especially close to UCLA and in West LA, is unreachable for a Swede, unless you have a lot of money on the bank. Houses cost 10 times as much here.

It is a fantastic resource using retired experienced physicians as a teachers, but the ones I have met has not received any income from this activity. It is strange for me to know that they do work without getting any salary for it. And the use of forth year medical students for teachers is also a good idea, perhaps something to bring back to Sweden and my home university. These students would then both get pedagogical and clinical knowledge.

Recommendations

I would recommend anyone with a possibility to leave home for 5 months to take the chance and apply for this scholarship from STINT. It leads to an appreciation for what we have at home, and at the same time a possibility to compare and reflect over the differences. For example my 12 year old son who came here with me and my wife and one older brother, was taught through "home teaching" here. It was very stressful for both him and us parents to find a school here. All the schools close to our home cost around 35000 dollars per school year. The closest public school was not close. In Sweden we are proud of our SCHOOL-DUTY (SKOLPLIKT) meaning that all children has to goto school. So far it sound good, right? What about California? Here it is an EDUCATIONAL-DUTY (UTBILDNINGSPLIKT) meaning that all children has to be offered education by the adults/parents/teachers.

Is there a difference? Which is best? We have had neighbors in Sweden where finally the police had to come and try to get their children to school due to the school-duty. Their child refused. All children has to goto school. Why not turn it around and say that all children has to be educated and it is our duty as being adult to see to that. That leads us to home teaching which of course is the best alternative for some children, better than suffering through a school-system where they feel they do not belong. I come back to this fact again (see above text), all people including children are different and should be treated individually. Even though most children fit in school, not all do, but they should also be educated. My son has been taught in the same Swedish subjects from his Swedish school as the others in his Swedish class, by me and my wife. Besides that he has gained more insight in international behavior than most people in his age, and he has seen more of California than most Californians, reflecting over the world, the nature and us human beings and our behavior. He has become a true internationalist prepared for the future in this world.

UCLA and VISA

The next years fellow. Be prepared that you might not get the VISA until a few weeks before departure which is an extremely nervous waiting period. It would be great if UCLA could speed their part of this process to reduce the stress.

Department of Urology and DGSOM

The social activities together with colleagues has never been one of my strong and most important things in life but some activity would be nice and would not be hurtful for the department. I have had more social activities with the DGSOM than with my urology department here. It is good to meet outside of the working environment every now and then. Even if it is just for a beer somewhere.

Action Plan

As both a teacher, a Swedish course director, an International course director, an examiner and now the vice chair of education at my University Karolinska Institutet it seems I have many opportunities to affect the teaching at home. However, changing rigid structures like our educational system, methods and curriculum is not done easily. My gained experiences from this sabbatical will constantly help and guide me in all the pedagogical discussions and decisions to come both on the MD program, the University and at the clinical educational level. It is really important for us to make the future as good as possible for the next generation and ourselves.

The main take home messages are

- 1. Try to increase the use of active teaching and learning methods like PBL and TBL
- 2. Implement these methods in my University's new learning environments and learning studios
- 3. Work for others from my department and university to take an opportunity like this
- 4. Work for receiving of colleagues, residents and students to come to Sweden to see how things work out there/here
- 5. Work for increased pride in Swedish students
- 6. Work for more teaching and learning activities with standardized patients in Sweden
- 7. Try to implement something resembling the Grand Rounds system in my department
- 8. Continue working at the EAU level for a European Urology Curriculum for medical students

Thanks to

Karin Forslund Hans Pohl

Ole Petter Ottersen Annika Ostman Wernersson Gunnar Nilsson Rune Brautaset

Mark Litwin Jesse Mills Dawn M. Zelmanowitz and her team Kristy Fong and her team Joe Martinez All residents and fellows at the dept of urology

Ivan Shulman Marifrances Williams, Sharon Gambo and Ken Lay.

Pictures and images

Home



David Geffen School of Medicine



Ronald Reagan Medical Center



Wasserman building – my working place



PBL sessions



TBL sessions



Swedish students on UCLA



Standardized Patient Center - examination



Traffic situation in LA



Real Pizza at Buonos in Long Beach



Lake Tahoe Emerald Bay



Halfdome at Yosemite



Pacific Coast Highway







Avenue of the Giants at Humboldt Redwood National Park

Huntington Beach, my wife Mari-Anne



Sunset in Santa Monica



LA downtown and Griffiths Observatory seen from the Hollywood sign

