

The Reply



Interprofessional education and collaborative practice (IPECP) programs have the option of focusing exclusively on quality and safety issues.¹ Other clinically relevant IPECP topics, such as the team management of specific diseases, can be set aside. It's noteworthy that IPECP team-based management of specific diseases lends itself to in situ simulation-based training, along the lines described by Mileder in his thoughtful letter.

Mileder, an Austrian, may be unaware of the sad truth that medical science, foundational for IPECP case discussions of specific diseases, is a "third rail" topic for many US IPECP course planners. This is the result, in part, of embarrassing disparities in medical science coursework among the individual training tracks. It can be argued that IPECP program developers are the inheritors of the collateral damage resulting from a lack of sufficient medical science curriculum in our K-12 schools. Interestingly, another area where this pops up is with regard to the low health literacy in the general population of the US. This is a downstream ramification of archaic US K-12 medical science curricular misconceptions and traditions.

How did we get there? For one thing, US thought leaders have failed to connect the dots between these 3 interrelated items: the low health literacy in our general population; the narrow scope of sanctioned IPECP training; and our inadequate US K-12 medical science curriculum. Personally, I've taught medical science to K-12 students for decades in special programs, and I've been impressed with the fact that 8th and 9th graders can handle medical science coursework. They love it!

Of course, I can already hear the knee-jerkers complaining, "Medical science is too challenging for K-12 students," or "there's no time for medical science in our packed public school curriculum." Wrong! And, wrong

again! The level of difficulty of grade-appropriate medical science and environmental science, a totally different subject, are comparable, yet environmental science is a K-12 science requirement, while medical science is barely mentioned, except for several adolescent-relevant topics (eg, sex education, smoking, sunburns). Let's consider a 50-50 split in the current K-12 environmental science time allocation in order to accommodate the currently short-changed medical science blocks.

My point is that medical science education reform is urgently needed to address our costly society-wide medical science ignorance issues. I would argue that K-12 medical science education is the place to start. We should abolish the 1910 "Flexner wedge" that unknowingly forced medical science into its lofty "upper level" university course status for future generations. We should encourage a new generation of forward-looking K-12 medical science curriculum developers to respond to today's societal needs. Certainly, doctors have as much to gain as anyone from universal health literacy, especially if that incorporates a strong medical science component.

Personally, I like the "medical science for all" concept. And, I like the societal concept of encouraging children and grandchildren to embrace shared interests in their entire family's health care issues. It's okay with me if my grandchildren ask, "Grandpa, how's your heart today?"—HIPAA permitting!

Ronald S. Weinstein, MD

College of Medicine

College of Pharmacy

Mel and Enid Zuckerman College of Public Health

The University of Arizona

Tucson

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Reference

1. Schmitt MH, Gilbert JH, Brandt BF, Weinstein RS. The coming of age for interprofessional education and practice. *Am J Med.* 2013;126:284-288.