



Donald E. Wilson, MD

Senior Vice President for Health Sciences, Howard University

BY ANGELA MUNASQUE

Donald E. Wilson, MD, was recently recognized by the AAMC with the Abraham Flexner Award for Distinguished Service to Medical Education. Previously, Dr. Wilson served as dean of the University of Maryland School of Medicine, a position he held for 15 years, and as chair of the department of medicine at the State University of New York, Downstate. He has also worked with the AAMC, the Accreditation Council for Graduate Medical Education, and the National Institutes of Health, among other organizations.

You've had a long career in medical education—how did you choose this path?

I didn't! I think it basically chose me. I set out to be a practicing doctor. During my residency, I began to be bothered by all of the unanswered questions in medicine, and thought that maybe if I got involved in research, I could answer some of those questions—which is somewhat naïve, I guess, but it was a good thought. I became more involved in so-called academic medicine, and I began to do research in my area of specialization, which is gastroenterology. I went from being a faculty member doing research, to becoming a division chief doing research, to becoming a department chair doing research, to becoming a dean doing research—although, soon after becoming a dean, I didn't have time to do my research. In a sense, I didn't really select academic medicine—it just sort of happened, and it happened because I discovered there were more questions than there were answers in medicine.

I have not done any bench research now for almost 15 years. When I became dean at Maryland in 1991, I had my research team in New York poised to move to Baltimore, and I told them to wait for about six months or so until I saw how easily I could set things up. I became so immersed in trying to turn around the Maryland School of Medicine that after a year, I told them they needed to either stay where they were or



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seek other opportunities, because I would not have the time to do any of the research myself. If I couldn't do some of the research myself, I wouldn't want it done under my name, so I decided not to reopen my laboratory in 1992, and I became more of an academic administrator then. I always continued to teach—I enjoy that. The further up you go in administration, teaching becomes one of the few joys you have.

I retired in 2006, and I failed retirement in 2007, and came back theoretically for only one year to help jump-start some things at Howard. Right now, I'm trying to build the health sciences at Howard into a more formidable group than it was a year or so ago, and that's where I get my fun now.

What are you proudest of in your career?

When people start talking about what I've accomplished, it depends on whom you're talking to. Some will talk about medical education; some will talk about health disparities; some will talk about research. One of the most significant things that occurred

during my tenure at Maryland is the dramatic increase in external research funding, and that is a tangible piece of information. I think it went from \$66 million to \$68 million a year when I started to \$375 million a year when I retired, which placed the medical school in the top 10 for public institutions in the nation and in the top quartile of all institutions in the nation.

One of the things I'm most proud of is that we actually quadrupled the number of underrepresented minorities in the faculty at the medical school during the time I was there. This, I think, is a long-term goal that more people need to become interested in, because this is likely to have a pulling effect on getting young people into at least considering medicine, when they see there's a diversity of people who are likely to teach them. We have a lot of community projects with the schools in Baltimore: We let students spend six weeks in the medical school on various projects, and we bring teachers to help them relearn how to teach science and mathematics, because sometimes they're embarrassed to let people know they never really learned it that well. These things are still ongoing, and nothing has stopped since I left Maryland.

What are some of your biggest challenges at Howard, and how are you addressing those?

I think one of the biggest challenges has been getting people to want to compete aggressively in the real world—to seek excellence, at almost any cost. Getting folks to raise their expectations, because my expectations are reasonably high, and I had the same issue at Maryland, where people were sort of satisfied with where they were, and I wasn't satisfied with where they were, and told them they had to do better. That's exactly the same message I'm conveying here. I'm not satisfied with where the medical school is. I'm not satisfied where the nursing school is, or the health science school. I'm not satisfied with the hospital.

Everybody's got to do better—and in fact, people are beginning to do better.

One step is to be fairly straightforward about the expectations in terms of productivity—not only in research, but also in teaching and clinical care. There were a lot of folks at Howard who thought, at the time, if they had one research grant, that was wonderful, and I'm saying, "Well, what's wrong with two or three? Why is one 'wonderful' if you have the ability to get more?" If you'd like to build something and develop a program that is one of the best in the country, you usually have to expand it with people, and the way you expand with people is you either grow them or recruit them. You can only grow or recruit them if you base part of what their compensation is on soft money—nobody has enough hard money to pay for the salaries of everybody you'd like to have, and that's the real world.

Changing the concept of "the university should do this" to "we ought to do this" has been one of the issues, and that's being embraced now to a greater rather than a lesser extent. I've discovered that the folks who are practicing in the hospital now have much more pride in what they're doing. I see folks interested in physically improving the hospital. We're seeing improvement in patient satisfaction and in the numbers of patients who are coming to the hospital. We're seeing an increased interest in faculty relocating to Howard University. In that sense, it's been rewarding.

You are partly known for your work with technology in medical education—can you share some of your experiences in that area?

I think it was 1993 when we required laptop computers at Maryland. Other schools

were using them, but we required them. At the same time, we got rid of the microscope as a required purchase of equipment. It was really rather interesting, because the students said, "Well, wait a minute. We're not going to have a microscope anymore, so how are we going to learn?" And we said, "You're going to learn by using the computer, which will give you much better definition than anything you're likely to see under your microscope." The major objection to that was not that we were moving to laptops, but the first-year class, which normally sold their microscopes to the incoming first-year class, said, "What are we going to do with our microscopes?" So we bought them all from them, they were happy, and that was the end of that problem.

We progressively introduced computerized teaching modules as a way for students to better learn what they had to learn. We were dealing with students who were growing up with computers, and they would rather spend their time dealing with that than listening to people give lectures for hours on end. We introduced our new curriculum in 1994 at Maryland, and we diminished dramatically the number of lectures, allowing no more than two hours of lectures a day. We significantly increased small group teaching sessions: Groups of 15 or so students would meet with faculty—primarily as facilitators, not so much as lecturers—and students would discuss issues in medical education, be it physiology or biochemistry.

How else do you prepare your students for the real world after medical school?

We tell students, "We're not teaching you medicine. We're teaching you how to learn, because that's what you're going to have to

do for the rest of your life." One of the old jokes, which is not so far from the truth, is that half of what we teach you in medical school is probably going to be wrong by the time you finish or by the time you get out there, and right now, we don't know which half it is! It's not quite that bad, but in reality, the world changes, and the important issues change, and we've tried to get students to understand how they can get the information they need rather than memorizing something that's in a lecture or in a textbook.

Another issue has been to try to get them to understand the importance of professionalism in medicine, which is something you hear a lot about now, but for a period of time, we weren't hearing about professionalism. Professionalism is more than just doing the right thing—it's understanding what society expects and making sure you don't cross the line in terms of putting your patient first.

We try to get across the fact that they have an obligation to interact with and help their community when they can, and most of our students participate in a community activity somewhere during the four years of medical school. Some of these are highly structured, and others are not. It may be clinics that our faculty supervise and our students run to provide free care for those who cannot afford it. It might be things they do on holidays. It might be going to schools and helping students. We try to get them involved with community, as opposed to just going to medical school and getting grades and getting out. It's part of being the physician, rather than the educated medical person. And that's fun, seeing people change into what I call "the real doctors"—there's not enough time spent on the real doctors these days. ❖