The GEA 50th Anniversary Dispatch 1969-2019

At the Group on Educational Affairs reception at Learn Serve Lead (LSL) in November 2019, we celebrated the 50th anniversary of the founding of the GEA.

We announced that 2020 would be designated The Year of the GEA and planned a variety of activities for the spring 2020 regional meetings including social media events and a research project. We hoped to physically sort through the AAMC's archives and gather memorabilia related to GEA accomplishments. We planned to share the information and visuals collected in a gallery walk during the 2020 Learn Serve Lead Meeting. It was a good plan. But, as we all know, plans change.

Due to the COVID-19 pandemic, many GEA members and AAMC staff have worked from home since March and don't have access to old physical files. The 2020 Spring Regional GEA meetings were cancelled, and the November meeting will be virtual. Priorities have changed, a gallery walk is no longer on the table.

We are instead sharing these commemorative GEA 50th Anniversary Dispatches over three issues between September and December. In sum, the dispatches will contain reflections on our collective past as a professional development organization, opportunities for sharing memories via twitter, an announcement of a research project we hope you will participate in, and points of interest related to our accomplishments. We hope you enjoy the collection.

Happy anniversary GEA!

50 GEA Celebrating 50 years of medical education.

1969: The Beginnings of the Group on Educational Affairs

Carol Elam, Ed.D.
National GEA Chair 2018-2020

Some would say 1969 was a lifetime ago. Among many notable events, Richard Nixon became president of the United States, Vietnam War protests raged across America, the Vietnam Draft Lottery was implemented, astronauts walked on the moon, the Beatles performed their last live concert, the Woodstock music festival took place in New York, the Manson Family committed horrific murders of five individuals, the first ATM machine was installed in the U.S., the microprocessor was invented, and the Public Broadcast Service was established.

In 1969, change was also occurring in medical education. In that year, the Group on Medical Education (later renamed the Group on Educational Affairs) was formed. What was the medical education environment like at that time? One can gain a sense of issues of concern percolating across U.S. medical schools from reviewing articles published in the *Journal of Medical Education* (JME, the precursor to *Academic Medicine*) at that time. Articles from 1969 addressed a variety of administrative topics including governance, faculty service plans and salary scales, medical service plans, manpower issues, state and federal support and financing of medical schools.

Articles published in 1969 addressing educational issues were largely commentaries, a thoughtful exemplar of such being "The Primary Physician" by Dr. William R. Willard, the founding Dean of the University of Kentucky College of Medicine. In an early statement of advocacy for broadening the definition of medical education and training, Dr. Willard states that "a further point of relevance in planning the curriculum is the need to view the periods of undergraduate medical education, internship, and residency training as an integrated whole." (JME, Vol 44, 1969, p. 123) Noteworthy is the fact that the September 1969 issue of JME was largely devoted to graduate medical education. Other articles published in 1969 spoke to aspects of continuing medical education. Thus, 50 years ago, as today, efforts were underway to direct attention toward the continuum of medical education.

Other articles published in 1969 described honors programs, salary support for clinical faculty, and accelerated medical student programs, teaching medical students and other health professionals. A few articles described innovations in education such as use of closed circuit television, self-instruction, and a new emphasis on social sciences.

Arguably, the time was ripe for a transformative initiative in medical education, introducing theoretical approaches to teaching and learning, instructional design, evaluation of student performance and program evaluation. Across the United States, formally trained educators were hired into medical schools to study the educational process and prepare others to become educators. A review of the excellent series of articles conceived by Dr. Maurice Hitchcock and published in Advances in Health Sciences Education in 2002 details this introduction of professional educators into the academic medicine setting.

1969: The Beginnings of the Group on Educational Affairs

Six preeminent foundational leaders in medical education are profiled (see below), with each discussing the most important innovations, improvements, and lessons learned in medical education from roughly 1970-2000, as well as trends that should be the focus of medical educators in the early years of the 21st century. Importantly each of the leaders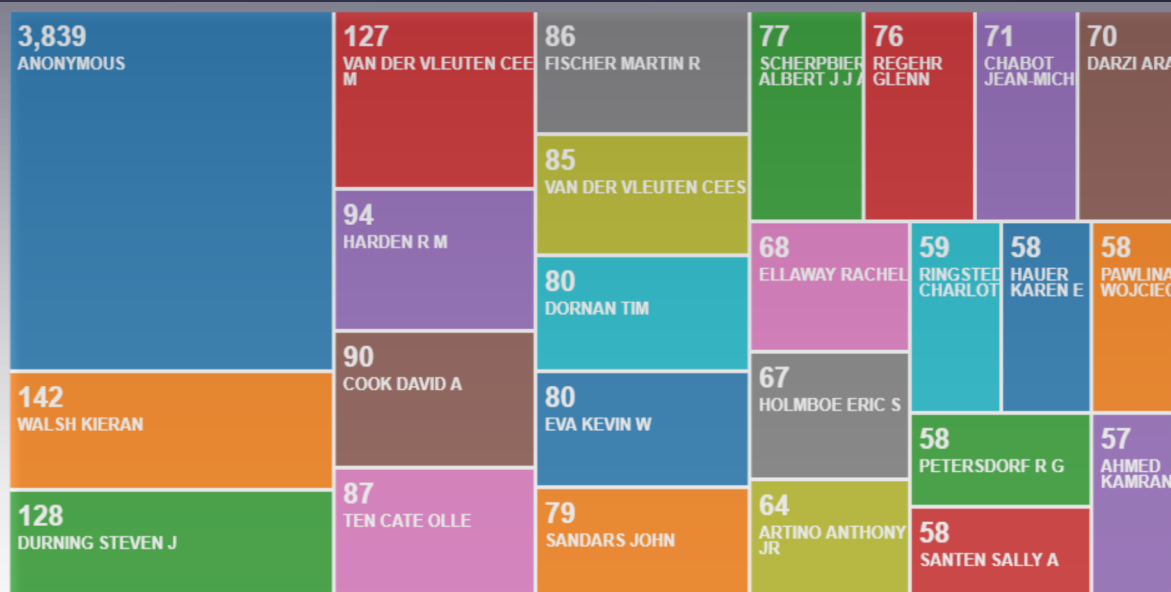 profiled attended AAMC Annual Meetings, published books, articles and or educational resources, and supported the development of the Group on Medical Education. Each demonstrated core tenets that remain part of the Group on Educational Affairs: scholarship, collaboration and sharing, collegiality, and a demonstrated desire and sense of responsibility to mentor the next generation of medical educators.

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25 most frequent medical education authors in Medline 1969—2019

3,839 ANONYMOUS	**127** VAN DER VLEUTEN CEE M	**86** FISCHER MARTIN R	**77** SCHERPBIER ALBERT J J A	**76** REGEHR GLENN	**71** CHABOT JEAN-MICH	**70** DARZI ARA
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				58 PETERSDORF R G		**57** AHMED KAMRAN
128 DURNING STEVEN J	**87** TEN CATE OLLE	**79** SANDARS JOHN	**64** ARTINO ANTHONY JR	**58** SANTEN SALLY A		

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Brownie Anderson's Oral History

Introduction

M. Brownell (Brownie) Anderson marked her 27th year of service at the AAMC in 2011. At that time, she held the title of associate vice president in the Division of Medical Education. Brownie sat with AAMC archivist Molly Alexander for an expansive interview related to her time and contributions to the AAMC as part of an oral history project.

She soon moved to the National Board of Medical Examiners (NBME) where she has now worked for 9 years. Brownie is currently the Vice President, Medical Education Global Initiatives of the NBME. She will retire from the NBME in December 2020.

To our knowledge, excerpts from this interview have not been released since its recording. With Brownie's permission and her review of this excerpt we take you back to the 1980s and move forward 27 years through her AAMC work with the GEA.

Expect 2 additional installments to be released in the upcoming GEA 50th Anniversary Dispatches.

♦ Chapter 1 — Brownie's beginnings at the AAMC, medical education changes and trends from the 1980s through the 1990s, and her 2011 projections of necessary medical educational evolutions.

♦ Chapter 2 — exemplars of noteworthy AAMC/GEA medical education project collaborations between 1980 and 2011.

♦ Chapter 3 — the GEA and its contributions to medical education.

Brownie Anderson's Oral History
Chapter 1 : In the beginning

I used to be a constituent of the AAMC. I was at Southern Illinois University, which was at the time (late 1970s to the early 1980s) one of the newer medical schools that was created when there was capitation money. I had participated in the AAMC's annual meeting, and one day my boss, Reed Williams, came in and said, "Well, there's a job at the AAMC that would be great for you. I'm going to put your name in for it. You love the AAMC annual meeting, and you love Washington." I thought to myself, "That's great, but there's no chance I'll get that job. But it would be interesting to look at it." I wasn't unhappy, I just thought, "What an interesting opportunity."

I came to interview, and the next day they offered me the job. I came thinking I would be here for two or three years.

I came to do a project that was focused on the basic sciences. There was a corresponding program in the clinical sciences, looking at the evaluation programs that were used in clinical clerkships. They wanted to do a similar one in basic science, but I never did that project because so many other things came up that I got engaged in. So, I never did the job I was hired to do here.

What I was doing was working with the Group on Educational Affairs, which had a different name, the Group on Medical Education, and I was working with the Research in Medical Education Conference. I got involved with the curriculum directory at that time, and I was working with the Group on Medical Education chair, Vic Neufeld, M.D., McMaster University Faculty of Medicine, on a project looking at an inventory of curricula.

The other thing that we started was -- people were saying that they wanted to be able to network with people. This was long before the internet. There were computers, but they were the big, huge, mainframes. There was no person-al computer. So, what we had then, were people who said, "I'm working on a basic science project, and I want to know who else is doing this, at another school." I had created these notebooks with telephone numbers, addresses, and contact information (no email address, mind you), for people who were working in various parts of the medical education curriculum. We printed the notebooks into little pamphlets. Hopefully, there are still some in the archives. There were six different colors. One was basic science; one was clinical science; one was problem-based learning; one was admissions; and I can't honestly remember the other two. What happened was, people said, "I don't know who these people are. Why would I call them? I don't know that this person actually knows anything." But it was interesting to reflect back and think that that was the beginning of a real networking activity.

- **Early exposure to patients**
  When I first came to the AAMC the curriculum was still divided into two years of basic sciences, and two years of clinical sciences, where the student sat in lectures for two years, and absorbed all sorts of details that they then were supposed to translate to a human being in the third year. While there was always (and still is) something called Introduction to the Patient, or Introduction to Clinical Medicine, or a patient/physician relationship course, where students worked on clinical skills, now that happens at some places in the first week of medical school.

- **Experiential learning**
  There's a recognition that people learn experientially. By being engaged in either patient care or with a standardized patient, students will learn and be able to apply what they're learning better than sitting in a lecture or reading a textbook. We have much more integration of the learning.

- **The business of medicine**
  Running a practice, the costs of medications, the evolving healthcare system, and the implications of all these changes

- **Problem-based learning and team-based learning**
  Recognition that the physician is a member of a team, not necessarily always the leader of the team

- **Patient-centered care**
  Providing the best care for the patient by all members of the health care team: physicians, nurses, social workers, pharmacists.

Brownie Anderson's Oral History
Chapter 1 : Medical schools greatest need in 2011

I think that one of the big needs is consistency. Let me explain that. We talk about change and how there has always been change in medical education. But I think that the changes that are underway in the healthcare system, the movement of the medical school from being a school into an academic center, that's part and parcel of the hospital. This has been a bigger change than anybody can even, I think, quantify. It's not been stable ground. The medical schools are wrestling with accommodating to the changes that are needed to produce the kind of physicians who are going to be able to practice in this new healthcare system, but we don't really know what this new healthcare system is. So, we're always a little bit behind in trying to identify that impact of systems change and respond to it. And the faculty are struggling with the change in their roles, from one of delivering information, to facilitating small groups, and putting everything on the web, and stu-dents not attending classes be-cause they can watch a podcast. So, there are these fundamental cultural changes that are happening.

Another big, big change that I have seen is that when I started, the medical school dean worked with the hospital; managed the relationships with the hospital, and paid attention to the educational program. The dean was the central figure for the curriculum. There was an academic dean who did things, but the dean, ultimately, was involved in education. That has changed dramatically. The person who is in the academic dean role is now doing the things that the dean was doing fifteen years ago -- working with the hospital; working with the faculty; and, managing the educational program. This change in administrative roles represents a shift in the culture and consistency in the medical education program.

I also think that the schools are facing the reality that the role of the faculty member has changed, especially the clinical faculty member. Medical schools are created, ostensibly, to educate physicians. If you look at the numbers of faculty, especially in that period when we had no new medical schools, the numbers of faculty, particularly the clinical faculty, have grown exponentially. Yet, the medical students, the number of medical students, has stayed the same.

So, you have to ask the question, what are all these faculty doing? Now the faculty are providing the revenue through patient care, and/or research, to sustain the academic enterprise. So, the role of the faculty member who is the teacher engaged in the activities involved in teaching and the scholarship of teaching is not valued the way it has been valued in the past. It's one of the projects we've been working to overcome, I would say, but that's been a big change, too.

To be continued in Issue 2...

Organization, Reorganization, and the Medical Education Continuum: The GEA 1969-1996

James Leach

James Leach is a history student pursuing his PhD at Carnegie Mellon University, Pittsburgh, Pennsylvania. He was invited by the GEA's AAMC staff to use original source material from the AAMC archives to document the history of the GEA's early years. He spent the summer of 2019 engaged in reviewing early GEA steering committee minutes and AAMC reports to write the following piece.

The GEA—Early Years

The AAMC was founded in 1876, when a group of deans and faculty met at the Jefferson Medical College in Philadelphia to discuss the state of medical education in the U.S. At that time, medical education was largely unregulated and of varying quality, leading to a lack of trust in the profession. This group of educators established basic practices for medical schools. The annual meeting of the AAMC became a forum for medical school deans to discuss issues related to medical education. Over the years, the AAMC worked on behalf of its members to improve the quality of medical education through a variety of innovations including accreditation and the Medical College Admission Test.

The GEA was born in a time of far-reaching change for the AAMC. In 1965, an AAMC committee led by Dr. Lowell T. Coggeshall released *Planning for Medical Progress Through Education*[1]. Among many recommendations, the report urged that medical education be viewed as a single continuum from premedical education through the physician's career.

The GEA began in 1969 and was formally recognized by the AAMC Executive Council in 1972. In these early years, the GEA's initial efforts were directed toward the formalization of its internal structure and governance: organizing the group into four regions which met annually and taking on responsibility for the Research in Medical Education (RIME) Conference. In addition to the steering committee, the constituency of the GEA consisted of appointed representatives from the AAMC's members. Recognizing the diverse interests of constituents, the GEA organized into three areas of focus: research, curriculum, and innovations in instructional technology (later renamed biomedical communications and, still later, instructional resource development). With this basic structure in place, the organization began to plan its own projects and initiatives. The GEA made its first move to address the medical education continuum in November 1973. Three steering committee members proposed that the GEA broaden its focus to include GME and CME. Their reasoning followed that of Coggeshall's report: taking on two new constituencies would break down artificial divisions of responsibility and thus advance the continuum. The topic was reintroduced in a February 1974 Steering committee meeting, when several possibilities for representing CME within the Association were discussed. Ultimately, the committee agreed the GEA could accommodate the two new constituencies. In addition to the three existing areas of interest, the GEA added GME and CME.

After discussion at the regional meetings, this structure was formally adopted in July 1974.

The GEA took several steps to deepen its engagement with the continuum over the next few years. In 1976, the AAMC appointed an ad hoc committee on CME to formulate AAMC policy toward CME. The GEA made important contributions to this project, with four steering committee members serving on the committee and regular members contributing their perspectives at regional meetings. The same year, a member of Northwestern University's faculty attended a steering committee meeting, explaining that school's approach to GME as a possible model for university responsibility for GME. Also, over the next few years, the GEA planned technical resource panels (TRPs) on GME and CME to explore how the group might approach to these topics.

During this time, the GEA also started to face questions about how to interact with other sub-interest groups without its activities becoming fragmented. In 1975, the steering committee was approached by a group of associate deans involved in CME. This group had met informally for the past decade but was now planning to formalize into an official organization (which would eventually become the Society for Academic Continuing Medical Education) and wanted to serve as a resource for the AAMC. Around the same time, the GEA had to navigate a changing relationship with another unofficial group, this one comprising directors of schools' offices of medical education research. The group had met since 1965 but suspended its activities in 1971, expecting that GEA meetings would serve the same functions. As time went on, the group of directors realized that medical education research was only one of several topics up for discussion at the GEA and that their cultivated sense of community was lost in the larger setting; in 1974, the directors decided to resume their informal yearly meetings. This arrangement continued until 1987, when the group formally organized into the Society of Directors of Research in Medical Education (SDRME).

In 1974, the steering committee appointed GME and CME consultants who would attend AAMC meetings without any voting power. Steering committee members justified this decision by pointing to the strength of the GEA's regional structure. Organizing constituents by region promoted cross-fertilization of ideas, whereas organizing by interest area would lead to a siloed, fragmented group.   It would be several years before the GEA began forming Special Interest Groups (SIGs) as a new method of organizing members around specific areas of interest, but when these began, neither area of the continuum was organized into a SIG. When the GEA did address the medical education continuum in the mid-1970's it was typically in the context of a larger AAMC initiative rather than some project internal to the GEA.

The General Professional Education of the Physician Project (GPEP) was a major educational initiative of the AAMC in the 1980's. As its name implied, GPEP was intended to examine the general professional education of doctors – that is, the portion of medical education common to all students which would serve as a foundation for a career in any specialty. The GEA was closely involved in this project, using its regional meetings as a forum to identify key issues and refining them into a report delivered to the GPEP panel. The project culminated in the 1984 report "Physicians for the Twenty-First Century"[2] (hereinafter, the GPEP Report), which recommended broad liberal arts requirements for admission to medical school, a reduction of lecture time in medical school, and development of tools to evaluate students' ability to learn independently, among other ideas. It is worth considering a passage from an AAMC annual report used to introduce the project:

Various pressures during the last five to 10 years have focused attention on the need to assess the direction and effectiveness of our education systems. In elementary and secondary education concern about the impact of "innovative" educational philosophy and practice prompted a call for a "return to the basics." In no small way a continuing decline in the standardized test scores of graduating high school seniors was responsible for raising the alarm. The dwindling supply of public monies available during recent years to support education has placed increased emphasis on selectivity in the allocation of educational resources. . .. In short, a variety of forces have combined to suggest a rather comprehensive reassessment of our educational mission and strategies at all levels.

This passage draws an explicit connection between the GPEP Report and the back-to-basics movement of the late 1970s and 1980s, which tried to counter a decline in the nation's standardized test scores by rolling back educational experiments and refocusing on the core subjects. The passage also highlights the importance of financial considerations to the GPEP Report. In a time of "dwindling supply of public monies," the project would have to push for reform in a cost-effective way: By concentrating on the period of medical education that all students experienced, the GPEP Report could make a major impact on medical education without focusing individually on the various specialties, thus maximizing its efficiency.

In many ways, the GPEP report continued the legacy of Coggeshall's report: It shared a similar concern with the fragmentation of medical education into many specialties and saw a "common foundation of knowledge, skills, values, and attitudes" as the solution. Also, like Coggeshall, the authors of the GPEP report recognized that medical education must account for the rapid pace of scientific progress; they argued that medical school should prepare students to continue learning throughout their careers.

That being the case, why was the GPEP report a departure from the GEA's earlier focus on the continuum? In the 1970s, the GEA attempted to bring GME and CME specialists into its constituency, creating a forum for discussion and planning that involved medical educators at all levels of the continuum. With the GPEP report, the goals of integration and lifelong learning remained, but they were now approached from within UME, rather than across the continuum. Crucially, this second approach did not present GME and CME educators with an obvious way of becoming involved in GEA activities.

The issue that finally led to a direct discussion of the GEA's relationship to the continuum was a plan for individual membership. This proposal was designed to increase faculty involvement in the group: Individuals (in addition to institutions) would be offered membership in the AAMC with official designation of some area of interest, such as the GEA or the GSA. As this idea was discussed, one Steering Committee member questioned the value of the group's current system of five activity areas: An individual membership plan would change how constituents interfaced with the GEA, making this a logical place to reconsider how those constituents were categorized. The discussion of how to increase specialized engagement in the AAMC led to a discussion of what sorts of specialists should be involved in the GEA. During the next meeting's discussion of the individual membership proposal, one Steering Committee member proposed that the group should concentrate on UME, with no representation from "groups for which it [the GEA] has no program." The committee ultimately ended the discussion with the following statement: "The primary focus of the [GEA] is medical student education, with the principle emphasis on the medical educator faculty member and the process involved in medical student education" but suggested that it was not abandoning GME or CME.

The GEA's most far-reaching decisions of 1988 saw the group's name change from the Group on Medical Education to the Group on Educational Affairs, as well as the introduction of SIGs as a means of focusing constituent activity around specific topics. One of these SIGs founded in 1988 was a group for basic science educators. In 1993, this SIG split off into its own organization, which would eventually become the International Association of Medical Science Educators or IAMSE.

Reorganizing the GEA

In 1996, the GEA formally completed its reorganization process, creating four sections that each represented a component of the medical education continuum. The idea of creating several sections (for UME, GME, and CME) came up in 1992, but the Steering Committee simply agreed to "continue to study the issue." In early 1994, the issue came up again: The Alliance for Clinical Education (ACE) approached the GEA with a proposal to closely affiliate itself with the group, essentially becoming a subgroup of the GEA. While the Steering Committee rejected this idea, it did prompt another discussion of the GEA's internal organization. As an alternative to partnering with the ACE, one Steering Committee member proposed five sections (basic science, clinical science, residency education, continuing

education, and curriculum deans) to cover different areas of interest along the continuum. In 1994, the Steering Committee initiated the review process that led to the 1996 reorganization. At the 1994 annual meeting, the GEA hosted a plenary session on "Reinventing the GEA to Meet the Challenges of the Future." By late 1995, the Steering Committee was well underway in planning four new sections for the group. There was concern that the group's new GME section would overlap with the soon-to-be independent Group on Resident Affairs (GRA), resulting in duplicated activities and wasted resources; the Steering Committee suggested matrixing between the two groups' steering commit-

tees and demarcating the different domains of the two groups (the GRA focusing on the administration of GME, the GEA focusing on the educational component). By the end of 1996, the GEA had instituted the core of its new organization, supplementing the four regions with four sections: UME, GME, CME, and research in medical education. As part of the reorganization, membership in the GEA was opened to all individuals associated with AAMC institutions (a list of about 4,000 people), each of whom was asked to associate with at least one of the new sections.

The 1996 reorganization went to the heart of the GEA's structure. Earlier attempts had

built on top of the group's core (UME-focused) activities, which remained unchanged. With the reorganization, GME and CME were placed on the same structural level as UME, each with its own section and representation on the Steering Committee. In practice, this arrangement placed the continuum at the center of the GEA's structure to ensure that CME and GME have remained on the group's agenda since the reorganization. Also important was the decision to open the GEA to individual membership. The reorganization thus represented a formal commitment to the continuum of medical education.

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2 Physicians for the twenty-first century. Report of the project panel on the general professional education of the physician and college preparation for medicine. (1984). Academic Medicine, 59(11), 1-208. https://doi.org/10.1097/00001888-198411000-00001

Connect then Lead: GEA Chair 2003-2004
Deborah Simpson, PhD

It started out with "there is a great group of individuals committed to medical education"... They meet two times a year. One a national meeting in the fall where one can learn about leadership and how medical education intersects with all the other aspects of a medical school. The second a much smaller, regional meeting held in the spring of each year that is just medical educators. This is where the nuts and bolts of what's working, what's not, float crazy ideas, and most important opportunities to connect with people who share interests in medical education (and sense of humor) abound! Sound familiar? It's how most of us get "connected' to a professional group – and in the GEA's case - led by volunteers.

Why is that "human connection" so vital to leading evidence-based change in medical education. Amy Cuddy et al's research[1] shows that when we judge leaders, we first look at two characteristics – their warmth and trustworthiness and then their strength and competence. At this time when external forces (per another former GEA chair) has been the "catalyst for change in our educational and clinical systems",[2] it's imperative to remind ourselves and each other – that it's the "human" in each – our values and actions – that is the soul of education (and medicine).

Ultimately, the GEA at it's best is a professional development home for medical educator. But its path will continue to be "rocky" as its purpose and unique role in the world of medical education – it's the only group that spans student to continuing professional development across disciplines and specialties - continues to evolve.

Connect then Lead: GEA Chair 2003-2004
Deborah Simpson, PhD

A Look to our Rocky Past

Who knew that the Central Group on Educational Affairs (CGEA) "almost stopped existing..." per one of the CGEA Laureates! "In the late 1980's the incoming GEA chair (Dr. Alberto Galofre) called every single school after the (spring) meeting and identified individuals who were interested in CGEA... (that brought) the CGEA to life..." Dr. Galofre harnessed the support of individual medical educators and leaders in the region to create the structure for an inclusive organization with leadership and member expectations framed as service to the regional group.

 The CGEA has an "incredible set of shared values..." per another early Laureate. Collegiality and inclusiveness became core values that enabled the development of deep, professional and personal relationships within the CGEA with citizenship expectations of mentorship, collaboration, and leadership succession development.[3]

As we celebrate the 50th Anniversary of the GEA – let's celebrate our past, honor those who have volunteered to serve the CGEA – and challenge ourselves to connect with the human in each of us around shared values to enact and sustain the changes we know must occur in medical education[4] and in ourselves as medical educators.[5]

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4 JGME Hot Topics in MedEd. Graduate Medical Education in 2030. Podcast June 15, 2020. https://journalofgme.libsyn.com/graduate-medical-education-in-2030

5 Simpson D, Marcdante K, Souza KH, Anderson A, Holmboe E. Job roles of the 2025 medical educator. Journal of graduate medical education. 2018 Jun;10(3):243-6. https://doi.org/10.4300/JGME-D-18-00253.1

Celebrate the GEA: I Am a Medical Educator

#WeAreMedEd

The academic year is in full swing with students back in class and clinic. Let's take a moment to come together and celebrate the amazing community of medical educators in the GEA!

How?

Using Twitter, we ask you to share what makes you proud to be a medical educator or what inspires you to do the amazing work you do! Open or close your tweet with "I am a Medical Educator" and utilize the hashtag **#WeAreMedEd**

The world is your oyster! Share pictures, videos, or text, as many or as few tweets as you like.

New to Twitter?

We have you covered! The resources linked below will help you set up a twitter account and describe how to tweet on IOs, Android, and desktop as well as a list of a few medical educators to follow to get you started.

Click on the following instructions for more information:

⇒ [Make a Twitter account](#)

⇒ [Tweet from an iPhone](#)

⇒ [Tweet from an Android phone](#)

⇒ [Tweet from your computer](#)

50 GEA Celebrating 50 years of medical education.