2006 OSR/GSA/GSA-MAS National Meeting Session Summaries:

Plenary I: "The Baby Boomers Meet Generation X: War of the Worlds or Close Encounters of the Third Kind"
Speaker: *Lawrence G. Smith, M.D.,* Chief Academic Officer, North Shore - LIJ Health System

Dr. Smith's talk focused on attributing a growing impression of a lack of professionalism in younger doctors by older, more established members of the medical community to the disparity in values, culture, and social attitudes that exists between the different generations comprising our healthcare system. Core to this discussion were the generational profiles given by Dr. Smith, who described a great contrast between baby boomers and members of the X and Y generations who are now carving out a place in medicine; baby boomers are agitated by the latter generations alleged disinterest in working long hours, in "paying their dues" and showing respect for rank and experience, and their insistence on doing everything their own way, while generation Xers are agitated by the baby boomers' supposed workaholic tendency, overly political and hierarchical system of rank within their profession, and their apparent hang up on experience and seniority over outright competence.

Dr. Smith goes on to suggest that instead of new members of the medical profession being unprofessional, as is so often lamented in medical literature by older members of the profession, newer members of the profession are equally committed to the same standards of professionalism (e.g. excellence, commitment, altruism, caring, honesty/integrity, patient advocacy, courage) but due to their different generational frame of perspective and their newly defined and expanded professional and life goals, go about achieving these standards in ways that appear to deviate from past "professional" behaviors.

Moreover, as the field is handed over completely to newer generations, the nature of residency training and the medical practice environment will change accordingly to accommodate an increasingly diverse and dual-gender physician base that desires more and more flexibility, personal time, and quality of care over quantity of hours worked. In addition to points made during the lecture, follow-up questions helped illustrate the conflict that also exists within the institution of medical education, as the model of education that prevails is largely targeted to an older generation that values rigorous hours of work, rank, and the educational incentive of competition vs. a younger generation that values flexibility, the opportunity to pursue career-related interests not directly involved in their education (e.g. research, dual degrees, patient advocacy, community service), and does not feel that long hours of lecture and rigorous competition for rank within one's class is very valuable in their education as physicians.

Summary written by Adam Travis, University of Louisville SOM

#102: **Medical Student Volunteerism**

1. Talk by *Carol Galper* from University of Arizona (cgalper@u.arizona.edu)
2. Talk by *Sutin Chen*, OSR from Vanderbilt University

Enclosed is the scanned handout of the first lecture.

Additional notes on the first lecture are as follows –

Important Points about cost:

- CUP Cost –> $6000 to $7000 a year
- Shares space with campus health clinic for family clinic
- Salaries of employees absorbed in the cost
- Beg contracts for free services
- Fund raisers

Important Points about student issues:

- CUP handbook
- Curriculum requires a rural rotation that could be filled with CUP hours
- Honors in the rotation requires a paper written on CUP experience.
- Leadership in CUP is mostly 2nd semester first year.
- Ability of students to graduate with Honors in community service

Important Points about Programs, Physicians, etc:

- Malpractice covered under the State Risk Management Pool – as it is legally deemed as a part of teaching
- Board Certified physicians volunteer
- Physicians are honored for their services at the same function as the faculty
- LCME liked CUP and was specially mentioned in the accreditation
- Quality assurance maintained – HIPPA related
- Every program has objectives, should meet LCME criteria, there are CUP reports and there is a medical access database where these are displayed/personalized for each student.
- Future goals include being more active with the LGBT program and not repeat mistakes like the failure of some programs – did not elaborate

#103: Student Wellness Programs

Why is student wellness an issue? Medical student mental health has been studied since the 1950's, and one study revealed that 20% of medical students sought psychiatric consultation at some point during their four years of school. Their conditions are often adjustment disorders, relationship problems, mood disorders, or issues of role strain. A study of medical student CAGE scores demonstrated a significant number of medical students with scores of 2 or greater, suggesting problems with alcoholism. Additionally, there is an LCME standard (MS-26) which states that each school must have an effective system of personal counseling for its students.

(*Diana Alli* – University of Toronto) This speaker started by recounting the year when their medical school had three students commit suicide, which highlighted the need for student wellness programming. The Office of Student Affairs has the philosophy "…that what students do outside of the classroom is as important as what they do inside the classroom." As a part of this mission, they partner with a variety of programs to provide learning opportunities and a wide array of activities. These areas include: debt management, career counseling, emotional well being, physical well being, social activities, spirituality, and their Peer Support Centre. Some of the students organize nights to baby-sit for other students who have children. Diana Alli hosts cooking lessons for 20 students or so at her home, and claims that she can teach them to cook meals for the whole week for just $20.00! For physical well being, they have student involvement in academy challenges (sounded similar to intramurals). One aspect of emotional well being is addressed by stress management workshops.

(*Peggy Dupey* – University of Nevada) At the University of Nevada, they have been using a Medical Student Needs Questionnaire since 1980, and their data shows reveals a consistent list of the top three concerns of medical students: 1) Uncertainty regarding the ability to learn everything needed to be a physician 2) Balance in life 3) Lack of a sense of control over one's life. There is also evidence that wellness programming may decrease depression and anxiety, increase sensitivity toward self, peers, and patients, decrease the perception of isolation, promote greater use of positive coping skills, and decrease the use of negative coping skills. Some elements of their wellness programming include an incentive and reward program. By participating in wellness activities, students earn wellness cards. Later, potlucks are held, and the wellness cards are turned in and prizes are raffled off (e.g. smoothie coupons, REI gift certificates). They also have a Student Assistance Committee with 2 members from each class, and the meetings are open to all students and often serve as therapeutic sessions during which students vent their frustrations and concerns. Peggy also mentioned things that they have found to be unsuccessful: structured coaching sessions, weekly wellness tips via email, and judging students who don't participate as not interested in wellness.

(*Yukari Kawamoto*, M3, OSR – Creighton University) At Creighton, the medical students publish *The Wellness Chronicle* quarterly, and copies of all of the issues are available online at: http://medicine.creighton.edu/wellness/ . Its objective is to promote well being in the areas of spirituality, exercise & fitness, nutrition, relationships, and mental health. The issues are available as paper copies as well as PDF files online. They involve a number of "regular" columnists whose work the students look forward to reading. Other features include "From the Desk of the President" (the student government president) and "Diamond Rings and Babies" (engagements, weddings, and birth announcements to keep classmates informed).

#106: Teaching Humanism in Medical School

During this breakout session, humanism and its place in the medical school curriculum were discussed. Humanism is a common term that envelopes respect, compassion, empathy, honor and integrity. It is an essential part of professionalism, which also

includes excellence, accountability, and altruism. By emphasizing humanism in medical school, these other parts of professional medical behavior can be facilitated more easily.

Humanism is an academic skill in that it is observational, didactic, and measurable. Rituals, ceremonies, in-school activities, and service learning can all aid in teaching humanism. Rituals such as the White Coat Ceremony are already common at many medical institutions. Additional in-school experiences through courses, mentor relationships, professionalism portfolios, and peer assessments can also serve to further humanism education. The Gold Humanism Honor Society, sponsored by the Arnold P. Gold Foundation, can add a recognition and reward element to reinforce such behaviors.

Service and experience are essential teaching tools for humanistic behavior in medicine. It was suggested that different kinds of reinforcement are necessary for students at different levels of their medical education. Such reinforcements may be grades, activities in the curriculum, lectures, extracurricular activities, and recognition for exceptional service. Furthermore, students and physicians can benefit from new experiences, such as service overseas, to reawaken the humanism that can be repressed by the daily struggles of medical school and practicing medicine.

#109: The 5-Year Plan: Why Medical Students Leave School & What They Do While They are Gone

Presenters: *W. Scott Schroth, MD, MPH*, Sr. Assc. Dean for Academic Affairs, GWU-SOMHS; *Linda Don, M.Ed,* Director of Minority Affairs, University of Arizona COM; *Roberto Gomez, MD,* Assc Dean of Students, University of New Mexico SOM; *Emily Haynes, MS IV,* Virginia Commonwealth University SOM

The number of students taking a leave of absence (LOA) from the traditional 4-year medical school curriculum has almost doubled since the early 90s. Some schools have high numbers of students taking additional time. For example, the avg. student at Stanford takes 5 1/2 yrs to graduate b/c of enrichment activities. Students are taking LOAs for a variety of reasons:

1) Personal: medical, mental health, child rearing, divorce, other family issues, unforeseen circumstances
2) Academic: academic difficulties necessitating repeat course work or taking fewer courses concurrently
3) Enrichment: dual degree (MPH, MHA, MBA, JD, PhD), research, international rotations (clinical, research, or both)

Dr. Schroth shared a few statistics regarding which students are taking LOAs and when.

- Men are taking LOA more often than women, and are twice as likely to take them for enrichment purposes than women, however both genders take personal leave at the same rate.
  - He noted it may be important to encourage women to consider enrichment LOAs in order to increase the number of women in academic positions
- LOAs following the 3rd year of medical school are usually academic or personal
- LOAs in years 2-4 are predominantly for enrichment purposes
- How do residency program directors view LOAs?

- 66% view enrichment LOAs favorably
- 77% view medical leaves neutrally
- 90% view family leave neutrally
- 55% view mental health leave unfavorably
- Any LOA not described in the MSPE is viewed as unfavorable by 100% of programs
- LOAs taken after the 4th year were viewed as neutral or unfavorable (33%)

Emily Haynes, MS IV, commented that the type of residency program a student applies to will affect how they view the LOA. For example, she received all favorable responses regarding her MHA from FP program directors, but her classmate interviewing for Gen Surg received only 2 out of 11 positive responses. She noted that the financial implications of taking the LOA were the most shocking to her. She reached the limit on grad school loans and consequently had to work during her MHA studies, so she couldn't volunteer as she had intended to keep up her clinical skills.

Students may need to take alternative loans and more expensive loans to afford LOAs, particularly if pursuing a dual degree. The Budget Reauthorization Act should help by making students eligible for graduate PLUS loans with virtually no limit (but still pretty high interest rate: 8.5% w/ 3% fee). Some schools have an enrollment status available to students taking enrichment LOAs that allows them to remain enrolled in the medical school without paying tuition (e.g. LOA with continuing enrollment or detached study). This may help students avoid using up a year of loan deferment or avoid having loans going into repayment.

Dr. Don provided more background on how specific demographics are related to LOAs. Older students tend to encounter more experiences requiring LOAs. The avg. age of Native American students is higher, with 25% being older than 32 years of age, compared to 5% of all other students over 32. Academic difficulties may often precipitate a LOA, and this more frequency occurs in minority students compared to non-minority students. There may be several explanations for this, including higher number of URM students from socioeconomically disadvantaged communities, and a greater value placed on cultural ceremonies and extended family needs (particularly in Native American & Latino cultures) which places increased demands on these students.

Some other considerations:

- Faculty/administration have to deal w/ unpredictable class size when students take varying amt of time to get through the curriculum and loss of clinical knowledge during time off
    - Some schools require or provide an optional clinical refresher course, usually after >1 yr of absence (e.g. MD.PhD studs)
    - Many schools only allow students to return during certain months of the year to avoid difficulties scheduling clinical rotations
- Students going into competitive specialties may feel they need to take yr off to get into desired programs

- The proposed increase in # of med students may create a more competitive environment that gives students doing enrichment activities an advantage
- Educate marginal students that this is NOT a sure-fire way to get into a competitive specialty (but sometimes it may help)

Plenary II: Valuing Differences in Medicine: Your Identity Zones

This plenary featured *Mark Williams*, author of *Your Identity Zones*. In this session, Mr. Williams stated that demographics are too narrow to be able to distinguish between individuals. Identity can be divided two broad categories–affiliations (such as age, race, gender, religion, socioeconomic status, and marital status) and values (like honesty, integrity, generosity, patriotism, individual freedom, community, etc.). Recognizing that identity is a complex construct, Mr. Williams then introduces Identity Zones as a way to measure how strongly individuals feel about given affiliations and values and how they might react when their values are challenged. The Identity Zone framework recognizes that people can share affiliations, but simultaneously prioritize, integrate and define themselves differently than others sharing the same affiliation. Identity Zones measure:

- Temperature: using a scale ranging from hot to warm to cold; temperature assesses how sensitive individuals are, as cold on a subject would indicate a person is disinterested and hot would indicate the person is very passionate.
- Circle of Inclusion: from closed to selective to open; allows assessment as to how willing the individual is to associate with others that do not share their interests or values.
- Commitment: from activist to engaged to passive; to what extent is the individual willing to effect change.
- Strategy: from transformational to reformist to conformist; is a person more likely to "get radical" and battle the issues, or work within the system.
- Power: from high to medium to low; how much power/control does the person feel he has over a given situation.

Ultimately, Identity Zones provide a way to analyze people based on the above measures, providing a tool for understanding the influences that impact the feelings and actions of others. Once a person is classified based on the Identity Zone measures, it should be easier to approach and talk to the individual based on your knowledge of the factors that influence their thinking and behavior. This will ultimately lead to a greater understanding of others and strategies for learning how to get along better at work and home.

#202: Valuing Differences in Individuals with Disabilities
Speakers:

- *Patricia J. Metting, PhD.* (Moderator) – Medical University of Ohio
- *Robyn A. Gandy, M.D.* – Medical University of Ohio
- *Hershel Perry Wall, M.D.* – University of Tennessee Health Science Center College of Medicine
- *George A. Markakis, M.S.* – Medical University of Ohio
- *Georgia L. Hinman, Ph.D.* – University of Wisconsin School of Medicine

- *Elizabeth D. Azari, J.D.* – NBME
- *J. Abram Doane M.A., J.D.* – NBME

Each Speaker took anywhere from 10-45 minutes on various topics:

Robyn A Gandy, M.D. – Medical University of Ohio
New Frontiers: Differing Abilities – Not Disabilities
Main Points:

- In our society disability is perceived as inability
- 50million Americans, or 1 in 5 have a documented disability
    - 1.5 million undergrad students have documented disability (out of 14.4 million)
        - This breaks down into : 40%- Learning Disability, 19%- Health related, 14% Ortho-Mobility, 9% Speech disability, 8% Mental emotional, 10% Deaf/Blind.
    - 4.5% of professional degree students report having a disability
    - 3% of US Medical Students are affected by a learning disability – 2/3 of these didn't know they had it until undergrad or later.
- Cited many examples of famous and successful people with various disabilities
    - Epilepsy (200,000 new cases each year) – Van Gogh, Danny Glover, Niel Young,
    - Speech Impairments (2.7 million currently in US) – James Earl Jones, Tiger Woods
    - Mental Illness (Depression alone affects 19million)
    - Dyslexia (10% of US population, many have very high IQ) – Tom Cruise, Cher, Whoopi Goldberg
    - ADD/ADHD (1.6 million kids) – Robin Williams, John Lennon, Steven Spielberg.
- We must transform our perceptions in working with people with disabilities: "Providing education, role modeling, and removing societal barriers are the keys to change."

Hershel Perry Wall, M.D. – University of Tennessee Health Science Center College of Medicine
Valuing Differences in Individuals with Disabilities
Main Points:

- Described AIMS program developed at his school
    - AIMS = Aid for the Impaired Medical Student
    - Established in 1982
- Physician impairment due to substance abuse/mental illness is significant problem
    - 10% of practicing physicians are or will become impaired during careers.
    - Purpose of AIMS: To reduce number of impaired physicians by identifying and treating impairments that may begin in medical school.
- Goals of AIMS

  - Provide compassionate assistance to chemically dependent students before they are irreversibly harmed.
  - Provide help in a way that fully protects the rights of impaired students to receive treatment with strictest confidence.
  - Assure that recovering students are able to continue medical education without stigma/penalty.
- Program summary since inception (24 years)
  - 44 cases total
    - Emotional/Marital problems -8
    - Substance abuse/dependency – 36
  - Results in those treated for chemical dependency (20)
    - Completed treatment with no relapse prior to graduation – 15
    - Relapse prior to graduation, left school – 3
    - Relapse prior to graduation, suicide – 1
    - Spouse of student, not followed – 1

George A. Markakis, M.S. – Medical University of Ohio
Recognizing Disabilities
Main Points:

- Third year student at U of Ohio at Toledo
- Shared his experience of discovering ADD in Medical school (unable to finish tests on time, developed severe test anxiety).
- Also shared how degenerative corneal disease/visual impairment has affected his medical studies (gets double vision after one hour of reading)
- Bottom line: Disabilities are insidious in some cases
  - Individual may not know they have a disability.
  - Disabilities may not have an exact starting date
  - Individual may go to extremes to hide their disabilities
  - Disabilities can be compensated for—to a point.
- Accommodations for disability: achievement in Med school measured by Standardized exams
  - Everyone deserves a level playing field with these
  - The goal is to evaluate Ability, not disability. "The day I got time and a half was the day that I showed what I knew, not how quickly I could read!"

Georgia L. Hinman, Ph.D. – University of Wisconsin School of Medicine
Navigating by Touch
Main Points:

- Co-director of Student Academic Development at UW
- Discussed the school's experience in accommodating a blind student
  - How to appropriately restructure curriculum

Elizabeth D. Azari, J.D. – NBME
J. Abram Doane M.A., J.D. – NBME
Understanding and Applying the ADA in High Stakes MCQ and Clinical Skills Testing

Main Points:

- ADA = Americans with Disabilities Act
    - Title III requires entities that offer Exams make them accessible to persons with disabilities, or offer alternative arrangements
- How to define an individual with disability? The person
    - Has
    - Has a record of, or
    - Is regarded as having
    - … a physical or mental impairment that substantially limits a major life activity.
- Disability does not include:
    - Normal pregnancy, temporary injury, predisposition to disease or illness.
    - Psychoactive substance use disorders stemming from current illegal drug use.
    - Sexual behavior disorders
    - Kleptomania, pyromania, compulsive gambling.
- So the big questions with ADA coverage:
    - Is the condition "impairment"
    - Is the limitation "substantial"
    - Does it affect a "major life activity"
    - Is the major life activity relevant to the program?
- Determination of these questions must be made on an individual case-by-case basis.
- Reasonable Accommodation:
    - Must be made to allow a qualified person with disabilities to participate in testing.
    - Accommodation is not required if providing it would fundamentally alter the program or result in undue burden.
- Applying the ADA In the NBME
    - To request test accommodations the examinee must
        - Complete request form.
        - Self-identify as a person with a disability.
        - Provide necessary documentation.
        - Request specific accommodations.
        - Work with NBME to implement accommodations.
    - Necessary documentation. Individual must have been:
        - Evaluated by qualified professional with testing that is current or has been updated.
        - Have a specific/formal diagnosis, with conditions that have been ruled-out, rationale for diagnosis and clear explanation of current functioning.
    - Nuts and Bolts of the process:
        - Each examinee is assigned a case coordinator in NBME
        - Estimates 6-8 weeks of processing time if all necessary documentation submitted with request.

    - Most common delay is lack of sufficient supporting documentation.
    - Reconsideration of accommodation may be requested, and additional documentation provided.
    - Decisions regarding test accommodations for Step 1, Step 2 CK/CS are made by NBME
    - Decisions for Step 3 are made by state medical boards.
  - Examples of some accommodations on computer-based tests
    - Extended testing time
    - Enlarged text and graphics
    - Amanuensis for keyboard tasks
    - Additional breaks
    - Separate testing rooms
    - Audio rendition.
  - Examples of accommodations for CS exams
    - Additional time for patient encounter
    - Additional time for patient note
    - Individual examination session
    - Assistive devices
    - Additional breaks
    - Sign language interpreter
    - Scribe for patient note.

#203: Changing the Face of Medicine (The new URM Definition)

In 2003 the definition of URM was changed so that individual states could determine what ethnic groups were under represented in medicine locally. Many schools felt that this change was necessary because this allowed individual institution to focus on recruiting minority students from populations that were prominent in their area, but not discussed nationally, and schools could set their own priorities. The presentation illustrated two examples. One was in the state of New York, where there is a large Dominican population. Schools in New York wished to focus on recruiting these students, who were previously classified as "other Hispanic." Schools in New York now allow students to choose from four categories of Hispanic, and individual schools (depending on location within the state) can determine what focus they will have on recruitment of such students. The second example was given by Mount Sinai School of Medicine, where they discussed their attempts to diversify their student body, emphasizing their focus on non-Hispanic minority students. The final topic that was discussed was the question of multi racial students and allowing students to self report ethnic identity by checking as many boxes as they feel apply. The issue of whether multi race students will report a URM identity in order to gain admission was raised. A statistic was presented that between pre-admission and post-admission students reported identity 92% similarly, indicating that students do "game the system" but only slightly.

#204: How to Talk to a Gay Medical Student

I. Administration of GLBT survey amongst GSA members - Preliminary Results
II. What Students Want - A Student's Perspective
III. Barriers to Implementing GLBT-friendly Changes

GLBT Survey

- 88% resort there are GLBT-specific programs or services at their school, mostly student interest groups
- Unmet needs (as reported by respondents) include housing, insurance needs, GLBT-specific counseling/career counseling, links to other GLBT resources
- Reported lack of role model availability in the Student Affairs Depts.
- Inclusion of GLB in non-discrimination policies at clinical training sites:
    - University-based: 63%
    - Non-university-based: 33%
    - Do these represent actual lack of policy, or just lack of knowledge?
- 11 out of 71 respondents reported knowledge of mistreatment of GLBT students in 2004-5

Student's Perspective

- Be clear about state/school/clinic non-discrimination policies
- Be clear about consequences
- Have visible role models
- Remember, identity does NOT equal behavior
- Students shouldn't need to seek out paths to report offenders

Barriers to Implementing Change

- Societal, including legal (i.e. Domestic Partner benefits)
- Institutional
    - student may be evaluated by the very people discriminating against them
    - policies/consequences not common knowledge or even inclusive of GLBT concerns
- Personal
    - Read through hand out to see what you can do to help!

Summary of Plenary III: Access and Diversity in Medical Schools: Important Lessons from the Federal Courts Regarding Ways to Achieve Institutional Goals

Tuesday, April 4th
Katie Iossi

This session was led by Holland and Knight's Education Policy Practice partner, *Art Coleman*, who previously served as the Deputy Assistant Secretary for Civil Rights in the US Department of Education.

The purpose of the session was to explain why certain school's policies regarding school access and diversity have been found to be constitutional while other cases were not and to discuss principles that should be taken into consideration when writing these policies. Mr. Coleman asserted that most schools' policies currently fall in the gray area between being constitutional (like the 2003 Michigan Law and 1978/1998 Harvard Undergrad policies, both individual review systems) and unconstitutional (like the 2003 Michigan Undergrad policy, a point system, and 1978 Cal-Davis Med policy, a quota system). He says that decisions on further cases rest especially with Justice Kennedy, who has shown a nuanced view of those cases he has been presented with.

From the major cases that have been decided in the past, Coleman emphasizes that context (the ends and the means of the process), goals of the institution, evidence, and strategic processes are important in supporting specific policies. He stresses that the ultimate goal of policies cannot simply be diversity, but must be *educational benefits* of diversity. The idea of diversity should encompass factors other than simply race and ethnicity, and the definition of success and how it is measured at the institution (how you know it when you see it) are also key (Michigan's successful Law School case proved that a "critical mass" of students from diverse backgrounds was needed—not a specific number, but a range). It is important to show how authentic the efforts behind these goals are, that the institution is committed to seeing them through, and that the policies accomplish the goals. Ultimately, Coleman recommends that schools 1) take inventory and know the program through the work of an interdisciplinary team, 2) justify solid goals with solid evidence, 3) assess design and operations in light of goals and evidence, and 4) take steps to improve and monitor developments over time.

Specifically, red flags in policies include separate admissions processes for minorities and automatically assigning points without meaningful, nuanced comparisons among applicants. Yellow lights that will trigger scrutiny include consideration of race/ethnicity as part of the admissions process or race/ethnicity-conscious financial aid, recruitment, outreach and retention practices.

Plenary IV: Workforce: Increasing US Medical School Enrollment: What are the Issues?

Edward D. Salsberg, AAMC

The production of US medical graduates is not enough to fill current demand; there is a projected increasing shortfall due to the aging of the boomer generation. The gap is

being filled by increasing numbers of DOs, IMGs, and especially graduates of for-profit offshore medical schools. AAMC projections place the shortfall as worsening even if medical schools increase enrollment by 15%; the shortfall will only be stemmed if an increase of 25-30% takes place. Minimal mention was made of the impact on underserved populations.

#315: Is Medicine Still a Good Investment?

This session examined the rising cost of medical education resulting in high debt levels, long hours, and delayed personal goals with the median American worker with a 4 year college degree (BA). The rising cost of attaining an MD and the opportunity cost (lost income due to further schooling) revealed that it would take an MD with a median yearly income of $150,000 to work 7 years out of residency to begin having a total life net income greater than the BA who began working directly out of college with a median yearly income of $50,000. Obviously, these figures do not take into account any specialties with a higher income or those academic and primary care positions that pay slightly less. The session also showed that osteopathic school costs are rising to a median debt of $140,000 for their private schools which compares to the AAMC GQ median of $120,000 (both public and private). The ten year repayment of the AAMC GQ median of $120,000 with the current 4.7% interest rate is $1,511/ month with $64,969 paid in interest.

Does this high level of debt reflect the choice of a medical student choosing primary care over fellowship training? Well, this session along the presentation by VCU showed that the level of education debt is still low on the list for factors influencing the choice of fellowship or to remain in primary care. The main factors that led to choosing primary care were the teaching by mentors and role models during medical school and lifestyle choices. Articles and data are available at http://www.aamc.org/.

Is Medicine Still a Good Investment? That is up to you! Yes, you may be emotionally impacted by patient suffering, time away from your family, future financial uncertainty, and probability of change. Yet, the rewards that come with caring and helping others have drawn and committed us to the profession. The opportunity to learn about and care for patients and their families is priceless. The pros and cons existed when we applied and will be there when we graduate; but what would it take for you to not have this opportunity.

Just always remember that first person whose life you help to improve.

#317: Workforce: Fostering Student Interest in Rural Practice

Carol Galper, University of Arizona

While 20% of the US population lives in rural areas, only 9% of the physician workforce does so. In rural areas, patients are much more likely to bee seen by physician extenders. The University of Arizona has an intensive experience for selected students (about 20-25% of the class applies, and 15% of the class is eventually selected to participate).

Students attend extra sessions during their first year, getting them up to speed on physical exam techniques and topics related to living in a rural area. They then spend a year in a rural community, and can have additional rural rotations 4th year. This program has seen graduates successfully transition to practice in rural areas. Felipe Perez spoke of his experiences on these rotations as a student. Evaluation of this program is ongoing.

#404: Away Rotations: Travel ands Liability Insurance
Bruce L. Ballard, Weill Cornell Medical College

Dr. Ballard basically outlined the guidelines and experiences they have had with foreign clinical rotations. 25-40% of their students do an international rotation for elective credit. 8-12% of them do this rotation following their 1st year – in which case it is a research experience rather than a clinical experience.

For their international rotations the project guidelines are:

- Students must submit a project proposal.
- They must have a faculty sponsor.
- They must apply at least 3 months before departure.
- There are selected sites that are options for 4 week rotations (mostly in Europe).
- The rotations must be a minimum of 8 weeks if not at selected sites.
- They must have a defined host country or organization sponsor (faculty sponsors often have connections all over the world)
- Students must cover their own living expenses while on the rotation.
- Students can get funding support for airfare (through various organizations that work with the University).
- Students are required to present a write up of their experience when they return.
- Students then receive a certificate of participation in the Cornell international program.
- The school gets feedback from the student and the site (the faculty sponsor usually has a working relationship with the site organization).

Health and insurance details for foreign rotations:

- Cornell has student health insurance tailored to the needs of the students (i.e. It covers immunizations for international travel).
- SOS insurance – students are covered financially for an emergency return to the U.S.
- Students are advised to return to U.S. immediately if they have a needle stick accident.
- If sent to an area with high HIV prevalence students are equipped with 5days worth of HIV prophylaxis – to last them until they can get back to the U.S. (no student has had to return yet).
- Malpractice Insurance: If rotation is set up correctly students are covered under the Med School's regular malpractice insurance.
- School monitors governmental travel warnings and will not send students to dangerous areas.

Foreign Campus:

- Cornell runs a foreign medical school in Qatar – on an island in the Persian Gulf.
- Cornell was approached and asked by the Qatar government to establish the school.
- Not approved for LCME (because on foreign soil) but has same curriculum and main campus.
- Students enter and take 2 years of premedical sciences and then continue on with 4 years of medical school.

Premed courses generally taught by Cornell medical faculty.

#406: Transition to Residency - Is the Tail Wagging the Dog? Loss of the Fourth Year

Fourth year of medical school is an interesting period because it brings together three different parties, all with somewhat conflicting interests: the medical school, the student, and the residency program. The school would like the student to have a broad-based education, the residency program is interested in ensuring they select the "right" candidate, and the student is focused on: choosing the "right" residency, improving their competitiveness in that specialty, meeting graduation requirements, having "enriching" experiences (often travel-related), and having a break before residency.

4th year often breaks down into several sections. In the beginning of the 4th year, focus is placed on selecting a specialty, doing rotations in that specialty to get letters (including away rotations), and compiling application materials. The middle part of the year is frequently focused on interviewing and fulfilling graduation requirements, while the last part of the year is concentrated on matching, fulfilling the last requirements, "capstone" experiences, travel, and vacation.

Common themes/trends:

1. **Residency application process:** becoming more intense (increased pressure to do many rotations in chosen area, pressure to do research, earlier interviews, increased frequency of "second looks")
2. **Step 2:** more students taking step 2 seriously, taking time off to study (perception that step 2 is having increased importance with program directors)
3. **"Capstone" experiences:** class where students are brought together one last time, intended to "cap off" med school, can be for integration of basic/clinical sciences or other various pre-internship preparation
4. **"Last chance" experiences:** more students traveling to foreign countries, exchange programs. These experiences are often highly rated by students
5. **Vacation:** increased perception of students that they deserve vacation prior to residency
6. **Away rotations:** almost all schools have a limit on the number of away rotations completed (~3 months, but variable)
7. **Repetitive rotations:** most schools also have limit on number of rotations in certain specialty (often 2). While this limits students applying to some

competitive specialties, these students will frequently go ahead and do multiple rotations and not receive direct "credit" for them. The theory here is that if a student is going to be doing a certain specialty the rest of his life, he/she should gain exposure to other aspects of medicine for a well-rounded experience.

8. **5th year:** taking a 5th year becoming more common, but a small review of curriculum of one year from one presenting school revealed that often this has very little educational value (frequently just vacation) unless there is significant pre-planning and commitment to a long-term project.

Ideas/suggestions:

-**Re-examine curriculum:**

-Do rotations necessarily need to start at half-way point? Earlier start may provide more options for discovering right specialty, while allowing for broad-based clinical education.

-More integration of basic/clinical sciences?

-Change clerkship format to be more interdisciplinary?

-Re-examine vacation:

-What is the right amount? Most schools have between 6 weeks and 4 months, but what is appropriate?

-Reinforces need for strong career and academic counseling