AAMC Organization of Student Representatives Annual Meeting 2010

A Digest of Meeting Sessions in Washington D.C.

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INSIDE THIS ISSUE:

Alternative Career Paths

By Timothy Borden
Across the country, medical students are considering a greater diversity of career paths; they are pursuing advanced degrees in business, public policy, and law. During the 2010 AAMC Annual Meeting, the Organization of Student Representatives hosted a panel discussion with leaders from various alternative medical careers in order to expose students to the breadth of medical career options and to share experiences, wisdom, and advice.

The first speaker, Dr. Robert Bollinger, discovered through his medical education, that his true passion was international health and development. After spending time overseas, both before as well as after completing medical school and residency, he chose to pursue a Masters in Public Health in order to gain further insight into the development of international health. Currently, Dr. Bollinger is a Professor of Infectious Diseases and International Health Director at Johns Hopkins School of Medicine. Dr. Bollinger found that his career choice awarded him the freedom to practice medicine as a clinician both internationally as well as in the Baltimore area while also actively developing international health programs and conducting academic research.

The second speaker, Dr. Gregory Gruener, shared his experience relating to management in an academic medicine setting. After completing his medical training, Dr. Gruener practiced neurology. During his tenure as an academic clinician, he found that his skills and interests aligned well with a career in academic medicine management. He chose to pursue additional education in the form of a professional Masters of Business Administration. With regards to MBA programs, Dr. Gruener stressed the importance of considering both what you specifically want to get from an MBA and what it will give you. He found that it was in a hospital setting as a resident and as an attending physician before beginning his MBA. Dr. Gruener is currently serving as the Senior Associate Dean for the Education Program, Director of theLeischner Institute of Medical Education, and Associate Chair and Professor Department of Neurology at Loyola University of Chicago Stritch

AAMC HeliX

The AAMC has created an online community to help the OSR communicate! It is named Helix! Helix has many great features including a place for OSR documents, meeting presentations, and options such as OSR blogs. Please visit Helix, establish a profile, network, and participate in discussions about specific topics and more. All national meeting presentations that were collected are posted on Helix! http://helix.aamc.org.

Match Day

By Lauren B. Moneta
Match day represents the pinnacle in a medical student's voyage towards success as a physician. Students across the country open their match day envelopes with great anticipation as they unveil where their journey will continue. While U.S. seniors still remain the most successful in the match (94%) compared to osteopathic graduates (70%), previous year graduates (40%) and international medical graduates (40%), the process is becoming increasingly competitive. In 2010 there were

Alternative Career Paths continued

The final speaker, Dr. Kamiar Khajavi, completed law school and practiced law before beginning medical school. After completing his residency in internal medicine, Dr. Khajavi received a Masters in Public Health. Equipped with a diverse educational background, Dr. Khajavi chose to pursue a career as a consultant, working for McKinsey & Company. He felt that the medical education and training that he received gave him a unique skill set and perspective that allowed him to succeed as a consultant. Dr. Khajavi recently began a new career as Principle Strategy Advisor for the Global Health Initiative at USAID.

All of the speakers expressed the importance of following your instincts, keeping an open mind, taking advantage of opportunities and, ultimately, finding a career that you find rewarding.

International Opportunities

By Lauren B. Moneta

The CDC-Hubert Global Health Fellowship is a 6-12 week program available to third and fourth year medical and veterinary students. The program allows fellows to embark on journeys to developing countries where they are mentored by an experienced CDC staff member while completing projects involving priority health problems. Overall, the fellowship provides a hands-on opportunity to jump start a career combating global health disparities. Fellows are awarded a $4000.00 stipend and required to attend an orientation at CDC headquarters in Atlanta, GA in January 2012. The application opens in January 2011. For more information visit the CDC website: www.cdc.gov/hubertfellowship

In the Fogarty International Clinical Research Scholars Program, doctoral students are sent to 25 sites in 15 countries around the world for a minimum of 10 months. The extensive time spent abroad at an NIH funded research center in lower and middle income countries provides a unique experience to engage a community and implement change that is sustainable and progressive. It is recommended that fellows join an ongoing project in their choice location as all projects must be IRB approved. Medical students who have completed at least one year of clerkships and will have at least six months before graduation from medical school upon return to the United States are eligible to apply. Fellows attend a 2.5 week orientation at NIH headquarters in Bethesda, MD before embarking on their trips and are awarded a 25,000 stipend for their year abroad. For more information: info@fogartyscholars.org

Child Family Health International is an NGO founded in 1992 that aims to improve underserved community healthcare while increasing cultural awareness. CFHI's motto 'let the world change you' illuminates cultural competence and healing through 20+ programs in 5 countries. Aiming to promote open, collaborative and respectful change in underserved international communities, CFHI transforms perceptions about self, global health and healing. Open to pre-medical, medical and nursing students this program provides an excellent introduction to the intricacies of fighting global health care tribulations. The program costs $2095 to $2385 for four weeks and involves language immersion, 4-6 hours per day spent in clinical rotations with a designated preceptor, and a home stay with a native host family. For more information: www.cfhi.org or students@cfhi.org

Match Day continued

22,809 PGY1 positions available in the Match, 14,492, which were filled by graduating U.S. seniors. 2010 saw the first year where the number of unmatched graduating seniors participating in the match (1078) exceeded the number of unfilled PGY -1 positions (1060). This trend threatens to continue as the number of applicants grows more rapidly than the number of available first year residency positions. This means the "Scramble" will surely become more competitive than ever.

In 2012, the Scramble process will be transformed into the new Supplement Offer and Acceptance Program (SOAP). SOAP aims to decrease stress placed on both the programs and applicants involved, forbidding frantic phone calls, faxes, and emails to institutions with available positions prior to the program initiating contact with the applicant. Violation of this new policy could potentially bar the applicant from entering the program or future match weeks for one to three years, depending on the severity of the offense. Requiring applicants and programs to communicate through ERAS aims to standardize the "Scramble" process, effectively eliminating networking as the primary manner of acquiring an open position and leveling the playing field among all applicants who enter the SOAP. On Monday of Match week, schools will receive their unmatched seniors report and ERAS will open only to unmatched seniors and programs. Tuesday programs will enter their preference lists and Wednesday the first two rounds of offers and acceptances will occur. It is anticipated that the majority of positions available during SOAP will be filled by 5:00pm on Wednesday. Nevertheless, rounds of offers and acceptances will continue until match day ceremonies commence on Friday. Is SOAPing better than Scrambling? It's too soon to tell.

Table explaining proposed Match Week Schedule

	Current - Scramble	SOAP - 2012
Monday	11:30am School unmatched senior report	11:30am School unmatched seniors report
	12:00pm Applicant – Did I match? Regional match statistics	12:00pm Applicant-Did I match? Program-Did I fill? Unfilled positions on web Applicants apply to programs via ERAS
Tuesday	11:30am Program-Did I fill? Unfilled positions pdf for school	All day: Applicant/Program Communication
	12:00pm -Unfilled positions on web	
Wednesday	8:00am School match notification letters School match results Applicant choices by specialty	11:30am Programs finalize preference lists
		12:00pm Program offers begin: valid for 2 hours
Thursday	12:00pm Match Day Ceremonies	8:00am School match notification letters School match results
	1:00pm Applicant – Where did I match?	2:00pm Program roster of matched applicants
Friday	None	12:00pm Match Day Ceremonies
		1:00pm Applicant – Where did I match?
		5:00pm Last offers expire
Monday	12:00pm Match results by ranked applicant Match Outcome for all programs	12:00pm Match results by ranked applicant Match outcome for all programs

Plenary on Healthcare Reform

By Derrick Kuntz

Dr. Darrell Kirch, the AAMC President and CEO, discussed what he saw as the three major events that occurred in 2010 regarding healthcare. The first event was the Flexner Report Centennial. The Flexner Report was an assessment of medical education in North America in which Dr. Flexner noted problems within the curricula of medical schools and recommended changes. The centennial of this landmark report has led to a reassessment of the principles noted in the original report and the progress made within medical education since that time and an evaluation of the areas that need further renovation. The second event was the passage of the Accountable Care Act by Congress. The new healthcare bill was the most momentous step toward healthcare coverage for the general public since the passage of the Medicare bill 45 years ago. While the bill will insure more people, it fails to fix many of the additional problems within the healthcare and clinical care systems. The third major event was the economic recession and recovery. Medicare and Medicaid are becoming overly burdensome of the government and funding the programs is going to become increasingly difficult as more citizens qualify for the programs. In addition to the growing costs of the Medicare and Medicaid, it also coincides with government budget deficits, making funding the programs increasingly difficult. Dr. Kirch also sees the current rate of tuition increases as unsustainable. A tipping point is coming where the level of debt that begins to eat up a disproportionate amount of physician after-tax income making it financially untenable to many of the specialties within medicine. He challenges all of us to change the culture of medicine by not simply writing well-intended mission statements, but having the courage to enact those ambitious statements even in the face of opposition. Dr. Atul Grover, the AAMC Chief Advocacy Officer, discussed some of the changes

Plenary on Healthcare Reform *Continued*

undertaken with the Accountable Care Act, issues still being discussed within reform, and physician issues that loom on the horizon. Changes that occurred with the new bill include the establishment of an Accountable Care Organization. However, no one yet knows how the insurance changes will work and whether they will result in cheaper, more affordable insurance policies for consumers. It also is unknown how Medicare will change from a passive payer into a more active payer system. Even though Medicare reimbursement rates are poor, Medicare pays claims without sufficient evaluation of the medical claims being submitted. Another major change was the ACA Student Loan changes. All new student loans will be direct from the government instead of through an intermediary. The change also caps primary loan service at 10% and reduces noncompliance rates from 18% to 7%. It also sets a 10% Income Based Repayment for new borrowers in July 2014; it also triples the funding for the National Health Service Corps. Of immediate concern to physicians is the looming 23% Medicare payment cut effective December 1, 2010 if not changed with an additional 6.5% cut on January 1, 2011.

The requirements for the utilization of Health Information Technology (HIT) are of concerns for Medicare reimbursement. Other healthcare reform includes an evaluation of authorized versus appropriated programs, reversal of the expansion of the 1099 tax, an attempt to weaken or eliminate the individual mandate requiring the purchase of insurance, eliminating language that some believe permits federal funding for abortions, and establishing an independent payment advisory board. Another change is the need for the expansion of Graduate Medical Education (GME) slots and acquiring funding for the spots. Maintaining current GME funding was difficult as Congress looked for areas to cut funding from the Medicare budget. The Nelson-Crowley Bill hopes to expand GME spots by 15%, although how to determine which specialties and teaching hospitals would be in line to receive the extra slots is unclear; the bill currently lacks the Republican support necessary to pass . Dr. Grover also discussed the need for physician groups to begin working together to truly effect meaningful change within healthcare and voiced his concern that physician groups often look like subspecialty trade unions working only to pass changes that either benefit their specialty and or attempt to block anything that may help the general healthcare system at a detriment to their specific specialty. To effect truly meaningful change, physician groups need to stop fighting among themselves and work together.

Please contact Ally Anderson aanderson@aamc.org if you have questions. She will relay them to Dr. Kirch and Dr. Grover.

NBME and Project Professionalism Update

By Derrick Kuntz

USMLE Update

Dr. Dillon discussed topics related to the USMLE. Examination security is of concern, but problems with security are rare. However, even though rare, these problems disrupt the USMLE system, schools, students, and state boards. Security issues they face are falsification or misrepresentation of educational or performance records, bringing or taking notes away from test site, bringing devices to the test site, and receiving or providing assistance in recreating or redistributing test materials or seeking to obtain access to test materials. They are discussing limiting the number of attempts that the exam may be taken at six or eight times to allow students sufficient attempts to pass while limiting abuses by outside parties. They are also looking into usage patterns to locate security concerns. Second was that a standard setting committees revisit the exam every four years and look at independent feedback of test content, surveys, performance trends, and information on score reliability and potential decision error. Third, were changes to the two-digit score report. A score of 75 is the minimum for passing and this score was and is intended for use by state licensing authorities. However, some residency programs utilize the two-digit score. As changes occur to the exam during revisions, the two-digit and three-digit scores do not move in lockstep making residency program utilization of the score worrisome as it is not relational across time as a comparison for candidates. To fix this problem, the USMLE is looking at restricting reporting of the two-digit score to only the examinee and the State Board of Medical Examiners.

The fourth topic discussed the review of the current design and format of the exams. Five recommendations are being assessed; focus on licensing decisions, applying a competencies framework, assessing fundamental sciences, enhancing clinical assessment, and investigating assessment of Evidence Based Medicine skills. Step 1 is currently going through a change in content outline moving towards clinical medicine integration and away from fact-based test questions. Step 2 CK and Step 3 will start paying more attention to skills in quantitative reasoning and interpretation of the literature with an increased emphasis on biostatistics and epidemiology starting in 2011. It will also begin testing the evaluation of drug advertisements and medical abstracts likely starting in 2012. Step 2 CS is looking to move toward enhanced authenticity, a richer assessment of communication skills, and increased rigor of clinical reasoning with a target of 2012. Beginning in mid-year 2011, all Step 2 CS notes will be typed instead of hand-

written. To Contact Dr. Dillon: Gerry.dillon@nbme.org

NBME Assessments
NBME Subject exams are used as a way to standardize examinations for U.S. and Canadian medical schools for comparison of students that include equated scores that can be compared over time. The subject exams are in the process of becoming web-based. Basic science and comprehensive exams are already web-based. Clinical science exams are targeted for a web-based release in July 2011. The NBME is also looking to do the same for Shelf exams in the future. They are also testing software designed to provide a secure web-based exam that includes locking browsers, disabling transfer of content, and allowing a proctor to monitor the exam. The NBME also allows for faculty to build a custom exam for class use by selecting items for use and how the score will be reported. The test is graded by the NBME and score information is reported back to the school. The NBME also has self-assessment services for Step 1, Step 2 CK, and Step 3 MCQ that is designed to reflect coverage of the USMLE exams. New exams will have expanded feedback and will show the user the questions that were incorrect and the answer chosen, but will not show the correct answer. Users will be required to look up the correct answer. They are also instituting a longitudinal performance profile to track progress over time.
To contact Assessment of Professional Behaviors (APB) Program: Colleen Canavan – apb@nbme.org

The APB is designed to provide formative feedback to help gain insight into strengths and developmental needs of residency students utilizing multiple sources including preceptors, administrators, nurses, peers, and other residents. It is designed to track and assess observable behaviors with intended benefits of focusing on observable skills and improving evaluation skills. Their plans for the future include a current pilot student of 20 residency or fellowship programs to streamline the implementation process and exchange of information infrastructure. They are also piloting the program in medical schools and developing an APB instrument more appropriate for a medical school. The assessment is designed to be formative and have no influence on standing in the class or on grades. Schools requested that behaviors be assessed on a qualitative scale. The assessment includes four clinical and four classroom forms each consisting of faculty evaluation of students, students of faculty, and a self-assessment exam for both. Feedback would only be returned after a minimum of three surveys were completed to insure confidentiality.

NBME Professionalism Update
Exam Security – new regulations have been added to further secure the USMLE exams.

- Standard Setting Activity – Exam standards are reviewed every four years. The 2010 Step 2 CK review increased PASS from 184-189.
- Comprehensive Review of USMLE – This is a multi-year process to survey stakeholders reviewing current design and formats. In 2011, Step 2CK & Step 3 will require evaluation of abstracts and pharmaceutical ads.
- NBME assessments – New shelf exams for Ambulatory Medicine & Medicine Sub-I. Also all exams have Performance Profiles to show strengths and weaknesses. Soon the NBME will move to Web based shelf exams.
- APB update **–** Assessment of Professional Behavior: A web-based observable behavior evaluation system has been developed by the AAMC for Fellowships, Residencies and medical schools.
- The NBME is concerned about exam falsification, misrepresentation of credentials, students bringing in or taking notes away, and students bringing in "devices" (cell phones). Others included re-creation and distribution of test materials. The company Optima made efforts to steal test content and sell as test prep.
- As this has been done through "students" taking exams an inordinate number of times without passing in order to take away content, there has been a limit to the number of attempts allowed to take the USMLE. The limit would be 6-9 attempts, only set to avoid pirating and not hurt students.

Standard Setting Activity:
Step Committees revisit the examination standards every four years. Current standards are evaluated based on feedback from independent review of content, results of surveys from stakeholders, and performance trends. As a result, the passing score for Step 2 CK was increased in 2010 from 184 – 189. The next round of activity will address either Step 2 CS or Step 3 in the second half of 2011.

Other changes include restricting access to the two digit score that is resulted with your usual three digit USMLE score. The two digit score exists only to satisfy states regulations for licensing. The two digit score standard of 75 to pass never changes, unlike the three digit. Since it is a calculation, it doesn't reflect interclass differences and should not be used to compare between individuals. Sadly, some residency program directors are using two digit score as a minimum cut off.

Comprehensive Review of the USMLE – Multi-year process to

survey stakeholders reviewing current design and formats
The five recommendations are:

1. Focus on licensing decisions
2. Apply a competencies framework
3. Assess the fundamental science throughout
4. Enhance the Clinical Assessment (CS)
5. Investigate Assessment of EBM-like Skills

Results of these reviews

Step 1 – fewer fact based questions (now facts are tested in clinical vignettes)
Step 2 CK & Step 3: Attention to skills in quantitative reasoning and interpretation of the literature has led to two additions in 2011. Students will need to interpret a fictitious pharmaceutical add for quality and analyze an abstract.
Step 2 CS: Targets include enhanced authenticity of encounters, expanding opportunities for a richer assessment of communication skills (less scripted), an increase in the rigor or clinical reasoning (announcements to come in 2011) and ALL notes must be written on the provided computers.

You can read more at www.nbme.org/apb or email at apb@nbme.org

Challenges & Innovations: Meeting Student Debt Head On

By Chase Peterson
This session addressed three of the most significant issues facing the medical profession today:
• The increasing cost of medical education,
• The mounting student indebtedness and,
• The growing urgency to address the inadequate supply of physicians.
Here is brief summary of the speaker comments:
University of Chicago REACH program – *Repayment for Education to Alumni in Community Health.* If residents from University of Chicago work in a federally qualified center in *any specialty* in South Chicago they earn a 40k/year stipend in addition to salary since there is as great a need in subspecialties as PCPs. This allows practitioners to work part time and also earn an additional stipend, encouraging grads to stay in the primary service area.

Do Doctors have an Obligation to Serve? Medical Marshall Plan
Goals – Restore public trust through a commitment to service, reinforce student altruism, and remove financial barriers to medical careers, address primary care shortages and mal-distribution of physician problem
Proposition – The first two years will be funded and students would still take out loans for years three and four. After graduation, students would be part of a rotating internship followed by one year of compulsory service as a GMO. Year for year debt forgiveness is available for the additional years of service with preferential treatment in residency application after service is completed.

Patient Protection and Affordable Care Act require us to think BIG
Medical schools could enable graduation in 3.5 years and a two year residency program could be set up within network hospitals. The first year would be a general internship year with one subspecialty/primary care year; with opportunities in the internship to cover some subspecialty requirements. No match program would be required for this process. Those entering the program would receive tuition support for 2-3.5 years with additional financial needs met by other resources. Payback would begin in network clinics after two years of residency. This would require the cooperation of accreditation agencies to adjust regulations to permit participants to meet educational and board certification requirements with additional 501C3 health center clinics serving as loci for repayment.
Advantages of the program include the services component reducing debt by covering at least tuition and fees = 60-70% of educational costs. This affords two year of post graduate training in the medical school area. This increased exposure to primary care would hopefully increase attractiveness of primary care, and attract low income students to medical school (less debt), and serve growing primary care need.

Myth Busters & Building Bridges: Inter-professional Development

By Chase Peterson
All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence based practice, quality improvement approaches and informatics. Safety and Quality: - Quality chasm. Institute of Medicine 2001 (Citation from presentation)
We are not socialized with other pre-professionals. We are educated in silos and then thrown in to work together. Many challenges to better integration exist and must be overcome to improve our healthcare system. Several institutions have models for promoting such practices. (Citation from presentation)

One from the University of Kentucky COM is highlighted.
An update on work regarding collaborative work being done with other professional associations to improve Inter-professional Education is also included.

Dean's Clinic: University of Kentucky College of Medicine, Jay A. Perman, M.D.
Who's involved and the basics: The Dean runs his pediatric subspecialty clinic as a model for inter-professional practice. He involves the patient, family, learners (from M1s getting longitudinal clinical experience, M3s on clerkship and residents to undergrads

in nursing, pharm and pre-med) and other professionals (PAs, NPs, Pharmacy, SW and Nutritionists) and staff. It is made clear from the first consultation that each member of the team is essential to the patient's care and this is reinforced at all future visits.

The Nurse Practitioner: A focus of this presentation was to elucidate the role of Nurse Practitioners. The scope of this Master's degree program is to take histories, do physical exams, diagnose common illnesses, order labs and prescribe medications. They may choose to work with or without a collaborating physician. They work from their own license and orders and notes need not be co-signed.

In Deans Clinic – The team approach with medical students, residents, nutrition and psychologist creates a highly collaborative environment allowing independent and interdependent work which is more satisfying to NPs. This atmosphere also utilizes their specialized skills in education, potential patient gender compatibility, etc. The physician provides insight into mechanisms of disease and treatment for the team and the patient as well as staying up to date on literature and sharing this with team members.

Keys to success: For successful inter-professional collaboration there must be trust and respect; treating NPs as a colleague and not a subordinate. Practice styles must be complementary and reciprocal consultation allows for sharing knowledge, expertise and information, the exchange of ideas and goals of treatment.
Through appreciating the NP role and scope of practice, creating an inter-professional chemistry which is made apparent to patients and family and avoiding a perception of competition, this has become a great model for all involved. The key is early integration of pre-professional students and positive examples to prepare them for future collaborative environments.

<u>Preparing for a workforce for inter-professional collaborative care</u>
The concept of medicine as a single discipline concerned with only the restoration of individual health from the diseased state should be replaced by the concept of 'health professionals' working in concert to maintain and increase the health of society as well as the individual. – Coggeshall report 1965. We've known for a long time that we should be working more inter-professionally.

Professional Society Alignment: The AAMC has been aligning with other health professions including the: AACN (Nursing), AACOM (Osteopathic Medicine), AACP (Pharmacy), ADEA (Dentistry), APTA (Physical Therapy), etc. In Jan 2009, there was an agreement to work together to foster a common vision of team-based care and promote efforts to reform education to ensure every medical, nursing, dental, pharmacy and public health graduate is proficient in core competencies.

Preparing clinicians for collaborative care: This drive is reinforced by concerns over patient safety, which results from miscommunication and understanding of other professionals' roles as well as one's own role in the system. This is being accomplished by helping member institutions advance the field by: promoting a common language and shared competencies, facilitating effective faculty development, fostering shared learning resources, indentifying effective organizational models, and facilitating linkage with clinical and translational research. The associations are working to recommend a set of foundational core competencies for inter-professional collaborative practice appropriate to the pre-licensure learner.

Core competencies expert panel: This is composed of two (2) members appointed from each association with Madeline Schmitt, Ph.D. as Chair. The panel met in March of 2010 building on existing work by others to prepare a report targeted for January of 2011. Some projects have included developing a consensus definition of Inter-professional Education (IPE) which is: Two (2) or more professions working together to better understand each other so they can work more collaboratively to improve patient care.

The Communications Committee would like to thank the National OSR Administrative Board and AAMC staff for all of their outstanding work with this digest.

Especially:
David Friedlander — Current Chair
Catherine Spina – Past Chair
Joe Thomas – Chair Elect
Ally Anderson — Director, Student & Community Service Programs

For more detailed information on any of the items discussed in these pages or any comments about the digest, please feel free to e-mail Naseem Helo, National Delegate for Communications, nhelo@lumc.edu

2009-10 OSR Ad Board