AAMC Update

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Editor's Note:

The Association of American Medical Colleges (AAMC) is the primary representative body of medical schools. The AAMC provides a forum for the discussion of important issues and the presentation of innovations in all areas of medical education. Einstein is well-represented at the AAMC, including two representatives to the Organization of Student Representatives (OSR); Bradley Mackler, Class of '88, and myself.

The new format of the AAMC Update includes articles authored not only by students, but also by faculty and administration members. The goal of this journal is to keep Einstein students abreast of issues in health care delivery and medical education. Medical education is extremely demanding, and students often lose sight of these broader issues.

This is the first attempt at this type of collection. No doubt improvements can be made. Brad and I look forward to your constructive criticism and feedback. We can be reached at:

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I wish to extend a special thank you to the following people, without whom this journal would never have been possible:

Ms. Bunny Bell
Dr. Jean Cook
Ms. Donna Gerardi
Mr. Lloyd Greenberg
Dr. Albert Kuperman
The staff of the Kennedy Computer Center

Sincerely yours,

Seth M. Rubin, Class of '89
Editor, **AAMC Update**

Issues in Student Affairs

Jean L. Cook, M.D.
Associate Dean for Students

As usual, I spent most of my time at the 1986 Annual Meeting of the Association of American Medical Colleges in New Orleans attending sessions of the Group on Student Affairs.

I attended an interesting panel discussion on "Student Advocacy vs. Institutional Responsibility." This was an opportunity for Deans of Student Affairs to share their guidelines for playing their necessarily dual role: that of advocate for individual students, and protector of society against the graduation of impaired students.

A panel discussion with the Director of a surgery residency program was very discouraging. The Director said his problem was to fill eight PGY-1 (First Year Resident) slots for five-year general surgery training, selecting from more than 400 applicants. To do this, someone in his office reads and evaluates the last paragraph of the Dean's letter, sifts out applicants who describe no research experience, and passes over Pass/Fail/Honors transcripts which do not show Honors in surgery. This arbitrary process was roundly booed by the student affairs officers, as you may have guessed.

In everyone's mind was an awareness of the decline in the number of applicants to medical school. Between 1981 and 1985, the Northeast group of schools experienced a 13% decrease in the size of its applicant pool. The National pool declined 10% during this period, and as a result the applicant/acceptance ratio has decreased. Some medical schools believe that the decrease in the applicant to acceptance ratio has resulted in the consideration and acceptance of applicants who previously would not have been competitive for selection at these institutions. In a presentation of their findings, Drs. John B. Molidor and Cynthia Tudor concluded that to date there had been no observable declines in the quality of the national applicant pool as measured by MCAT scores and GPA's.

At the Business Meeting of the Group on Student Affairs, the presentations and "business" discussions were rather dull; but the theme was one that has been with us for the last few years in one form or another: The pre-residency syndrome, and the fact that the National Residency Matching Program (NRMP) needs to be changed. It is important that NRMP become attractive to the training programs which now ask students to submit early Dean's Letters and transcripts. In this case "early" is before the clerkship year ends in most medical schools.

The NEGSA (Northeast Group on Student Affairs) Executive Committee met in New orleans to plan the April 1987 regional meeting, which will be held in Boston. One item on everyone's mind was the decline in the number of medical school applications, so the theme in Boston will be "The changing applicant pool and a changing profession: Implications for the future of Medicine." Two of us in student affairs will be putting together some workshops for the April meeting on 1) Counseling the Married Student, 2) The Counseling/Advocacy Conflict, and 3) Racism, Sexism, and Other Discriminations in Medical Schools.

I would appreciate any ideas Einstein students may have about these topics as we go about planning the workshops. Thanks in advance for your help.

Improving Basic Science Education

Albert S. Kuperman
Associate Dean for Educational Affairs

This **AAMC Update** is a wonderful idea and a good example of our students' interest in the process of medical education. I am delighted to have the opportunity of contributing to the second edition.

There is a well established tradition at Einstein of encouraging medical students to play an active role in curriculum planning, the development of new programs and the improvement of old ones. Students have been especially helpful in maintaining a congenial and supportive environment for learning and in establishing programs to neutralize strains and stresses. I certainly applaud the students' success in injecting a large dose of humanism into the academic program, and efforts in this direction must continue.

As usual, the annual AAMC convention offered a wide range of ideas about medical education. The recent report on "Physicians for the Twenty First Century" was a stimulus to many of them and is a springboard for new programs at medical schools across the country, including one in the Bronx. Many of these programs focus on changing the nature of basic science instruction, and it is this issue that I want to address.

Year after year, I am an unhappy witness to the unreasonable demands that a compressed and fast-track preclerkship curriculum makes on students. Information overload, the excessive use of the lecture as a mode of teaching, the emphasis on fact acquisition and recall, the lack of clear learning objectives, the poor quality of many examinations - all these and more contribute to student dissatisfaction. In order to survive, many students rely on old examinations as primary study aids and are content to slip through the wide pass window in basic science courses. A philosophy of minimalism has crept into students' attitudes and work habits. Considering the nature of the preclerkship learning environment, this behavior may be viewed as rational and appropriate. After all, almost all students do pass the basic science courses and are promoted to the clerkship year.

Unfortunately, the type of coping behavior developed during basic science courses can have adverse effects on students' clinical education. With the continuing explosion of knowledge in molecular biology, good clinical practice is more strongly linked than ever to basic science information and to the use of that information in making sound clinical decisions. Thus, a just-passing approach to basic science courses will simply not suffice.

So much for the diagnosis and prognosis; what is the treatment? My own recommendation is in line with current conventional wisdom. Basic science learning must shift to one that is problem based with plenty of opportunity for independent, self-directed activities. We must shift from the information storage/retrieval approach to one that focuses on the application of information to problem solving. Furthermore, clinical education must build on these new approaches and focus more on the cognitive skills of clinical reasoning and decision making. Finally, our examinations should assess problem solving rather than information recall capacity.

This recommendation is not revolutionary. It is based on an abundance of good educational research, the ideas and wisdom of many first-rate educational theorists, and the actual experiences of a few medical schools that have already departed from the traditional. So much for the good news.

The bad new is that a problem-based learning curriculum is very demanding of faculty time. It is never easy to make drastic changes in curriculum, which is why we prefer to tinker and fine-tune. It is even harder to do while

simultaneously operating a large and complex research engine and providing good patient care in an already hard-pressed hospital environment. Also, our incentive-reward system does not encourage faculty to undertake major new educational responsibilities.

I am convinced that not too many years away, the best and brightest applicants will flock to those medical schools that have made the greatest progress towards adopting the new ways of teaching and learning. If I am correct in this assumption, and in view of the shrinking applicant pool, we will need to change at a faster rate than we would like. Our very survival as a great medical school is at risk. The faculty, students, administration - all working together, must find a way to overcome the obstacles to educational change.

I welcome the advice and support of students in changing the approach to teaching and learning of basic sciences with the goal of making the preclerkship experience more positive and productive. We may never see the day when students regret leaving the basic sciences to go on to their clerkship rotations; but we may change things in a way that all students really understand and appreciate the role of biomedical sciences as a foundation for clinical education and practice. When that day comes, I suspect that students will abandon the just-get-through approach and deal with basic science courses as energetically and creatively as they deal with their clinical activities.

Selected Topics

Elizabeth Kachur, Ph.D.
Coordinator, Introduction to Clinical Medicine

The Change in Health Care - How Does it Effect Medical Education?

Advancements in medicine made it possible to diagnose and treat more disorders in an ambulatory setting, which initiated a major shift from inpatient to outpatient care. Changes in insurance reimbursement procedures, DRGs (Diagnosis Related Groups), added to this trend, which resulted in a hospital population that is sicker and has a shorter stay. Overall medicine is moving from "non-profit" to "for-profit," with a steady increase in HMOs (Health Maintenance Organizations) and other staff/group practices. Approximately 12,000 physicians work in such settings now and it is projected that in a couple of decades, over 90% of the health care will be provided by corporations.

As a result of the above changes, medical schools and residency programs have to provide more training in ambulatory care. Teaching in these settings is usually on a one-to-one basis which increases the expense. Many clinics are not eager to get "entangled" with medical schools and some programs have to pay for student training. Other schools have bought outpatient settings such as HMOs or have taken over health care services in neighborhood clinics, schools and prisons.

Home health care is another delivery system that is expanding, and AECOM has piloted a program where 29 first-year students accompanied a health care provider to a patient's home. The testing phase of this project will continue this year and hopefully with the start of the Introduction to Clinical Medicine (ICM) course in 1987-89, all first year students will get an orientation to home health care.

Clinical Skills Assessment - How Valid and Reliable Are They?

Major efforts are underway to develop methods that will accurately measure clinical skills. The objective structured clinical examination (OSCE) has been introduced, and more schools are trying it. (Students rotate through a standard set of "stations." Each station

poses a different clinical problem on which the student is evaluated by an observer.)

Many educators agree that OSCE's are worthwhile, and certainly can be utilized as an evaluation instrument or teaching exercise. In order to make OSCE's an integral part of evaluations, research has to find answers to questions such as: How many stations are needed? What kind of skills can be tested? How do OSCE's compare with conventional evaluation methods; grades, NBME (boards), patient feedback?

Last year, AECOM was the first New York school to pilot an OSCE in the physical diagnosis course: 25 students rotated through 25 stations. This year, a similar exercise is planned, which should involve most, if not all, sophomores. Since it will be a teaching exercise rather than an evaluation instrument, it has been named "GOSCE" (group oriented structured clinical exercise). Watch for it!!

Content Versus Process or Knowledge Versus Skill

What factors determine success or lack of success in medical student and physician performance? While knowing the facts is important, more attention has to be given to how these facts are accumulated and how they are used. Study skills -- which include reading and thinking skills -- cannot be remedied by just going over the material (content tutoring). It must be noted that poor diagnosticians tend to decode fewer signs and symptoms, ignore predisposing factors, and jump to premature conclusions.

Such findings should bring about changes in the design of tutorial programs. Learning, critical thinking and problem-solving seminars may be of benefit to all. Although such endeavors require time to implement, in the long run they are bound to save time by increasing accuracy and productivity.

Content/process dichotomy is also an issue in teaching. Although there are few schools who have problem-based curricula, medical education is clearly moving away from overloading students in lecture halls to "hands-on" experiences, small group teaching and independent learning. Faculty development efforts have started to prepare teachers for this change

Medical School Admissions

Noreen Silverman, M.P.A.
Admissions Officer

One of the major problems facing medical school admissions persons in these days of declining applications is the shift of applicants from one school to another in the months just prior to September enrollment.

The AAMC discussed this problem at length in New Orleans. The key concern was allowing applicants enough time to decide on which school to attend, while also allowing enough time for schools to fill places vacated by applicants. The problem lies in the fact that the two situations cannot exist, presumably, simultaneously.

A few suggestions were made to alleviate the problem. By May 1 or earlier, schools must offer enough places to fill their classes. By June 1, schools may require that applicants holding places in their classes do not hold places at other medical schools. After July 1, schools desiring to make an offer of admission to a student holding a place at another school may do so only after consultation with that school. The two schools may agree upon a date whereby the applicant will be holding only one place. The time period for this decision should not exceed one week. Furthermore, accepted applicants should be given a preliminary estimate of financial aid not later than June 1 if their needs analysis form and other required documents have been received in the medical school financial aid office by May 15.

The concern expressed by GSA members regarding the above suggestions centered on the assumption that once a student receives the acceptance of choice, he/she will relinquish all other acceptance and wait-list offers. The suggestions fail to take into consideration the applciant's ego and desire to know just how far the fruits of one's three years (or more) of labor will take him/her. Understandable!

The chances that an offer of acceptance will be made to any given student this year are better than any other year since 1981. Applications are down, while the number of first-year places holds constant. More offers of admission will be made this year than in the last six years. Students will be under great pressure from schools to make up their minds quickly so that the schools may rest assured that their places will be filled.

The GSA (Group on Student Affairs) also discussed age-old problems such as preadmission requirements and the need (or lack of need!) for the MCATs. It sought to encourage the development of guidelines to assess non-cognitive indicators of applicants' characteristics and looked at the characteristics and changes in non-traditional applicants over time

Improvements in Teaching Medicine

Dr. Martin G. Levine
Director, Audio Visual Center

Instructional technology, educational methods and teaching effectiveness are my specific interests both at Einstein and at the AAMC.

Following a Sunday morning meeting of the Association of Biomedical Communications Directors, I participated in a GME (Group on Medical Education) workshop, "Evaluation and Rewarding Excellence in Teaching in Medical Education Programs." The workshop, organized around a "Self-Management Model" by Dr. Howard Stone (University of Wisconsin Medical School), discussed evaluation in unique organizational settings, means to reward teaching effectiveness and alternatives for dealing with ineffective teaching. His model requires establishing an "effective relationship," whose components are knowledge, skills and the effective use of "self" ... human warmth, spontaneous concern and immediate response and feedback to patients or students. While unique in placing the responsibility on the individual instructor, this approach joins numerous others presented over the years. Most have not succeeded due to lack of more than verbal support.

The next day, the morning plenary session included several major presentations, though highlighted by one given by the Chancellor of SUNY, Dr. Clifton Wharton, who provided a unique perspective on the challenges of diversity in medical educational leadership. The innovations in medical education exhibits, in the afternoon, as usual, provided a wealth of approaches by individuals and institutions to problems faced at many schools by faculty, students and program directors in the general curriculum and particular courses.

Due to time constraints, my greatest attention at the exhibits was drawn to approaches that spanned immediate areas of interest, e.g., Computerized Tomography learning modules for anatomy and the integration of educational video into the teaching of basic sciences in a traditional medical curriculum. The first, for example, has potential in an interdisciplinary, self-directed, problem based learning environment, whereas, the latter as a means to enhance teaching effectiveness.

This year included an ever-growing number of exhibits on computer applications in medical education. This ranged from level II interactive video for "socratic" style instruction in courses dealing with largely visual subject matter to large interactive video data banks for diagnosis and training.

The remainder of my day and convention included the Group on Medical Education regional and national meetings, for I had a late plane to catch and gross lab the next morning.

Higher Education Amendments of 1986[1]

Robert G. Petersdorf, M.D.
President
Association of American Medical Colleges

President Reagan has just signed into law P.L. 99-498, the "Higher Education Amendments of 1986." This five year revision and extension of the Higher Education Act (HEA) will have profound and generally beneficial impact on all of the HEA student financial assistance programs that are heavily relied upon by medical students.

STUDENT FINANCIAL ASSISTANCE

Guaranteed Student Loan

The *annual GSL maximum* for graduate and professional students is increased to $7,500, and the cumulative GSL borrowing limit is raised to $54,750, effective January 1, 1987. The current authority for the Secretary of the Department of Education to increase annual and aggregate GSL borrowing ceilings for students "engaged in specialized training requiring exceptionally high costs of education" is retained.

The *interest rate* for new GSL borrowers is set at 8%; after 4 years of repayment, the rate increases to 10%. This change will take effect on July 1, 1988.

Needs analysis will be required of all GSL applicants before they can receive the loans as of January 1, 1987.

A *One-time insurance premium of up to 3%* of the loan principal will be taken out of each new GSL. Individual state guarantee agencies will determine the specific percentage. Presently, insurance premiums are tied to the number of years remaining in the educational course. Also, the present 5% loan origination fee is maintained.

The current *2 year deferment* for service in an internship "required in order to receive professional recognition required to begin professional practice or service" is retained.

The *"special allowance"*, i.e., effective interest rate, paid to GSL lenders is lowered by 0.25% from the current formula of the average quarterly 91-day T-bill rate plus 3.5%.

ALAS/PLUS Program

The program has been divided into two: *Supplemental Loans for Students* (SLS) and *Loans for Parents*.

The *maximum SLS loan*, which will be available to all graduate and professional students, is $4,000, with a cumulative borrowing limit of $20,000. As with the current ALAS/PLUS program, the loans can be used to replace Expected Family Contributions (EFCs) for other Title IV programs. This change became effective on the date of enactment.

The *SLS interest rate* will be set at the average of the 91-day T-bill rates auctioned over the previous 12 months plus 3.75%, beginning July 1, 1987. The rate will change yearly, but will be capped at 12%. Previous ALAS/PLUS borrowers will have the option of refinancing their loans at the new interest rate for a one-time fee of no more than $100. Lenders who do not provide refinancing must notify borrowers of other lenders offering this option.

Loans for parents of up to $4,000 will be available annually to the parents of graduate students, with a cumulative borrowing limit of $20,000. The interest rate and other terms are similar to those of SLS.

The bill's report language states that medical residents are eligible to receive SLS if they are enrolled in hospital training programs that comply with the Department of Education's institutional eligibility and related requirements. SLS funds will be available only to cover those non-educational costs, i.e., living and related expenses, that are not met by stipends. The report also states that SLS eligibility is intended for residents in programs that charge tuition. It does not appear that any physician residents would qualify for such loans at this time.

National Direct Student Loan (NDSL) Program

The program is renamed *"Perkins Loans"* after Carl D.

Perkins, the deceased chairman of the House Education and Labor Committee.

The *cumulative loan limit* for graduate and professional students is raised to $18,000, the *grace period* on the loans is extended to nine months, the current interest rate of 5% is retained, and the *statutory standards on loan defaults* will bar institutions with default rates above 20% from receiving new Federal capital funds, while those with rates above 7.5% will receive reduced contributions.

Loan Consolidation

The program is substantially revised and enhanced. All Title IV (GSL, SLS, ALAS/PLUS and NDSL) plus Health Professions Student Loans can be included in the packages. The interest rate on consolidated loans will be the higher of nine percent or the weighted average of the loans to be consolidated, rounded to the nearest percent. The loan repayment span is tied to the level of an ex-student's total indebtedness; however, loans not being consolidated can comprise no more than 50% of total indebtedness for the purposes of determining the repayment length of the consolidated loan. Payment schedules can be income-sensitive or graduated, but monthly payments are to at least meet the amount of accruing interest.

Also, new *"Combined Payment Plans"* are authorized, under which borrowers can simultaneously retire Health Education Assistance Loans (HEALs) and consolidated loans. The terms of HEALs are not to be altered in any way. However, in cases where a borrower selects a lender for a Combined Payment Plan that does not hold all of his or her HEALs, those held by other entities will need to be reissued. Borrowers choosing this option must first contact holders of their HEALs and any Title IV or HPSL loans they wish to consolidate (or holders of loans already consolidated) to see if the lender(s) will offer a Combined Payment Plan; and if so, use that lender (or one of a number of willing lenders). If none are offering the Plan, another lender may be employed.

The loan consolidation and related provisions became effective upon enactment.

Other Provisions

Title IV program participation agreements (made between the Department of Education and each institution eligible for student assistance programs) will require schools to certify that they have an institution-wide drug abuse program (as determined by the institution).

Additional facts not mentioned in Dr. Petersdorf's Memorandum:

Starting in 1987, and retroactive for all previous student loans, interest payments on student loans will no longer be deductible for federal income tax. In addition, all students 24 years of age and older are automatically considered independent.

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[1]An abridged version of a memorandum sent to AAMC representatives by Dr. Petersdorf, dated October 31, 1986, Memorandum #86-73.

Medical Education and Health Services Research

Robin Kupfer
Program Evaluator
Office of Educational Research and Evaluation

Two sessions of the Research In Medical Education Symposia at the AAMC meeting in New Orleans were of particular interest to me. They addressed issues concerning the interaction of medical education and health services research. Health services research (HSR) refers to the study of health care delivery systems. Medical educators endeavor to assess undergraduate and graduate medical training programs and suggest changes in the curricula. The changes are geared to maximizing the knowledge and skills students need as physicians, in relation to the environment in which they will be practicing.

The first symposium on this subject, "Medical Education and Health Services Delivery - Forging Research Links," presented divergent views on if and how much medical educators should be involved in HSR. Two of the three panelists asserted that medical educators should act as supplementary researchers in HSR because 1) HSR results impact directly on present medical

education, 2) Medical educators can provide their perspective so that the research is properly focused, 3) Interdisciplinary interaction is important and can raise issues that are pertinent to all involved, and 4) Interaction would facilitate the integration of HSR into medical education.

The third panelist, however, maintained that pertinent results of HSR are disseminated adequately through the literature and should be read, rather than collected, by medical educators. He felt that there is a surplus of ideas for research in medical education. Furthermore, medical educators should not take on projects that can be better executed by researchers with expertise in other fields.

The second symposium, "The Use of Health Care Data in Medical Education," began with the following excerpt from the Alma Alta declaration of the World Health Organization:

The Basic Goal of Medical Education is to educate medical doctors so they will contribute maximally to the alleviation of the burden of illness in the population which they serve.

According to the panelists, a major obstacle hindering the achievement of this goal is that students in traditional medical educational programs are not familiar with the real burden of illness within a population. Some reasons for this were offered: 1) Use of traditional vital statistics (e.g. mortality, life expectancy), rather than measurements of incidence and prevalence of health problems, 2) Failure to recognize non-medical disease causation (e.g. genetics, environmental and behavioral factors, as well as the availability of health services), 3) Incomplete awareness of disease prevention techniques, and when and why they may not be effective, and 4) Minimal emphasis during medical education on the functioning and efficacy of the health care system.

Two suggestions to alleviate these problems were better integration of HSR results in curriculum planning, and greater exposure of students to the general community to see, first-hand, the health status of the population being served.

Personal Anecdotes on the AAMC National Conference

Cirecie West
Assistant Director
Office of Special Educational Programs

Overall, I felt that the conference workshops, seminars, etc., were well planned and extremely insightful . I attended sessions sponsored by the GME (Group on Medical Education), GSA (Group on Student Affairs), and GSA-MAS (Minority Affairs Section). The "buzz" words at the conference were:

- *Computerized educational programming (clinical and basic science)*
- *Minority students (particularly in research)*
- *Demographic changes in medicine*

Recruitment Workshop

The pre-med workshop, sponsored by the AAMC Office of Minority Affairs, was well-attended by both students and medical school faculty. In addition to the AAMC information booth, two financial aid representatives were on hand to provide general information to students. Approximately 200 plus high school and college pre-meds were in attendance.

As a result of our summer research program, Dillard University students were extremely excited about Einstein and several seniors had already submitted applications through AMCAS for AECOM.

AAMC Plenary Sessions

The most interesting presentation came from Clifton R. Wharton, Ph.D., Chancellor of SUNY and Chairman of the Rockefeller Foundation. Dr. Wharton spoke on "Leadership in Medical Education: the Challenge of Diversity." Items of interest were: the non-white population; the female population; and demographics of the geriatric community. Proceedings of Dr. Wharton's speech have been ordered.

GSA/MAS Business Meeting

Dr. Volle, the newly-appointed president of the NBME (National Board of Medical Examiners), discussed anticipated changes in the examinations. The following items were discussed:

- The establishment of two comprehensive committees

(for Part I and Part II) to explore improvements in design of the exams

- •Possible changes in the exam:
  - -Questions which bear a greater relationship to the practice of medicine and medical school
  - -Fewer test items
  - -Fewer recall questions
- •Other issues:
  - -Pass/Fail
  - -Method of reporting scores.

There was also mention of establishing a computer-based exam for Part III based on case simulations (by 1989). The hopes are to develop an exam which will reflect clinical skills development.

Seminar: Admissions - The MCAT - Constructive Use or Abuse?

This program presented statistical data on how medical schools utilize the MCAT's. The proceedings from this session could be useful to the AECOM Admissions Committee, particularly in reference to under-represented minority students. For example: 69% of the medical schools surveyed indicated that they looked at MCAT scores differently when reviewing minority applicants.

Panel Discussion: Increasing the Minority Applicant Pool

This session presented successful comprehensive pre-med programs which link high school and college students into pre-med networks or enrichment programs.

Office of Special Educational Programs (OSEP)

What is lacking at Einstein is a comprehensive approach to minority admissions and retention based on substantive historical data. This will probably be the theme of the Office of Special Educational Programs (OSEP) in the current and upcoming years.

Innovations in medical education were very stimulative and suggestions from various professionals will probably be incorporated into OSEP programming. Items of note were:

- •MEDPREP program at Southern Illinois University (for the boards)
- •Minority High School Apprenticeship Program
- •Home Visit Project at the AECOM
- •Diagnosing Reading & Reasoning Problems, University of Missouri
- •Applicant Pools; Implications for Recruitment and Retention Programs, University of Arkansas
- •Student Stress and Student Attitudes, SUNY at Syracuse
- •The Network: A peer support system, Wayne State University School of Medicine

I also concentrated on various committee meetings, and on solidifying rapport with pre-health advisors from targeted undergraduate schools. Additionally, I met with several applicants from the New Orleans area

Humanism in Medical Education

Seth M. Rubin
Student Representative to the Association of American Medical Colleges
Class of '89

The faculty of this institution, as well as the majority of medical schools, expends great efforts to teach humanism. I am proud to say that based on my observations at AAMC conventions, Einstein is at the forefront of humanistic education. On a number of occasions, deans and professors of other schools have inquired, "I hear that Einstein has a wonderful emphasis on humanism, tell me about it ..."

This issue is best handled with a *good news, bad news* approach. The *good news* is that a variety of innovative educational opportunities are available to Einstein students thanks to the dedication of our professors. For instance, home visits have become a standard activity during the first year, during clinical electives and the Human Behavior Course. The home visit program during the Human Behavior course was based on the following objectives:

- •Familiarize the student with home health care:
  What tasks are accomplished during a home visit by a visiting nurse, social worker, or physician?
- •Give the student the opportunity to observe the patient in their home environment:

How can the home environment influence disease management?
•Give the student the opportunity to practice interviewing by performing a focused inquiry reflecting upon:
Patient's understanding of illness
Effect of illness on patient's functional status
Patient's social support system [1]

Furthermore, during the Human Behavior course, thought and discussion are inspired on the subjects of compassion, personal attitudes toward patients, and the value of holistic medical care. This emphasis is becoming more apparent in other courses as well. In addition, the clinical curriculum offers *Ethics Rounds* to discuss humanistic care of patients "in situ."

The *bad news* is that although these resources are available, most students do not take advantage of them. Many of my classmates describe humanism discussions in the classroom as "a waste of time." The reader might be quick to conclude that Einstein students show an outrageous disregard for humanism. I disagree. Medical education is a severely stressful process. During the basic science training period, the main evaluative instrument is the standardized examination where the student demonstrates his/her ability to memorize and understand a plethora of medical facts. With the insurmountable workload in the traditional basic sciences, and a grading system which places a higher value on these courses, humanism takes a distant second in the learning priorities of students.

Unfortunately, many faculty members place humanistic education a distant second as well. At the recent AAMC convention, when a series of seminars were presented concurrently, most faculty members of all schools attended seminars regarding basic science training, clerkships, and residencies, rather than a seminar entitled, "Approaches to the Development and Assessment of Values, Attitudes, and Personal Qualities." At this seminar, a number of programs at individual schools were discussed. Though differing approaches were offered, the main emphasis centered on cultivating the most important virtues in future physicians, namely, Integrity, Respect, and Compassion:

• ***Integrity*** *is the personal commitment to be honest and trustworthy in evaluating and demonstrating one's own skills and abilities.*
• ***Respect*** *is the personal commitment to honor others' choices and rights regarding themselves and their medical care.*
• ***Compassion*** *is an appreciation that suffering and illness engender special needs for comfort and help without evoking excessive emotional involvement which could undermine professional responsibility for the patient.* [2]

The difficulty in teaching humanism continues into the clerkships. Medical students receive their clinical education primarily from interns. Interns are the most overworked members of the housestaff ... besides the pressures of patient care, interns do not get sufficient sleep, are deprived of time with their families, and receive a small income as their loan repayment period commences. Under these circumstances, humanistic qualities are eroded from interns, the primary role models of medical students.

Excessive stress not only plagues interns, but medical students as well. B.N. Steenbarger, Ph.D., of the State University of New York Health Science Center at Syracuse, presented a project at the AAMC convention entitled, "Student Stress and Student Attitudes: Assessing the Medical School Experience." Among his observations of SUNY/Syracuse medical students were:

•One-third of students report daily or weekly experiences of debilitating stress.
•Students reporting frequent stress were more likely to report frequent anxiety, depression, and negative attitudes.

The stressful environment of medical education not only makes humanistic teaching difficult if not ineffectual, but also deteriorates existing humanistic values.

My classmates often talk of their cynicism and apathy and loss of idealism as the medical education process continues. Are these qualities reflected in medical students as they join the ranks of practicing physicians? Will idealism, enthusiasm, and optimism return once the stresses of medical education have been survived? It is a pity that the medical education process often destroys the humanistic energies of students, or at least is an intermission in their cultivation. At Einstein, opportunities to cultivate these skills exist in quality and quantity, but are undersubscribed. Priorities must be re-evaluated and adjustments made in the education process. If the adjustments are effective, humanism will add an exciting and essential flare to the daily lives of medical students, rather than being a "waste of time."

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[1]Objectives are from a memorandum by Elizabeth Krajic Kachur, Ph.D., Coordinator, Introduction to Clinical Medicine.

[2]**A Guide to Awareness and Evaluation of Humanistic Qualities in the Internist**, American Board of Internal Medicine, 1986. Though this guide was written specifically about internal medicine physicians, its themes are relevant for all fields of medical practice

Problems in the Residency Selection Process

Bradley Mackler, Class of '88
Student Representative to the Association of American Medical Colleges

Currently, there are approximately 1.3 training slots per U.S. medical graduate. Yet, a significant portion of the fourth year is spent in the quest of the "right spot." Many medical educators believe that this "pre-residency syndrome" is interfering with students' aquisition of a general education.

Many problems with the residency selection system were identified at the New Orleans meetings. For example, students are forced to make specialty choices too early, especially in programs like Ophthamology, Psychiatry, and Neurosurgery. These specialties have early matches separate from the National Resident Matching Program.[1] A partial solution to this problem was offered: moving the deadlines for the National Match to a later date. The director of the early match program said he would also delay his deadlines. For instance, he would postpone requests for dean's letters and transcripts. Though these changes are small, they would give the student more time to decide on a specialty.

National Board scores are used inappropriately to select among candidates. The Organization of Student Representatives (OSR) of the AAMC is trying to get the board scores reported pass/fail. Thus, residency program directors, especially in highly competitive programs, would not be able to use the boards to "weed people out" or as a yardstick to compare medical schools. This change will be particularly important for students applying to programs outside of the geographic location of his/her school. Furthermore, the boards, with their great emphasis on factual knowledge, would play a lesser role in shaping medical education.

Students are often asked to take electives at the institutions to which they are applying. This is particularly true for Otorhinolaryngology, Orthopedic Surgery, and Neurosurgery. However, the national program directors of these specialties said that these "audition electives" often hurt students because they expose weaknesses. Nevertheless, they suggested doing one elective in the specialty you plan to choose at the home institution and one away.

A strong research project is considered a big plus for a residency applicant. The chairman of the Department of Surgery for Tulane University suggested that a meaningful research project is often a more profitable endeavor than audition electives.

Abuses of the system exist. For instance, students are at times asked to make commitments to enter programs before the match results are received. This occurs relatively often in Anesthesiology, Psychiatry, Orthopedic Surgery, and Radiology. This is an unethical practice which puts students in a bind. These program directors do not allow students to hear if they got into the program they most desired, forcing a commitment before the Match results are received.

Though the current system has problems, it is unlikely revolutionary changes will soon be offered. Students will continue to face a confusing task of quickly, if not prematurely, choosing a specialty. Furthermore, the anxiety-ridden match process will continue, and the "preresidency syndrome" will doubtless remain.

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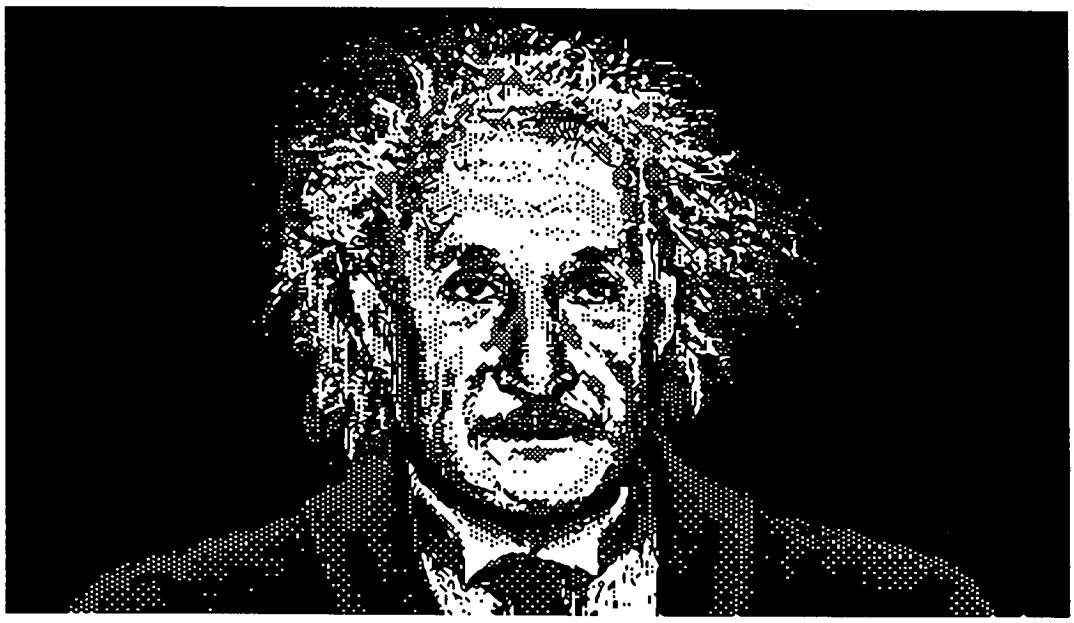
[1]Match programs work by institutions submitting a ranked list of students they want, and students ranking the programs they desire, with a computer matching the two. You will find out more about this at the start of the fourth year.



Ominous Trends in Medical Care Delivery

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Drs. Leon and Corola Eisenberg of the Harvard University School of Medicine held a talk entitled, "The Light at the End of the Medical School Tunnel: Watch Out for Trains." They commented on the recent, dramatic changes in the Medical Care System of the United States. Unfortunately, some of these changes may erode the excellent quality health care that has been the American standard.

Health Maintenance Organizations (HMOs) and Diagnosis Related Groups (DRGs), have a common goal: to provide the minimum amount of care to a given patient. Because the hospital/physician is paid a lump sum per patient (HMOs) or per illness (DRGs), the less care provided, the greater the profit. Patients are being discharged sooner, and cheaper therapy is replacing more expensive, with a greater emphasis being placed on cost that quality.

An additional recent development is the rapid emergence of private rather than not-for-profit health care. An example of the possible ill-effects of this change may be the **Humana Health Care, Inc.** artificial heart implantation research study. The primary goal of Humana's research is to boost publicity. This goal establishes a negative incentive for research which may be more important in the medical community's eye, though bland to the laypublic.

Additionally, the government has reduced its commitments to medical education. As a result, more costs are placed upon students; student debt figures have skyrocketed. Students are now pursuing more lucrative careers to help pay back their debt, rather than lower-paying fields which may be more important to the community's needs (i.e. family practice).

Many undergraduate students have been discouraged from a medical career as they become familiar with the problems medicine is confronting. Perhaps it is the job of physicians to also broadcast that though problems exist, medicine continues to be a rewarding field. In fact, Dr. Corola Eisenberg recently contributed an editorial to **The New England Journal of Medicine** entitled,"It is Still a Privilege to be a Physician."

Senator Thomas F. Eagleton and Clifton R. Wharton, Jr., Ph.D., Chancellor, State University of New York, emphasized that physicians must play a larger societal role. The public is unsympathetic to physicians who complain that their incomes are suffering from the liability crisis and federal cutbacks. However, if physicians argue as patient advocates, then the American public will be more likely to be sympathetic to their cause. It is not physicians who suffer most from increasing medical costs and decreasing governmental support, but the elderly, poor, and uninsured