Letter from the Chair

Dear OSR,

The Communications Committee, led by Amelia Goodfellow (UCLA), has created this digest to summarize the sessions at the 2015 Annual Meeting most relevant to our organization. This is a valuable resource for those who were not able to attend, and those who did attend will appreciate the key takeaways the writers included for each session.

If you have questions about the Annual Meeting or the projects the Ad Board is working on, please contact your Regional Chair, or feel free to get in touch with me. We truly are interested in hearing from you and in helping you make your time in the OSR as rewarding and meaningful as possible.

Thank you for the wonderful enthusiasm and ideas you brought to the meeting. I am excited for the year to come and look forward to hearing from you.

Sincerely,

Regina Kwon
AAMC-OSR Chair
University of Colorado School of Medicine
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Find presentation information and materials here:
https://event.crowdcompass.com/learnservelead2015

For the Learn Serve Lead 2015 Program:
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OSR Plenary: AAMC Arnold P. Gold Foundation Humanism in Medicine Award
Recognition & Luncheon
Elizabeth Wilson, MD, University of California, San Francisco

By Adam Thompson-Harvey
The Gold Humanism in Medicine Award is presented annually at this luncheon and recognizes a physician and educator who has contributed to a culture of compassion in medicine. Dr. Elizabeth Wilson of the University of California, San Francisco, (UCSF) School of Medicine is this year’s awardee.

Dr. Wilson began her remarks by reminding attendees that parents provide a good foundation for humanism. Through this, one can promote humanism by simply remaining open to yourself and what you want to do. She then touched on some of the pivotal points of her personal and career journeys. For example, prior to medical school, she became very committed to advocacy through her experience working with artists at an art gallery in San Francisco. Later, the importance of hope stuck with her after losing her partner to cancer. During medical school, she wanted more perspective in public health, feeding a newfound passion for improving health disparities. Attracted to community care, this passion to work with populations and underserved areas brought her back to San Francisco for a career in family medicine. Her passion for advocacy grew as she began working with students wherein she looked to amplify students’ voices within medical education. Regarding her enduring effect on students, patients, and her community, she noted that “it’s about listening.”

Dr. Wilson stressed the importance of support pipeline programs such as UCSF’s Program in Medical Education for the Urban Underserved (PRIME-US), a longitudinal track for medical students from diverse backgrounds interested in working with urban underserved populations. Without these programs, advocating for these populations would be even more difficult. Before ending, Dr. Wilson challenged attendees to “decide what’s important to you now and have someone hold you accountable.”

Takeaways:
• Continue to be open to new perspectives—you will continue to find new passions along the way.
• Humanism can be more about listening and understanding, rather than doing.
Saturday, November 7

Opening Plenary: Social Justice, Race, Health, Education, and Culture

Eugene Robinson, Pulitzer Prize-winning columnist and author of Disintegration: The Splintering of Black America

By Mallory Roberts

Race relations are as fraught as ever, with an upcoming election ensuring intense discussion about issues around race. Baltimore as the site of this meeting has a particular relevance, given the recent riots following the death of Freddie Gray.

Robinson reflected on his personal experiences with race relations, from growing up in the final years of Jim Crow-era legal segregation, to the integration of local high schools, to his eyewitness account of the Orangeburg Massacre. His desire to write about his experiences led to a rich career as a journalist. When he began work at the Washington Post—at the time a predominantly white institution—he felt compelled to act as an “ambassador” of the African-American community. He settled eventually on editorials as his favorite style of writing, and recalled an emotional experience working as a live television commentator for the 2008 presidential elections when Barack Hussein Obama was elected.

Now, Robinson said, issues of race and inequality are closer to the surface than they have been in many years. Ferguson, Staten Island, and Baltimore invite open debate about inequalities in our justice system—and also in healthcare. As we advance toward the mid-century, when there will likely be no white majority, as well as work through issues of globalization, loss of the middle class, economic woes, and societal anxiety about threats from “outsiders,” we must reflect on the inequalities we see around us. Robinson also encouraged us to recognize symbols of progress—like the image of our first black president walking across the White House lawn with his family.

Takeaways:

• Inequalities are deep and racial relations are still tense, but there are glimmers of hope.
• The Affordable Care Act is not perfect, but it takes us closer to universal healthcare.
• Progressive Democrats and conservative Republicans can find common ground in recognizing the need for reform in the U.S. justice system, including priorities like reducing the incarceration rate.
• We can take hope in the overall increasing prevalence of discussions about inequalities; these conversations are central to progress and will take center stage in the 2016 elections.
• Growing recognition that institutionalized racism exists is a form of progress in bringing more public attention to the issue than perhaps ever before.
• Social change is very uncomfortable, and we often do not recognize progress until we look back; the fact that we are fighting more may indicate that we are actually moving and agitating in a generally forward direction.
Reflecting the Nation’s Diversity in Medical Schools and Beyond

Concurrent Session
Michael Railey, MD  
Associate Dean/Associate Professor of Multicultural Affairs  
St. Louis School of Medicine

Elisabeth Wilson, MD  
Director of Education for the Department of Family and Community Medicine, University of California, San Francisco

Basil Williams, MD  
Ophthalmology Resident, University of Miami Leonard M. Miller School of Medicine

Christine Tung  
Medical Student, Rush Medical College

By Adam Thompson-Harvey

This session provided an overview of the current environment of diversity in medical schools with perspectives from a panel that included a medical student, a resident physician, and school administrators, as well as bidirectional community discussion. Small-group table discussions focused on “effective diversity,” improving faculty diversity, career development for faculty who dedicate their time to mentorship, inclusivity in defining diversity, among other topics. Innovative strategies included a longitudinal humanities curriculum and monthly roundtable discussions on inequalities and health policy. Administrators emphasized the importance of creating and sustaining pipeline programs. This session was a chance for medical schools across the country to share and evaluate their progress with recruiting and training diverse students and faculty.

Takeaways:
- Engaging in difficult conversations in a safe space may help increase not only diversity relations but also cultural competency.
- More work needs to be done on the infrastructure of teaching medical students and faculty how to be successful mentors.
- When returning to our home institutions, think: Are we providing the right tools for those who champion efforts to improve diversity in medical education? How can we all pitch in?

Please note: A more detailed report on this session, including content from small-group discussion topics and key priorities identified by session panelists, will be released in the coming months.
Student Programming Showcase: Transformative Student Initiated Innovations

Concurrent Session

Kirsten Devin  LeeAnne Flygt
Medical Student, University of Kansas  Medical Student, University of Michigan
School of Medicine  Medical School

Kimiko Warlaumont  Michael Maguire
Medical Student, University of Michigan  Medical Student, University of Miami
Medical School  Miller School of Medicine

Ted Cybulski  Korie Zink
Medical Student, Northwestern Feinberg  Medical Student, University of Michigan
School of Medicine  Medical School

By Adam Thompson-Harvey

Five medical students from across the country presented student-led innovations at their schools, selected by OSR. Innovations addressed approaches to medical training, community service, and student leadership.

University of Michigan: Emergency Medicine Clinical Reasoning Elective

EM and IM faculty and preclinical students are identified and matched based on interest, and students attend bimonthly clinical sessions with their faculty preceptors, which include diagnostic reasoning discussions. Students are not evaluated, allowing them the freedom to advance their clinical reasoning skills without concern that they have the “right” answer. Students may also attend “differential diagnosis lunches.” Students felt the elective prepared them for third year.

Northwestern University Feinberg School of Medicine: PRISM: Longitudinal Science and Medical Mentoring

PRISM, or “Promoting Inner-City Youth in Science & Medicine,” partners medical students with a branch of the Chicago Boys & Girls Club for longitudinal mentorship in science and medicine. Students develop the curriculum and present lab-style sessions to high school students, cultivating greater interest in STEM careers. Medical students involved in the program reflected that there remains overwhelming need—and high demand—for similar mentorship programs.

University of Miami Miller School of Medicine: Student-Directed OB/Gyn Clerkship Integration and Clinical Skills Lab

In a program occurring prior to the third year and sustained by fourth-year student leaders, this initiative improves student comfort with teaching OB/Gyn content and creating test questions, providing exposure to the goals and skills of medical teaching.

University of Kansas School of Medicine: Foundations of Interprofessional Collaboration

Various health professions students already attend classes in a shared building; they now participate in TeamSTEPPS, a program that encourages group learning and the breaking down of professional stereotypes. Students lead discussions and work through case-based activities together, with each profession contributing differently to the discussion. The program has been
well received, and program coordinators recognize a need for representation by other non-direct patient care health professions in the future.

University of Michigan: A Model for Effective Student Engagement in Curricular Transformation
This program, which functions through steering and operating committees comprising students from each year and dual-degree programs assists in surveying areas of weakness in the curriculum and conducting a curricular review prior to the Step 1 exam. The program also advocates earlier exposure to clinical bedside learning, with increased leadership and mentorship opportunities as well as support for broader student engagement and better integration with the school administration.

Takeaways:
- To make a successful program, it’s crucial to identify the angle of approach (i.e. through curricular affairs, clerkship directors, health ally chairpersons).
- Faculty champions and supportive staff are key.
- Students are effective at educating others and advocating for curriculum changes.
- For more information on the initiatives, visit: https://event.crowdcompass.com/learnservelead2015/activity/G5kAmeuQKI
The Reality of the Match: Perspectives from Key Players

Concurrent Session
Georgette Dent, MD
Associate Dean for Student Affairs,
University of North Carolina School of
Medicine

Calvin Kagan, MD
Internal Medicine Resident, Johns
Hopkins University

Jeffrey Zabinski, MD
Psychiatry Resident, Johns Hopkins
University

Jerry Clark, MD
Chief Student Affairs Officer, University
of Mississippi Medical Center

Jeffrey Berger, MD
Anesthesiology and Critical Care
Program Director, The George
Washington School of Medicine

Jeffrey Love, MD
President, Board of Directors, Council on
Program Directors in Emergency
Medicine

By Mallory Roberts
This panel session comprised two residency program directors, a dean of student affairs, and two PGY-1 residents. It’s long been recognized that the Match can sometimes seem like a black box: Student affairs deans may not have up-to-date, complete, and equal information about all residency programs and so must often advise students with limited information; however, program directors are protective of their chances of getting the best residents they can, and may not feel it in their best interest to “show all their cards.” This scenario-based discussion presented the following two vignettes, with panelists and attendees weighing in on each.

Scenario 1: A student with a 245 Step 1 score who would like to apply in both Anesthesiology and ENT has a wife who is geographically restricted to the Chicago area.

- Double-applying may be OK, as even at the same school each program’s directors are unlikely to discover you’ve applied to both; however, every school works differently and some schools do use a central GME office and would thus notice a dual applicant. Such an application would often be viewed negatively.
- Considering the logistical difficulties of applying in both specialties, as well as the much-increased expense, it may be best to do rotations in both specialties early in fourth year and decide on one.
- It may be smart for this applicant to apply for a preliminary year in surgery as a backup, which could fit well with both ENT and anesthesiology and afford the applicant some extra time to decide, rather than double-applying.
- If you do away rotations, try to get a letter from the program director if you did well; be cautious about sending a letter from an away rotation to other schools, as it may “tip your hand” that the school where you performed your away rotation is your top choice.
- Advice for schools: Begin talking about residency and Match anxiety early and often—advise students to use AAMC resources for support as much as they can.
Scenario 2: A student with a 198 Step 1 score who would like to apply in Family Medicine is concerned that in applying broadly to many programs in order to give himself the best chance of matching, it may be difficult to tell which residencies are “good” training programs.

- Some factors that can differentiate the strength of different programs include:
  o The program’s ACGME accreditation status and whether (and why) they have ever been on probation
  o Residents’ success rate at passing certification exams
  o The residents that you meet when you visit the programs (think: would I want to work with these people at 2AM?)

Takeaways:
- Are away rotations helpful or harmful? Should we get rid of them? Some feel that the fourth year has become purely about matching, possibly to students’ detriment.
- Student affairs needs to give students honest and strategic advice about their prospects of matching; difficult conversations are worth it to prevent the devastation of not matching.
- Anything resembling holistic review in GME may be a long way off, as the process is still largely ruled by metrics and scores; however, whether a program is a good fit should be considered by both sides (student and program), rather than just if a student is a top-scorer or if a program is top-ranked.
- The problem remains that there is not yet a national consensus on how to limit the number of residency applications.
- Program directors have a lot to lose in the process of the Match, too, and are trying to avoid attrition: They want to find out if they are plan A or plan B so that they don’t fill their top rank spots with people who don’t really want to be there.
Sunday, November 8

Chair’s Address: Toward a More Just Society and Healthcare System: The Role of Academic Medical Centers

AAMC Leadership Plenary Session

Darrell G. Kirch, MD
President and CEO, AAMC

Peter Slavin, MD
Chair, Board of Directors, AAMC
President and CEO, Massachusetts General Hospital

By Mallory Roberts and Amelia Goodfellow

Dr. Peter Slavin began the Plenary by emphasizing that issues of racial bias and disparities are important to discuss in medical leadership and the healthcare sector, because healthcare professionals have the responsibility to improve society and forge a system that is more equal and just than the one we have today. The six pillars of quality are efficiency, effectiveness, safety, timeliness, patient centeredness, and equity—it is clear, therefore, that we cannot achieve quality without addressing inequality.

Even after controlling for education, socioeconomic status, and other factors, healthcare outcomes remain stratified by race and ethnicity. We must strive to see how this issue manifests not just in broad theory but in everyday examples from the healthcare setting. Massachusetts General Hospital adopted a recent initiative in which they assumed they were “guilty until proven innocent”—that racial disparities do exist, and are prevalent, at their institution. Detailed demographic and quality data were collected, published on their website, and shared with the community. As Dr. Slavin said, “you can’t manage what you can’t measure.” The data were then used to close gaps in equity: For instance, African-American patients experienced subtle racism in the way they were greeted in waiting rooms, leading to retraining in staff greetings. Multidisciplinary diabetic group visits were offered for Latino patients, who were more likely to be in poor diabetic control; Mass General found that this program boosted diabetes outcomes for Latino and non-Latino patients. Clearly, focusing on health equity improved quality.

Dr. Slavin also emphasized that diversity in medical education lags sorely behind: underrepresented minority staff are less likely to hold senior positions and less likely to be promoted than non-URM staff. We should assess future medical students on more qualities than just board scores, and move toward factoring resiliency and personal background into selection.

Dr. Darrell Kirch followed in the second half of the plenary, emphasizing the medical profession’s ethical commitment to reducing inequality. He framed academic medicine’s role thus: “Teaching hospitals represent only 5% of the hospitals in the nation, but provide 40% of the charity care in the country.” Some of the biggest groups affected by health inequity include those with mental illness, African-American men, the LGBT community, and the veteran community. Dr. Kirch mentioned several innovative programs across the country that focus on reducing inequality in these groups, including the University of New Mexico’s four-year curriculum, Educating for Health Equality; the University of Massachusetts’ Inmate Medical
Health Textbook; Philadelphia Children’s Hospital’s Community Health and Literacy Center; and Johns Hopkins’ Center to Eliminate Cardiovascular Disparities. He closed with the statement that advocating for increased GME funding and holistic admissions is important; if we continue to tolerate the physician shortage, our most vulnerable populations—those cared for by the 5% of hospitals that are teaching hospitals—will suffer first.

Takeaways:
- We must address healthy inequity in order to fulfill our institutions’ promises of quality.
- Though the Affordable Care Act has improved healthcare for many, it still does not guarantee access; thus health inequity persists, particularly among certain underserved groups, such as the LGBT community, under-represented minorities, veterans, and the incarcerated.
- Teaching hospitals account for a disproportionate amount of care to underserved populations, and thus play a vital role in overcoming health inequity.
- Increased GME funding, holistic admissions processes, and improvements in the diversity of medical school staff and faculty are critical pieces of addressing health inequity.
Communities, Social Justice, and Academic Medical Centers

Concurrent Session

Michelle Gourdine, MD
Medical Director, Clinical Assistant
Professor, Departments of Pediatrics and Epidemiology, Sinai Community Care-LifeBridge Health, University of Maryland School of Medicine

Stacey Stephens, MSW, LCSW-C
Clinical Instructor/Director, B’more for Healthy Babies Upton and Druid Heights, University of Maryland School of Social Work, Promise Heights

By Amelia Goodfellow

In this project by a local Baltimore community clinic, patients were filmed as they responded with their thoughts to several prompts on the relationship between community and health. Responses were compiled into four videos, shown at this session with time allocated for audience reflections after each.

Video 1: How does your community affect your health?
Patients identified food deserts, chronic psychosocial stress, lack of safe places to exercise, poor availability of dental care, the tradeoff between paying for medication and paying for food, and illiteracy (“If you don’t know how to read, how can you get to a doctor?”) as factors of their community impacting health. One respondent said, “What would a healthy community look like? I don’t know, I have never ever seen one.” The audience reflected that there may be a breakdown in community over time that prevents people from uniting to work on these issues; an international guest remarked that in other countries, health care is a right, because no one chooses to get sick.

Video 2: Do you talk to your doctor about how your community affects your health?
Many respondents reflect that they don’t discuss social factors in their health with their providers, because they don’t want to cast themselves in a negative light, and because physicians may not care anyway. Respondents listed the following ways that a doctor can address a community’s health:

- Ask patients about community stressors and the neighborhood they live in
- Do more home visits when relevant (i.e., an asthmatic child and evaluation of home triggers)
- Ask about practical considerations before giving someone a new device or complicated medical instructions (e.g., if they need a heart monitor, are they able to pay the electric bill so that it can be charged?)
- Spend more time in the community getting to know the stressors there firsthand
- Simply listen more.

Audience reflections included the importance of teaching students that patients are a doctor’s gift: They give us an education by continually challenging us to understand what our patients really need in order to be healthy. Some programs teach students to ask, “Where are you living? How do you source your medication? How do you source your food?” as part of the HEADDSSS interview.
Video 3: What are your views on medical education?
Many respondents felt that students are trained to be in charge rather than to learn by absorbing the information all around them; to command rather than to listen. One patient wanted medical students to know that although we learn in school that certain groups have certain diseases, any disease can occur in anyone and not to “profile” patients. They reflected on the need for training in economics, social diversity, and asset mapping in the curriculum, and emphasized that students need to spend time out in the community in order to truly understand it. Students should do a better job of eliciting the patient’s chief concern rather than just arriving at a diagnosis.

Video 4: What are your views on biomedical research?
In general, patients would be interested in participating in research if they were only asked; however, researchers should be conscientious stewards of research since they don’t know the outcome of a particular intervention. The best chance of success occurs when researchers involve representatives from the community early on and use the research project to work on shared goals. Researchers should always return after the research is completed to share the outcomes and teach the community what they’ve found. A good goal to include in any research project should be to help the community to learn about health. Audience members reflected that perhaps next year, the AAMC should invite patients to be plenary speakers: the community is wise, and there is nothing more valuable than hearing from the people who actually have the issues we’re trying to solve.

Takeaways:
- There may be great value in duplicating this video series in many communities throughout the United States to help us better understand the communities in which we work; a toolkit on doing so would be eagerly anticipated.
- There is tremendous value in simply listening to your patients, their concerns, and their own ideas on how they could improve their health.
- Learning to communicate medical information clearly and simply should be an ongoing priority.
- For researchers: Incorporate short-term, visible outcomes, even in a longitudinal project, so that the community can be aware of the progress and findings. Incorporate community development as an outcome of your research.
Learner Wellness and Resilience: Partnering to Foster Strategies of Engagement

Concurrent Session

Johanna Von Hofe, MD  
Chief Resident, Department of Obstetrics and Gynecology, University of Alabama School of Medicine

Lyuba Konopasek, MD  
Designated Institutional Official, New York Presbyterian Hospital

Michael Kavan, MD  
Professor of Family Medicine and Professor of Psychiatry Associate Dean, Student Affairs, Creighton University School of Medicine

Stuart Slavin, MD, MEd  
Associate Dean, Curricular Affairs, St. Louis University School of Medicine

By Amelia Goodfellow

This group of speakers, including an OB/Gyn chief resident, dean of student affairs, hospital administrator, and dean of curricular affairs from various institutions across the country, emphasized a shift in how to think about stress and wellness in medicine. Medical school and residency training are challenging periods for learners. Though a focus has been placed on stress reduction in the past, perhaps a new conversation should be about cultivating wellness and resiliency while giving tools for learners to use to adapt to new challenges and promote lifelong wellness.

Each partner in medical education has a role to play in promoting wellness. Program directors can create a departmental well-being plan, recognize burnout and stressors affecting residents, endorse and model self-care, and diagnose the learner with resiliency trouble and point them toward helpful resources. Learners themselves face the barriers of perceived incompetence and dependence when asking for help, and struggle with feelings of isolation as they grapple with stress alone. Programs can mandate well-being assessments and construct accessible support systems that take into consideration cost, site, times available, and confidentiality; but most important, they can work to cultivate a culture of wellness, acceptance, and support.

Takeaways:

- Everyone has a role to play in cultivating a culture of wellness and resiliency, including program directors, residents, medical students, deans, and hospital staff.
- Open conversations about barriers to wellness can be used to develop better and more useful new tools.
Transition to Residency: Updates from ERAS and NRMP

Concurrent Session

Amy Mathis, MBA
Senior Director, Electronic Residency Application Service, AAMC

Mona Signer, MPH
President and CEO, National Resident Matching Program

Geoffrey Young, PhD
Senior Director, Student Affairs and Programs, AAMC

By Christopher Doucette and Amelia Goodfellow

Updates from ERAS this year included assurances that the 2016 MyERAS software now has a new infrastructure and improved security. The software also provides new fields to input BLS certification and Gold Humanism Society membership, as well as a cleaner messaging interface and a feature for applicants to upload a photo. Other updates include letter of recommendation notifications and a policy change that protects the security of letter documents.

In-progress changes include a potential feature allowing third-years to access MyERAS in order to begin uploading letters of recommendation earlier, as well as the ability to queue applications prior to the actual application date of September 15 so that applicants don’t have to assign documents to programs and line them up on the date of send-out when the system may be slow or down. In addition, ERAS emphasized that more students are always needed to complete their short surveys.

NRMP reported an all-time high of 27,293 PGY-1 positions, an increase of 615 over 2014. More than half of the increase was due to growth in Family Medicine and Internal Medicine programs. Six hundred and thirty-five more applicants submitted rank order lists in 2015 than in 2014, for a total of 41,334 registrants. The increase was primarily due to a greater number of U.S. medical school seniors and osteopathic medical school students and graduates. The 2015 Match saw a 95.7% position fill rate, with 1,306 positions remaining unfilled, of which 650 were PGY-1 only positions in Preliminary Surgery, Preliminary Medicine, and Transitional Year programs. The 2015 PGY-1 match rate for U.S. seniors declined slightly to 93.9% from 94.4% in 2014. The PGY-1 match rate for students and graduates of osteopathic medical schools rose from 77.7% in 2014 to 79.3% in 2015. The ratio of active U.S. seniors to PGY-1 positions was 1.51 in 2015, the second highest since 1976. Of the U.S. seniors who matched, 78.4% matched to one of their top three choices. The couples Match rate for 2015 was 94.8%.

Top factors in student match lists, in order, were geography, reputation of the program, and perceived degree of “fit” with the program. Programs’ top factors for their rank lists, in order, were perceived “fit,” geography, and quality of residents.

This year, the number of unmatched U.S. seniors was higher than the number of positions available through the Supplemental Offer and Acceptance Program (SOAP), though certain specialties, like Neurology, ended up with leftover spots after SOAP. In 2015, 13,657 applicants met SOAP eligibility criteria, a rise from 2014 mainly due to a greater number of non-U.S. international medical graduates (IMGs). A total of 606 U.S. seniors remained with no position post-SOAP regardless of whether or not they had participated in SOAP.
U.S. seniors averaged 37 applications in their preferred specialty, 12 interviews, and 11 ranked, with similar trends in alternate specialties. Unmatched applicants completed an average of 58 applications, 6.9 interviews, and 7.6 ranked, with 17 applications and 1.9 interviews in a “backup” specialty.

This year, ERAS opened on September 15 at 9:00 am Eastern Time. Programs were able to begin downloading applications the same day. Registration for the Match began on September 15 at 12:00 noon Eastern Time. The NRMP Match early registration deadline was November 30. The NRMP Match registration and rank order list certification deadline will be February 24 at 9:00 pm Eastern Time. On March 14, matched and unmatched applicant information will be posted to the NRMP website; at 10:30 am Eastern Time, each school will discover who their unmatched seniors are, and at 11 am empty spots will be listed. The SOAP program is open from March 14-March 17. Results of the Match are announced by NRMP on March 18.

NRMP has created a new website (“The Match, A to Z”) with information for applicants, schools, and programs. It has also released the free PRISM app, which helps applicants keep track of interviews.

More materials and information on ERAS and NRMP in 2015 can be found here: https://event.crowdcompass.com/learnservelead2015/activity/cyeUCmj8U

Results and data released by the NRMP for the 2015 Main Residency Match can be found here: http://www.nrmp.org/wp-content/uploads/2015/05/Main-Match-Results-and-Data-2015_final.pdf
Unlocking Secrets to Improve the Learning Environment

Concurrent Session

Will Bynum, MD
Uniformed Services University of the Health Sciences, F. Edward Hebert

Scott Wright, MD
Chief, Division of Internal Medicine, Director, Mille-Coulson Academy of Clinical Excellence, Johns Hopkins University School of Medicine

Frank Warren
Artist, PostSecret

Ann Bonham, PhD
Chief Scientific Officer, AAMC

By Amelia Goodfellow

This session uses the example of artist Frank Warren’s PostSecret project, an anonymous venue where people can mail in their “secrets,” to facilitate a discussion about the lived experiences of medical learners to better understand the causes of emotional and physical stress in medical education.

Speakers at this session discussed their experience bringing the PostSecret project to their home institutions. Students were invited to anonymously share their “secrets” about their most challenging moments in the medical school experience. Submissions to the PostSecret project for medical learners described feelings of shame, guilt, and depression, as well as honest reflections on how the process of learning and practicing medicine could be made more compassionate, more supportive of its practitioners, and, ultimately, more human.

Some schools and residency programs may find value in repeating the exercise with their own learners at their home institutions.

Takeaways:

- A truly anonymous forum such as PostSecret offers windows of insight into problems in medical education and its learners’ mental health, as well as opportunities to cultivate a more supportive learning environment.
- Future PostSecret initiatives at home institutions should ensure those submitting can be connected to mental health resources as needed and desired.
Monday, November 9

A Conversation with Steven Brill: America’s Bitter Pill
Plenary Session

Steven Brill, author of America’s Bitter Pill and featured in Time magazine

By Mallory Roberts
With a law background and an appetite for writing about intriguing issues he “knows nothing about,” Steven Brill became interested in the finance of healthcare around the time of the first Affordable Care Act debates. He also acknowledged a personal interest in the topic that arose after undergoing open-heart surgery and aneurysm repair. He states that healthcare is a unique policy issue and market commodity: It has the potential to affect people deeply; its possible necessity can be frightening; and those buying care often feel like they have no bargaining power because they have no idea what they are buying or what the price should be.

After his own confusing experience sorting out explanations of benefits, paperwork, and insurance jargon after his surgery, he interviewed the CEO of his own plan, United Healthcare, and showed him his post-surgery insurance paperwork. Brill was shocked to find that the CEO had no idea how to interpret the insurance paperwork, either.

In Brill’s view, the private sector’s attempt to provide health insurance doesn’t work, yet the public sector is not designed to handle it either—so how do we fix it?, he asked. Some potential solutions include reducing the enormous financial incentives tied to certain markets, such as medical devices, as well as converting the current health insurance oligopoly into a consumer-focused system that provides insurance plans through tightly regulated plans from university hospitals. Because consumers have a lot of “skin in the game” of health insurance, said Brill, a free-market system could never work. Patients cannot truly be rational consumers, because rather than choosing the fairest price for a good product, they are scared into wanting the best of the best.

Brill stated that we must increase our voice as physicians in the healthcare insurance conversation. Medical device and pharma companies, with powerful lobbyists in Washington, already speak loudly: Let’s speak equally as loud, said Brill.

Takeaways:
- The shifting healthcare insurance market has still not settled, and there are still major opportunities to push for fair-priced, good products.
- The way health insurance is provided in this country may soon change drastically, with university hospital systems building their own insurance networks.
- Health insurance policy changes are an opportunity for physicians to increase their own advocacy efforts.
Getting Back on Track: Holistic Strategies for Supporting Learners Facing Academic Difficulties

Concurrent Session

Beverly Vidaurreta, PhD  
Program Director, Student Counseling and Development, University of Florida College of Medicine

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By Amelia Goodfellow

A variety of systems support students experiencing academic difficulty, ranging from remediation to cognitive therapy. However, non-cognitive challenges can also prevent students from learning to their fullest ability. This session described a holistic, multifaceted approach to assessing student wellness and performance. Speakers supported taking into account a student’s family dynamics, cultural strains and factors, financial wellbeing, and mental health when developing interventions that will improve student success in school.

In addition, academic advisors must understand their school's promotion and exam policies to present the widest array of options to students struggling academically, such as leaves of absence. They must also be aware of and comfortable referring to other campus resources, such as student mental health services, chaplain offices, and financial aid offices.

Takeaways:

- Success in medical school is multifactorial; similarly, when a student is struggling academically, it can be due to a variety of factors.
- Academic advisors must be comfortable advising students on a variety of stressors as well as pointing them toward the appropriate resources.