

OSR Digest | Professional Development Conference St. Louis, MO

Letter from the Chair

Dear OSR,

In June, members of the Group on Student Affairs, Careers in Medicine, and OSR gathered in St. Louis for the 2016 Professional Development Conference. The goal of the conference was to promote the knowledge and skills of attendees through discussions and workshops on topics ranging from mentorship to dealing with tragedies to survey design.

The conference also provided plenty of time for networking. Almost 100 students attended to share solutions from their schools and to ask for advice from others—and to enjoy the city of St. Louis.

This digest summarizes the PDC sessions most relevant to students. It was created for you by National Delegate for Communications Amelia Goodfellow and her team in collaboration with the Ad Board and other OSR reps.

If you have questions about any of the sessions or the projects the Ad Board is working on, please contact [any one of us](#). We all want to know what is important to you and how to support you.

Thank you for all the work you do at your schools to promote student voice. I look forward to seeing you at the Annual Meeting in Seattle.

Sincerely,



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Find presentation information and materials here:

<http://www.cvent.com/events/2016-aamc-gsa-cim-osr-professional-development-conference/event-summary-d51131b1c1184e2f8b4bda780008b77a.aspx>.

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Friday, June 24

OSR Session: Applying Smart with Careers in Medicine

George Richard, PhD, Director, Careers in Medicine, AAMC

Facilitators: Regina Kwon, Aaron Parzuchowski

By Marie Walters

If you haven't visited the Careers in Medicine (CiM) website yet, do it now! The CiM resources are based on the foundation of understanding yourself (M1), exploring options (M2), choosing your specialty (M3) and landing your residency (M4). Note that there is a CiM Timeline on the bottom left side of the CiM homepage.

CiM sent out a survey in January 2016 to ask students what kind of information they wanted to assist them in the residency application process. The results demonstrate that there has not been a lot of change since 2007. Students want information about the following topics:

- Residency programs: geographic location, fellowship match rates, research opportunities, curricular highlights
- Application Process: USMLE 1 and 2 scores, top 5 application screen criteria, research requirements, number of residents accepted per year, application requirements
- Residents and Alumni: graduate career choices, specialty board pass rates, resident demographics.

The session included a roundtable discussion where attendees discussed current resources used to find information about residency programs and discussed what further information students would like CiM to provide. Students at the session voiced that they would like information about the personality of current residents and culture of a residency program before submitting an ERAS application (and ideally before spending the time and money to do an interview); information about the specialty culture overall; training for academic advisors and mentors to give higher quality, less biased information about a broad range of specialties; "red-tape" information such as strict board cutoff scores; and data on which programs guarantee an interview to students performing an away rotation.

Main takeaways:

- Careers in Medicine (CiM) CiM has revamped their website and expanded the services and information available to students
- Students can start taking year-specific self-assessments now and continue to take them throughout medical school for continued growth
- CiM is still requesting feedback on how they can improve. If you have comments, suggestions, or questions for CiM, please reach out to your regional leadership to get you in touch with the appropriate parties

Plenary: Career Development of Clinicians in the Cultural Context: Mentoring to Promote Self-Efficacy

Angela Byars-Winston, PhD, Associate Professor, University of Wisconsin

By Grant Lin

This session focused on defining and describing professional identity (PI) and the impact of the learning environment on professional identity. First, the speaker provided a theoretical framework for PI, then provided concrete examples of assessment tools used for PI, and finally described the relationship of external influences on PI.

The theoretical framework of PI has three domains: individual beliefs about who we are, where we came from, and our values; collective ideas about membership in a group; and relational constructions of our role with peers, patients, family, and coworkers. Literature supports this framework being fluid and constantly changing. PI “does not answer the question of who I am at the moment, but who I want to become.”

Several tools exist to measure professional identity, and sometimes yield surprising results: one survey (Leach 2008) showed first year students rating higher on the extent of their PI development than did third year students. Many of these surveys also pose interesting questions about how PI fluctuates throughout one’s early medical career: for example, the Medical Career Development Inventory (MCDI) tool assesses incoming medical students’ PI scores during the interview season.

The learning environment also affects professional development and identity. Many have asked whether evolving healthcare technology removes the human touch from the practice, affecting the PI and socialization of modern medical students. Trying to build PI while grappling with the hidden curriculum of learning to work with others and communicate effectively, the influence of role models, “micro-ethical” challenges, the academic hierarchy, and a complex and evolving work environment can lead to burnout and cynicism. The speakers summarized that because we are encountering these issues as we form our professional identities, we have the opportunity to build resilience, grit, and perseverance. Audience members reflected that strategies to develop PI may include reflective writing at key times throughout medical school, easier and on-demand networking through social media apps like Slack, and utilizing the Gold Humanism Society project requirement to build PI.

Main takeaways:

- Development of one’s professional identity is ongoing and fluid, and incorporates individual beliefs, experiences as a member in a group, and relationships with others.
- Professional development is the product of challenges and growth opportunities that help to build resilience and wellbeing

OSR Session: Mentorship in Medical Student Specialty Education

James Woodruff, MD, Pritzker University of Chicago School of Medicine

Maureen Garrity, PhD, Associate Dean, Student Life, University of Colorado

Facilitator: Grant Lin

By Auriel August

This session's aims were to discuss mentorship challenges that students encounter at different stages of medical school, offer solutions to improve career information provided to students, identify effective practices for mentors to provide better advising to students, and to share available mentorship and advising AAMC resources with the audience.

The session began with three case presentations, with the following tips from facilitators bulleted below:

- An M1 student is interested in a specialty that is not available as a required third year rotation, and desires strategies to increase her exposure to it
 - Start a student Interest Group to learn more about the specialty of interest
 - Begin preparing early for the most competitive specialty you might be interested in, knowing it's OK to change later
- An M4 student switches his specialty choice just prior to submitting his ERAS application
 - Speak early on with advisors about doubts or ambivalence about a specialty of interest; keep a broad differential and don't feel pressured to commit too early
 - Engage with faculty mentors in all specialties of interest
 - Learn about and plan for the ERAS timeline and procedures
- An M3 student wants to know how to overcome an "average" performance in his specialty of choice during third year clerkships.
 - Check in with your advisor: depending on your school's clerkship grading system, your situation might be fairly common!
 - Try to make up for a lackluster "Pass" with extracurricular activities and/or research demonstrating commitment to the field.
 - Talk to upperclassmen students who rotated through your site and specialty about how to perform well--*before* starting the clerkship

Next, the invited speakers laid out a systematic method to address mentorship needs that fluctuate by year in medical school:

- **Know your resources** – engage in Careers in Medicine early on for "leads" on specialty choice as well as to investigate specialties of interest; sign up early for career planning conferences, clinical shadowing, clinical conferences, and sessions with faculty advisors.
- **Know your timeline** – if you have any interest in a highly competitive specialty, apply yourself early on in medical school, knowing it is much easier to switch into a less competitive specialty. If interested in a more competitive specialty, engage early on in longitudinal "application-building" activities; if interested in a less competitive specialty, a student may spend more time increasing clinical exposure.
- **Know the difference between advising and mentorship** – advisors have established expertise and are assigned or informal; mentors are established in their specialty area and invest time and resources into your development, and are usually not assigned. Follow a "dating model" to find a specialty mentor: first, decide on a specialty; next,

reach out to and meet many people in your specialty of interest. Then, choose someone special you 'click' with and take the relationship to the next level by observing and assisting in clinic or writing case reports or research projects. Check whether the mentorship relationship is strong: a good mentor needs to reciprocate.

Main takeaways:

- Engage early on in [key resources](#) that can keep you ahead of the game (and the timeline) in medical school
- Actively seek high-quality mentors in specialties of interest and cultivate opportunities for application-building activities through these individuals
- Seek adjunct advising or mentorship early on in if confused or unsure about specialty choice

OSR Session: When Tragedy Hits Medical Schools: Coping Strategies for the Learning Community

Kate Carroll, Donna Elliott, Carolyn Kelly, Charles Pohl

Facilitators: Luke Burns, Stephanie Han Yu Liou, Franco Pillsbury, Sarah Williams

By Victoria Wu

This session, organized by students at the University of Southern California, covered both the incidence of tragedy at medical schools across the country and the effectiveness of the response to tragic events at the administration and student levels, with the goal of beginning to generate best practices for tragedy management.

First, speakers reviewed the results of a survey on tragedy sent out to students across the country. According to the survey, 62.9% of students have experienced a tragedy affecting their medical school class. Thirty-one percent of these students stated the tragedy was a serious accident, illness, or accidental death of a student, and 20% reported the tragedy was a student suicide.

Students reported the following most common institutional strategies for responding to tragedy:

- Memorial service
- Extended counseling services
- Fundraising
- Permanent Memorial

Whereas the most effective institutional strategies for responding to tragedy included the following:

- Canceling or rescheduling classes
- Memorial service
- Permanent memorial
- Extended exam/study hours
- Administration addressing students early, before rumors have a chance to start

Invited panelists Dr. Donna Elliot from USC Keck School of Medicine, Dr. Carolyn Kelly from UCSD, Dr. Charlie Pohl from Sidney Kimmel Medical College, and student Kate Carroll from UCSD then responded to the following prompts. Their answers are reproduced directly here rather than summarized.

Question 1: Tell us about when your institution experienced a tragedy and how your school responded.

- Dr. Elliott: “[there have been a] number of events over the past 5 years: student death, suicides”.

- We canceled classes and drew the affected class together. Our deans were there, many faculty were there – not just administration, but the entire faculty community was there.
 - What happened organically: students all took care of each other. There were small gatherings and students in the class got together that evening in groups. We knew who some of the friends of the student were and we made phone calls to make sure that these students weren't alone that night.
 - You develop a relationship with the student's family. You want to work with the family to make sure that they are comfortable with the information released. To keep the family's wishes, to protect the family, to keep them at the center.
 - Our counselors extended hours and made themselves available in a semi-private place on campus every day at lunch for two weeks.
 - We did ultimately have a memorial service and the students planned most of it with a little guidance and framing from us. The family was included and approved of everything and the students did a wonderful job of celebrating.
 - I hadn't heard the survey data, but some of our instincts were right.
- Dr. Kelly: "grief comes in waves and hides in pockets. And a year later, our community was remarkable in terms of mobilizing and coming together."
 - My two priorities were: trying to do the best thing for our students and trying to do the best things for the families involved.
 - The back-to-back tragedies were absolutely overwhelming for some people.
 - Dr. Pohl: "murder, suicide, and cancer – tales of 3 students."
 - We did lots of things right and lots of things wrong, but what we learned is that preparation is key.
 - We were forced to create algorithms and protocols that have served us well.

Question 2: What barriers prevented your institution from mounting the most effective coping response?

- Kate: My choice to take time off was not one shared by many of my classmates. As medical students, we don't like to reveal weakness and I tried to make it very loud that I decided to take time off (from the scheduled curriculum).

Question 3: What can be done to prevent medical students from committing suicide?

- Dr. Pohl: We should really be talking about prevention – I spend a lot of time thinking about the learning environment. It comes down to creating a safe, respectful learning environment that provides quality. Communicate and communicate often.

- Dr. Kelly: I've gone from barely getting contact from faculty watching (higher-risk) students to getting contact from faculty 2-3x/month regarding suicidality potential. Most of the time, students are happy that we are concerned.
- Dr. Elliott: I hired a part time psychologist just for our medical students and we are going to start something called "Keck Check" that allows for students to answer "How you're doing?" with the idea of normalizing seeking care.

Main takeaways:

- Students appreciate administration strategies for coping with tragedy that allow them to take the necessary time from their duties as medical students to be well and grieve, that deliver information about the tragedy in a timely manner, and that memorialize the lives of students affected by tragedy.
- Tragedy can be an impetus for working on wellness and resiliency resources; many schools are realizing the value in bolstering these resources as a method of prevention, even before tragedies occur.

Concurrent Session: Financial Wellness, It Takes a Village

*Cynthia Gonzalez, Senior Assistant Director Financial Aid, Northwestern University
Feinberg School of Medicine*

By Marie Walters

This session's aim was to provide financial aid counselors with a comprehensive approach to better assist medical students in developing their financial wellbeing. The speaker drew a distinction between "financial literacy," or having the knowledge, and "financial wellness," or actually implementing the strategies into one's life. To help students better accomplish this ideal, and because students are managing their finances in a variety of settings, the speaker underscored the need for financial advisors to provide a sense of community and interact with students outside the typical office environment. For example, Feinberg has enacted a program in which students meet monthly in small groups to develop skills to deal with stressors, including financial worries. Fifty-three percent of participants agreed that these sessions have reduced their stress.

Specific ideas for advisors to cultivate financial wellness included:

- Coordinate with admissions, office of diversity and inclusion, student affairs, and the dean's office for new ideas and integration of financial wellness principles in other aspects of student programming
- Invest in marketing and communications to help brand, name, and advertise financial programming
- Incorporate AAMC resources such as FIRST presentations, debt calculator, and loan repayment options into financial programming
- Time presentations opportunistically with different stages of medical school, such as releasing information on loan history before financial aid award notices go out

Main takeaways:

- Financial aid advisors should teach financial wellness rather than just financial literacy—and this means incorporating healthy financial practices into all aspects of student's life. Advisors can encourage this by collaborating with other campus departments for maximum impact
- Advisors should incorporate AAMC resources and tools into programming
- Jointly promote financial acumen and holistic wellness to help reduce student stress

Student Affairs & Programs Annual Address

Darrell Kirch, MD President and CEO, AAMC

Geoffrey Young, Senior Director for Student Affairs and Programs

By Auriel August

Dr. Kirch opened the session by acknowledging that the political climate of the United States has created an extremely divided constituency on issues related to medical education in recent years. He touched on several key issues detailed below, while emphasizing that the AAMC must remain bipartisan in its efforts to advocate for medical education and healthcare

First, Dr. Kirch reiterated the need for the medical education community to continue to support improvements in health care access. While the number of health care-uninsured has reached an all-time low, the number of people unable to find a provider is rising. This looming physician shortage is exacerbated by aging baby boomers with a large need for primary care, and a disproportionate lack of residency spots and GME funding to meet this need. Though both Republicans and Democrats recognize the need to increase GME funding, no concrete financial solution has been offered at this time.

Compounding the issue, the Medicare Revenue at Risk for Major Teaching Hospitals shows a projected funding decrease of 20% by 2024, and NIH research funding has failed to increase, and failed to demonstrate itself as a stable source of income for academic institutions, resulting in continued increased burden of the cost of medical education on the students. The gravity of the problem is set in sharp relief when considering that though teaching hospitals comprise 5% of the country's hospitals, they contribute 23% of clinical care, 37% of charity care, 100% of comprehensive cancer centers, 68% of burn units, 79% of trauma centers and 59% of PICU beds. These facts must be conveyed strongly to Congress to encourage real and prompt action.

Next, in mentioning the recent ruling on the Fischer Case, in which the Supreme Court upheld the University of Texas' admissions policies, Dr. Kirch emphasized that the AAMC will continue to celebrate and advocate for diversity in medical education.

Regarding recent changes in AAMC leadership, Dr. Kirch welcomed Dr. Alison Whelon as the new Chief Medical Education Officer, and Karen Fisher, JD as the new Chief Public Policy Officer.

The following are specific updates from various AAMC member departments.

- **Medical School Admissions Requirements (MSAR)**
Announces it is going live with a new electronic interface and conducting focus groups with applicants. Feedback on the new look can be sent to msar@aamc.org.

- **Aspiring Docs**

This resource for soon-to-be medical students provides an insider look at what it's like to study medicine. A new project called "Anatomy of the Applicant" will communicate holistic competencies sought in entering medical students.
- **Advancing Holistic Review**

This hot topic in medical education has its own site at www.aamc.org/holisticreview. The program is working to develop and share strategies for admissions departments to implement holistic review.
- **OSR Update**

The Arnold P. Gold Foundation Humanism in Medicine award recipient has been chosen and will be awarded at the upcoming 2016 AAMC Learn Serve Lead National Meeting. The OSR has also elected new OSR liaisons to various member committees, unveiled a speaker series on reducing the stigma of mental illness, and compiled a series of year-specific AAMC resources for students at all stages of medical school.
- **FIRST Update**

This comprehensive financial resource shared new MLOC/DLOC enhancements and recently finished planning the 2016-2017 FIRST Webinar series.
- **CiM Update**

Careers in Medicine is unveiling a new, modernized website with improved career assessments and a more user-friendly dashboard. Check it out at <https://www.aamc.org/cim/>.
- **SOAP**

The 2016 Match rate was 92.8%. After the Supplemental Offer and Assistance Program (SOAP), 615 students remained without a PGY-1 position. The most recent GSA Survey asks student affairs deans the reasons their unmatched M4 students did not match; results have been released and include not following advice from the dean's office, followed by low USMLE scores and failed exams and distantly trailed by professionalism issues. SOAP also continues to advocate for increased GME spots.
- **GSA**

The Group on Student Affairs is planning new webinars on financial literacy, understating state authorization, and medical student diversity, and is working on several projects including: a financial aid fact sheet for student diversity officers and a crisis response document. New survey topics include:

the impact of experience in clinical shadowing on medical student admissions; staffing; and standard immunization forms.

- **Learn Serve Lead: Seattle, Washington, November 2016**

The upcoming Annual Meeting will feature increased networking time with colleagues, as well as more sessions on wellness and resilience, unconscious bias, and the transition to residency.

Saturday, June 25

OSR Session: Specialty Choice: How Do You Measure Up?

George Richard

Gemma Costa

Daria Ellis

By Javier Farinas

This session stressed the importance of taking Careers in Medicine (CiM) assessments to identify underlying personality traits, values, and skills that will help students choose a satisfying specialty and career.

The science and research behind these assessments incorporates values, skills, interests and personality. CiM utilizes a four-phase career planning model to guide students through the process of choosing a specialty and designing a career. First, the student should seek to understand themselves, identifying values and interests and incorporating information about age, gender, race, ethnicity, location, and employment status. Second, students should freely explore medical specialties of interest. Third, students choose a specialty. Fourth, students land a residency. Currently, the heaviest use of CiM assessments, as measured by the highest number of completed assessments, is by M1s taking the medical specialty preference inventory. The speakers discussed several key CiM assessments by first guiding participants through a fun activity and then showing how it relates to the CiM tests.

To introduce the Physician Values in Practice scale, speakers conducted an activity in which participants took 5 sticky notes, writing down a career value on each and ranking them in order of importance. They then gradually took away the 5th, 4th, 3rd, and 2nd ranked values, discussing with a partner what it would be like to have a career without these values. Then, they were instructed to put back any values they felt they could not live without, and re-rank their lists.

The Physician Values in Practice scale is a 60-item assessment designed to help students discover the career and practice values most important to them but not to “match” the student with any particular specialty. Values included autonomy, management/supervision, prestige, service, lifestyle, and scholarly pursuits.

Speakers then guided participants through another activity designed to introduce the Medical Specialty Preference Inventory. Participants were shown sets of two pictures (i.e., eagle vs. dolphin, Mercedes vs. Chevy truck) and asked to choose which they preferred and why, to show that just like choosing one of two items, students can choose the same specialty for very different reasons.

The Medical Specialty Preference Inventory looks at career interests by showing students 18 medical interest scales and where they individually fall on each, and what specialties people go into with those interests.

Lastly, the speakers covered the Specialty Indecision Scale, which addresses ambiguity, lack of exposure, and lack of knowledge about two or more specialties a student is considering. The session closed with a reminder to complete assessments seriously and honestly, as the best information from CiM assessments comes from being true to yourself.

Main takeaways:

- The Careers in Medicine (CiM) site has several assessment tools available for each stage of medical school, and can help to guide students in discovering professional values, desired practice setting, specialty choice, and specialty indecision, with the eventual goal of choosing the specialty and career that are the best fit for the individual
- Assessments discussed include:
 - Physician Values in Practice scale
 - Medical Specialty Preference Inventory
 - Specialty Indecision scale

All assessments are available on the [Careers in Medicine](#) website after logging in with your AAMC credentials.

OSR Session: Survey Design 101: Covering the Basics of Developing Surveys in Medical Education

Dorothy Andriole, MD, Washington University

Donna Jeffe, PhD, Washington University

Facilitator: Marie Walters

By Regina Kwon

High-quality survey data are valued by students, administrators, and faculty alike. Too often, however, errors in the design of surveys lead to information that is difficult or impossible to interpret. In this session, Dr. Dorothy Andriole and Dr. Donna Jeffe provided a workshop-based introduction to the fundamentals of good survey design.

The speakers began with the basic distinction between surveys and questionnaires. A survey refers to the process of collecting information systematically, whereas a questionnaire is one of the tools used in survey research.

Questionnaire development should begin with a good-faith effort to determine if data already exist to answer the survey question(s). Drs. Andriole and Jeffe pointed to the AAMC Graduation Questionnaire (GQ) as an example of a rich data source that may be overlooked. GQ results are available as a national aggregate; OSR reps can also request the data for their school from their student affairs dean or from the AAMC.

If the data are not available, researchers should ask the following questions:

1. Does a validated questionnaire already exist? If so, use it.
2. How will the data be used? For example, will the data be compared with previous information? Is the purpose descriptive or predictive?
3. Is a questionnaire the best method of collecting the information? Would a focus group be better?

Creating a new questionnaire may be the right answer. If so, researchers should be aware that a comprehensive survey may require more information than that provided by the questionnaire; that questionnaire development is iterative; and that a high-quality questionnaire may take longer than anticipated to develop.

The speakers described common sources of error in survey research, including errors of sampling, coverage, non-response, and measurement. The remainder of the session focused on measurement error. Measurement error results from poorly worded questions and poorly chosen response options. Pitfalls to avoid include:

- Asking about more than one issue in a single question (“compound items”)
- Misaligning response options with the question (for example, providing a scaled response to a Y/N question)
- Negatively worded items

Drs. Andriole and Jeffe then took the attendees through a workshop exercise using a mock questionnaire about pre-clerkship grading systems that the speakers had developed. Each group of three to five attendees critiqued the questionnaire using what they had just learned. Groups

then exchanged critiques and evaluated the critiques themselves. The speakers then facilitated a lively discussion that contained much laughter and vigorous debate.

For the complete presentation, which includes a list of useful resources on survey and questionnaire design, please visit the conference website.

Main takeaways (bullet points):

- Use validated questionnaires if they already exist
- Questionnaire design is an iterative and usually lengthy process
- Cognitive interviewing can greatly increase the usability of a questionnaire
- Best practices exist for writing questions; refer to established texts (see resource list at end of presentation)

National Residency Match Program (NRMP) Update

By John Barber

Key facts:

- The number of residency positions filled was 6,015 more than in it was in 2007, but the number of applicants was 7,532 more.
- The rate of increase in US seniors applying is not as high as the rate of increase in other groups applying, such as students from the U.S. graduating from international medical schools (USIMGs) or students from outside the U.S. graduating from international medical schools
- The speaker stated that because of this discrepancy, relying on the Supplemental Offer and Acceptance Program (SOAP), from which U.S. seniors disproportionately benefit, as a backup plan is not recommended; a better option would be to rank additional specialties in the NRMP.
- Upcoming changes to NRMP include the following:
 - Starting next year, SOAP will conclude after 3 rounds
 - Residency programs cannot **ask** an applicant to reveal any info regarding what other programs they may be applying to (before, programs were allowed to ask but could not require an applicant to answer)
 - Couples' rank listing is limited to 700, including "no match" combinations
 - NRMP will produce 4 versions of the document Charting Outcomes in the Match (DO, USIMG, IMG, in addition to U.S. MD)
 - NRMP is now partnering with the American Medical Association (AMA) to track applicants matching to PGY-1 only positions

ERAS Update

Patrick Fritz

By Victoria Wu

Paired with the NRMP Update (entry follows this one), the ERAS Update session presents the latest data about the Electronic Residency Application Service (ERAS) fourth year students use to apply to their chosen programs. In 2016, there were 45,766 residency applicants, about 21,000 of whom are graduates of U.S. MD programs. There are 4,632 residency programs in 73 specialties accredited by ACGME and AOA. This year, there were approximately 57 applications submitted per U.S. MD applicant, a 10% increase over the prior year. The average for all applicants was about 87.

Other changes to ERAS services this year include the functionality to generate tokens for letter-writers to submit Letters of Recommendation directly to a student's application. These are issued late in third year for early LoR upload ability. So far, these tokens are only for the immediate next year, so would not be as helpful for students taking a gap year.

ERAS collects data about what students would like to know about the process of applying. Top questions include: "What does my personal statement look like to programs?" And, "How can I see which programs have viewed my application?"

Brief data on the Supplemental Offer and Acceptance Program (SOAP), the process through which programs try to fill unfilled positions with applicants unmatched during Match Week, were also presented. In 2016, there were 13,879 SOAP eligible applicants, and 10,602 SOAP users on the first day.

The timeline for ERAS 2017 includes the following dates:

- June 6: ERAS opens + tokens started to be issued
- September 15: ACGME accredited programs begin receiving applications
- October 1: MSPEs released to programs
- March 13: Match Day

PDC Session: Q&A on Student Loan Repayment Options

Julie Fresne, Nicole Knight

By Aaron Parzuchowski

In this session, representatives from select federal loan repayment and scholarship programs discussed opportunities available to medical and other health professions students and provided insights on the resident experience.

The average debt at graduation, totaled from undergraduate and medical schools, is \$183,000. Speakers reiterated that there are many different options to pay back loans. The best option for the individual depends on your priorities and financial abilities following graduation.

The following are helpful resources to find the best loan repayment options for you:

- AAMC Financial Information, Resources, Services, Tools ([FIRST](#))
- Calculate loans and repayment plans with the [Medloans Organizer](#)
- Check out the loan repayment programs [legislative update](#); note that the President's budget has proposed capping Public Service Loan Forgiveness (PSLF) awards at \$57,500

As always, students are encouraged to consult with their financial aid offices.

Sunday, November 8

OSR Session: Medical Student Communication: Tackling Tricky Topics

Amelia Goodfellow, M4, David Geffen School of Medicine at UCLA, National Delegate for Communications

By Amelia Goodfellow

This session explored several frequently encountered situations in which communication is critical to delivering a high-quality health care result: conducting an interview through a medical interpreter; giving an effective handoff to a team member; and giving bad news.

In the first segment, the speaker emphasized that using a trained medical professional to interpret is always preferable, when available; however, recognizing that ad hoc interpretation is often necessary, she provided the following tips for success:

- Assess the patient's and interpreter's proficiency in the language to be interpreted to gauge literacy level
- Never use a minor (<18YO) except in an emergency
- Concisely brief the interpreter on the purpose of the interview (i.e., an H&P, medication instructions, a code discussion)
- Request that the interpreter make no omissions or additions to what is said, and state that you may interject if there appears to be a misunderstanding
- Position yourself, the patient and the interpreter either in a triangle shape, or with you and the patient sitting face to face and the interpreter seated slightly behind and to the side of the patient
- Always speak directly to the patient and make eye contact with them
- Speak in short sentences or phrases and avoid jargon, acronyms, or medical terminology
- Pause more often than you think; it is difficult for an interpreter to keep track of long paragraphs of information
- Do not direct your questions to the interpreter, but to the patient (i.e., do not say, "Ask him if...")
- Observe for signs of confusion, and check in periodically for understanding and effectiveness of the interview

The group then watched and critiqued videos of a poorly conducted interview and a high-quality medically interpreted interview. The speaker provided the [Language Line Interpretation Card](#) and the [AAMC Guidelines for working with medical interpreters](#) as resources.

In the next segment, the speaker introduced the I-PASS format for effective medical handoffs, as well as the following tips:

- Don't make it a mystery: order your handoff by illness urgency with the sickest patient handed off first and with the most time and detail
- Clearly convey concern, urgency, doubt, and important action items or follow-up tasks; clearly convey who holds responsibility for each action item

- Avoid unnecessary detail, focusing on what the receiver of the handoff needs to know to keep the patient stable, and what they are likely to get called for overnight
- Relay your sickest patients' worst case scenario, and your contingency plans for what to do if that happens
- Maintain open communication, allowing time for clarifying questions; ideally, the recipient of the handoff should briefly, verbally summarize each patient

The group then read through three patient vignettes and paired off to practice giving and receiving handoffs. The [I-PASS handoff](#) format was provided as a resource.

Next, the group discussed giving bad news. The speaker utilized the [AMA Education for Physicians on End-of-Life Care handbook](#) as a resource for the following tips prior to giving bad news to a patient:

- Reflect on personal experience delivering and receiving bad news
- Commit to respecting the patient's autonomy
- Set goals of compassion, honesty, and directness
- Prepare factual information on diagnosis, prognosis, and treatment options but be aware that the patient may not ask for it, or may do so at a later time
- Identify those whose presence is important to the patient, ask whether the patient would like these individuals present, and arrange to meet together if the patient desires; also arrange a trained medical interpreter if necessary
- "Orient" the patient with a synopsis of course and diagnostics
- Introduce the news by asking: what does the patient want to know?
- Present the news
- Pause to acknowledge and validate patient's and family's responses, and be flexible to the pace set by the patient and family
- Reiterate your availability and arrange for future discussions, if desired; don't disappear and don't leave the patient with a sense of abandonment
- As appropriate, ask more about expectations for the future, worries, and goals
- Avoid giving precise answers on timeframe, as this is often unknowable

The group then met in triads to practice giving bad news to a patient and family member.

The full presentation is available [online](#), with discussion handouts available [here](#).