greater chance of filling this nation's health care needs. As Dr. Jack McCue has noted, "it is unlikely that optimal medical care can be delivered by unhappy or maladapted physicians. Empathic concern for a patient's distress, placing the patient's interests before those of the physician, and considering all the ramifications of a therapeutic or diagnostic intervention ("cost-benefit analysis") require concentration by a physician who enjoys the work and brings to it an emotional stability derived from his or her personal life."

In this vein, it seems several efforts should occur to improve and guarantee resident well-being and, consequently, quality GME. Many of these ideas were generated from the lunchtime discussion on this topic at the 1995 Annual Meeting. These ideas reflect the need, on one hand, to continue to work toward improving working conditions at the policy level, and, on the other hand, to work toward optimally coping with conditions that have yet to be improved. At the individual level, all residents should work to be aware of their coping skills, and strive to develop and maintain healthy, adaptive coping skills that contribute to continual personal and professional development and satisfaction. Since these skills are often not innate in medical students and residents, especially when exhaustion sets in (1), schools and residency programs should be responsible for teaching them to their trainees. Such instruction and role-modeling should occur throughout all years of training, and could be in the form of mandatory seminars as well as ongoing support and "professional development" groups (5,6). These sessions would cover and help develop and maintain healthy coping strategies such as self-awareness, sharing feelings and responsibilities, self-care, developing a personal philosophy, and limit-setting (7). If these programs are not yet available at schools, students and residents should initiate them informally and push for such resources to be institutionalized. Also, besides addressing individual coping skills, residents should regularly give feedback to their residency directors and programs regarding communication and other problems with hospital staff that interfere with optimal resident education and patient care.

At the policy level, we should aggressively monitor and push residency programs, especially more resistant surgical programs, to comply with already-existent ACGME working conditions guidelines. Scheduling strategies for achieving compliance include night-float systems, "jeopardy" systems (residents "on-call" and financially reimbursed for other residents who are sick), as well as many others. Compliance with specific, humane working conditions guidelines should be an essential criteria for accreditation. Resident and attending physicians should be active in uncovering and publicizing non-compliant programs. Resident and attending physicians should also work toward having support groups and other preventive, self-care programs included in the accreditation process.

Finally, at the research level, interested and motivated individuals should work to contribute to the body of evidence which supports the significance and pursuit of resident well-being as an essential component of quality GME. Topics yet to be thoroughly examined include: resident's mood changes and their effects on patient care (including the physician-patient relationship), the interaction of work stressors and social/personal factors, coping skills of residents who excel under stressful training condition (vs. those who become impaired or unhappy and maladaptive), and the short-term and long-term effects of intervention and prevention self-care programs on resident-physician professional development.

I feel we can all contribute to improvement in this area by developing and modeling healthy, balanced personal and professional values, attitudes, and behavior. I also believe that even small efforts by each of us in our busy schedules can combine to improve individual program policy, as well as national policy. I look forward to any feedback and continued discussion on this topic and my thoughts. I have sent a collection of articles, gathered by myself and Deborah Baumgarten to Alexis at the ORR office for those interested in more references. Good luck.

E-mail: natb@uclink2.berkeley.edu

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The Residents' Report

Published For The AAMC Organization Of Resident Representatives

Winter, 1996

Chair's Message

Nicholas Gideonse, M.D., ORR Chair

Welcome to the first 1996 ORR Newsletter. I hope you all had happy holidays, without too much call to enjoy them. Happy New Year!

I want to welcome all the new ORR members, and especially those who were unable to attend the annual meeting. The annual meeting is our main ORR event, and we hope you can join us next year in San Francisco, November 8-10. Meanwhile, we'll keep in touch via this newsletter. I encourage you to contact the ORR with any ideas, comments, or concerns.

To all those that came to Washington, I hope you got some feel for what the ORR is, and can become. Thanks for your feedback. We've included in the newsletter a piece from a new member about her impressions of the meeting; I hope that it, or other items here, will inspire your interest.

A change for us at the AAMC is that Dr. David Altman has returned to San Francisco, the home of his family, leaving us in the now capable hands of our staff associate, Alexis Ruffin. Dr. Michael Whitcomb, Senior Vice President, Division of Medical Education, will also remain as a resource and advocate for us. The generalist initiative that Dr. Altman staffed will remain under Dr. Whitcomb's purview.

We're excited about our biggest projects for the year. The first will be planning a professional development meeting addressing careers in academic medicine. This will be open to the ORR membership. The standing target now is to schedule this in tandem with the Spring 1997 meeting of the Council of Academic Societies. The second is to revisit how ORR members are appointed, and how we can do a better job of really representing physicians in training, those being served, and serving in, teaching programs. Your suggestions are warmly invited. Please call, write, or E-mail me soon!

Finally, our next newsletter will be in the late spring. Let me know what you'd like to see included, or would like to include.

You are a talented and ambitious group. The Ad Board and I look forward to serving you in any way that we can.

First Impressions

Cheryl Rucker Whitaker, M.D., ORR Chair-elect

October 1995. I felt fortunate to attend my first meeting of the AAMC-ORR. It was by no accident that I flew across the country a week before my wedding to attend. I had looked into opportunities for resident involvement in broader spectrum policy issues, particularly those that pertain to medical education. I did research and found that the AAMC had its own resident group offering front line input into medical education policy.

I got to the meeting and among the first speakers was Linda Fishman, Associate Vice President, Division of Health Care Affairs, summarizing the financing of Graduate Medical Education. From her first few slides, I knew

ıat I was hooked and had to get involved. Along the ay, we were introduced to other physicians who had ft prosperous academic careers to serve as executives in ıe AAMC. Jordan Cohen, M.D., our very dynamic and onfidant leader, was accessible and genuinely interested ı resident input. In addition, we had excellent staff edicated to our organization.

was impressed with the development of resident lead- ship and the vitality of all of my fellow members. lany opportunities exist for education and growth after ne becomes a member of the ORR: the newsletter, the ection on Residency Education, and the various AAMC ommittees where we contribute the resident perspec- ve. As the meeting progressed, I seriously considered nning for an elected office. I spoke with other ORR ıembers and decided that I would run for Chair-elect. m looking forward to the chance to serve residents with ıe premier voice for academic medicine and teaching ospitals in the country. My message to everyone: Get volved and Stay Involved!

esults of the ORR Survey on Quality ı Graduate Medical Education

vid Jones, M.D.

he ORR survey on quality issues in Graduate Medical ducation (GME) was done to obtain an idea from resi- ents in varying types of residencies about elements of ıality in their education. The survey instrument was ailed in early August 1995 and follow-up letters and ıone calls were made to delinquent ORR members ter 4 weeks. The overall response rate was 85%, which as astounding! This was especially impressive as the RR has many new members this year.

he survey focused on several elements of quality cluding: faculty involvement, mentorship, working nditions, and changes in GME secondary to healthcare form. The majority of the respondents felt faculty volvement in their education was very important and at working conditions could be improved. terestingly, most residents did not feel call or service- lated responsibilities affected their education in a gative fashion. In addition, most residents felt that ysician-extenders or other ancillary staff did not facili- e their education. Finally, 50% of the residents felt anges in GME secondary to healthcare reform had a gative impact on their education.

The results of the survey were presented at a joint ssion with the Council of Academic Societies (CAS) during the Annual Meeting in Washington, D.C. on Oct. 28, 1995. The presentation was part of a panel discussion on defining quality in GME. The program was well-received and several people from the Accreditation Council for Medical Education (ACGME), the CAS, and different medical schools have asked for copies of the survey results. A copy of the results (in the form in which they were presented) should be mailed to all the members of the ORR who asked for one. If you have not received a copy and would like one, please contact Alexis Ruffin at the AAMC.

Again, thanks to all of the survey respondents and to the AAMC staff who helped with the mailing and correct addresses.

1995 Annual Meeting Evaluation Survey Results

Denise Dupras, M.D.
ORR Immediate Past Chair

Thanks to those of you who completed the evaluation form at the end of the 1995 ORR Annual Meeting. A total of 22 new, 9 old, and 2 undesignated members evaluated the meeting. Overall, you rated the meeting very highly, all but two sessions rated less than 4 on a 5 point scale. Eleven members attended one of the Friday sessions. All but 1 individual thought the small group sessions/discussions should be continued for 1996. The highest rated program was the session on Graduate Medical Education financing presented by Linda Fishman, Associate Vice President, Division for Health Care Affairs. The lowest was the first half of our program on communication. (Data are available for those who want the breakdowns.)

The comments were very helpful. Linda Fishman and David Altman, M.D. were cited for outstanding presentations; it was suggested their materials be included in the ORR resource manual. A repeated suggestion was the need for more interactive time for members to voice their concerns and scheduling in more unstructured time. An additional small group topic suggested was women in medicine. Our joint session with CAS got mixed reviews, but overall was viewed favorably. The ORR/OSR session was a hit, coming at the end of a long day, though the price of drinks was cited as a "bummer." The review of the resource manual was positive. To those of you who wish to be designated and notified earlier, AAMC is definitely behind you, and is working to make the designation process smoother. Everyone's

Special Report, 1995 Annual Meeting: Small Discussion Group: Resident-Physician Well-Being and Working Conditions - An important Component of Quality Graduate Medical Education

Nathalie Bera, MD, MPH

I was very happy to have had the opportunity to revisit the issue of resident working conditions and well-being as one of the lunchtime, roundtable discussion topics at the 1995 ORR Annual Meeting. At Dr. Altman's request, I am sharing some insight that I gained while preparing for this discussion.

Graduate medical education (GME) has come a long way in establishing humane working conditions for resident physicians. Problems existent in residency training programs in the late-nineteenth and early-twentieth centuries included: call every night or every other night, nonexistent salaries, programs resistance and to resident marriages, and a complete absence of social and emotional resources for residents. Through gradual, incremental changes in residency policies, working conditions have improved significantly over the past century, a fact we perhaps take for granted as we labor our long hours. It also remains true, however, that there still exist many residency programs which allow their residents to unnecessarily suffer through excessively long work hours and inadequate resources. In the survey recently completed by David Jones of the ORR Administrative Board, only 59% of residents (35% of primary care residents) agreed that "call schedules allow time for family/leisure." Also, his survey found that 45% of residents lack adequate resident support groups in their programs. Attention to this issue of working conditions, duty hours, working environment, supervision, and other resources is extremely important as it impacts on the quality of resident education and patient care. Common sense, as well as established principles of adult learning, suggests that education is optimized when individuals are well-rested, comfortable, and alert (1). Also, even in the absence of conclusive empirical evidence, intuition tells us that rested, healthier, and happier resident-physicians lead to better patient care.

The most publicized consequence of negligence in the area of resident working conditions is the case of 18-year-old Libby Zion who unexpectedly died within 24 hours of admission to New York Hospital in 1984. Some charged that her death was the result of sleep-deprivation and overwork of the residents caring for her. The Manhattan grand jury that initially heard the case filed a report which lead to the establishment of the Ethic Committee of Emergency Services (the Bell Commission). This commission concluded that inadequate supervision was at the root of the problem. Its conclusions led to legislation mandating reform of residency work hours in New York State beginning July 1989. In February 1995, another jury hearing the case concluded that too great a workload assignment was at the root of the problem. Neither conclusion pointed to resident sleep-deprivation as the cause of death in this case. And, though a multitude of controlled studies exist linking resident sleep-deprivation to poor performance of specific activities, it is not clear that these findings correlate with job performance. One study has actually found that limiting hours could result in poorer patient care due to minor complications and test delays. It is also important to note that a main argument in support of long work hours (that long hours improve patient care by promoting continuity of care) has not been proven by research.

Because of the inconclusiveness of these main arguments, Dr. Michael Green, in a recent article in the Annals of Internal Medicine (1), proposes that other issues be carefully examined and included in the discussion whether the benefits of long work hours outweigh the harms. In his article, he states "because the data on the harms and benefits are mixed and because exploitation is difficult to prove, a stronger argument for reducing work hours is an ethical one: that overwork interferes with the development of professional values and attitudes that are an essential part of the moral curriculum of residency" (1). In other words, overworked and exhausted residents may, not-surprisingly, develop unprofessional attitudes toward patients, viewing them with disdain and trying to avoid them. Even more problematic is that instead of developing good balance and perspective in life, overworked and exhausted residents unnecessarily experience high rates of depression, suicide, substance abuse, and relationship problems at a very significant, influential time in their development as physicians. The impact of overwork and fatigue on personal life and relationships is especially concerning given that there is growing evidence that strong social networks and support are important, effective "buffers" of the stressors of residency (3). While it is true that some residents cope with residency stressors much more easily than others, it seems also true that the goal of GME programs should be to ensure that all resident's professional and personal needs are attended to in an effort to produce the largest possible proportion of healthy, productive physicians. This in turn will lead to a

biggest gripe was getting things so late, i.e., designation letters and registration materials for the Annual Meeting. We are working to remove the offending organizational obstacles. We depend on you to keep us up-to-date on your address and meeting attendance. Best suggestion regarding the election process: nominate the first day so members can meet the candidates and review curriculumn vita.

Highlights: Linda Fishman, Mary Beth Bresch White, David Altman, M.D., the opportunity to meet and talk with residents from around the country in different specialties, small group discussions

Lowlights: Not enough time for free-form discussion, late mailings, 7am wake-up, Saturday too busy (caused brain overload).

Once again thanks for the time you spent. See you San Francisco, 1996!

1995 Annual Meeting Political Spotlight: Summary in Brief

Denise Dupras, M.D.,
ORR Immediate Past Chair

The Speaker of the U.S. House of Representatives, the Honorable Newt Gingrich, addressed the AAMC Tuesday, October 31, 1995 to a packed ballroom about his vision for America. He outlined his management and planning models and their inter-relationship. He described his approach as "pro free market and individual responsibility." While his speech was eloquent, Senator Christopher Dodd followed with a sobering report of the financial realities of the proposed budget reconciliations, and the inevitable impact of the cuts on not only Academic Medical Centers, but on the poor and the elderly. His message was clear: under the current proposals those who can least afford health care are likely to be hurt the most.

Report: Project Committee on Increasing Women Leaders (in Academic Medicine)

Denise Dupras, M.D.,
ORR Immediate Past Chair

November 29, 1995 was the final meeting of the Project Committee on Increasing Women Leaders in Academic Medicine. The committee reviewed the AAMC survey of Women Academic Department Chairs. The survey was sent out during July, but returned by only a minority of women; therefore, a second mailing is planned. Stacey Tessler (OSR) noted that many of the responses were the same as those of students who completed a similar survey. Most of the meeting was spent discussing and revising the draft report. The revisions included modifications to the language of the draft, and the addition of personal anonymous vignettes to highlight special challenges women have faced in their careers. We plan for the document to be ready for review at the February Advisory Panel meeting.

Report from the Chair Officers Retreat, December 13-15

Nicholas Gideonse, M.D.
ORR Chair

The annual officers retreat of the AAMC brings together the officers of the Council of Academic Societies (CAS), the Council of Deans (COD), the Council of Teaching Hospitals (COTH), the Organization of Student Representatives (OSR), and the ORR. Each of these five groups are represented on the AAMC's Executive Council. The officers met with senior members of the AAMC staff for two days in a comfortable and informal setting outside of Washington to set the major themes for AAMC over the coming year, initiate annual meeting planning and familiarize each other with the various groups' individual plans for the year. Your chair elect, Cheryl Rucker-Whitaker and I represented the ORR. It is an opportunity for us to get to know the other leaders within the AAMC, and establish some recognition for the ORR among this group of Deans and teaching hospital executives.

Major priorities for the year include continuing AAMC advocacy for the research endeavor, particularly National Institutes of Health funding. There will also be continued efforts for explicit funding for the educational enterprise, to allow for an orderly transition to reconfigured production of physicians. We agreed that the best policy for reducing the total number of residency slots is to reduce federal funding for international medical graduates (IMGs).

The 1996 annual meeting is to be held in San Francisco, just after the presidential election, and will focus on restructuring academic medicine for the future. While the formal title is yet to be decided, we will certainly be focusing on the changes that market forces, information technologies, and the human genome project will have on medical education and academic

medicine as a whole. One implication of the adjusted schedule for the meeting (November 6-11 overall) is that, because the ORR meets over the weekend (November 9 & 10), the ORR may have to adjourn for a couple of hours during AAMC plenary sessions. This will afford for ORR members the opportunity to participate in AAMC at-large programming activiites. The ORR Administrative Board will be further discussing annual meeting planning at its February and June meetings, and all ORR members are encouraged to send further ideas into the Chair, Ad Board members, or Alexis at the AAMC.

Other matters, some less directly applicable to the ORR, were discussed, and I think your representatives contributed appropriately. The AAMC benefits from being informed of our perspective.

Resident Physicians Section (RPS) of the American Medical Association, Nov. 30, 1995 - Dec.2, 1995, Washington, D.C.

Report from the RPS-AMA Liaison

Cheryl Rucker Whitaker, M.D., Chair-elect

I was fortunate to have the opportunity of attending the Resident Physicians Section (RPS) Interim meeting in Washington, D.C. as a guest of its Governing Council. The Governing Council of representatives is elected annually by the representatives' house of delegates.

On Thursday, Nov. 31, 1995, I addressed the Governing Council of the purpose, structure, and function of the ORR. I also fielded questions about how we choose our members, and our interest in a joint venture on the Internet to increase resident awareness and to educate them about the existence of both organizations and related opportunities.

On Friday, Dec. 1, 1995, I attended one of the Reference Committee sections, their policy making branch, which featured lively discussion on several important issues including: malpractice, the residency match and fairness, and the potentially catastrophic closures of residency programs and institutions. I can get a list of the resolutions if ORR members would like to see the issues that RPS representative residents are presenting for action.

I also attended several information sessions. Pat Clark from the AMA's media department gave an excellent session on lobbying techniques. After this session, delegates broke up in to sections, by state, and went to visit their senator or representative to address topics ranging from student loans to managed care. Her main point was to have no more than three talking points during any session; hopefully, the staffer will likely remember at least one thing that you said. She discouraged any propensity toward ostentatiousness. Pointing out, for example, that wearing a fur coat and a rolex while lobbying the on the burden of loan repayment might undercut one's credibility.

"Demystyfing the Net" was an informal and, overall, excellent session given by their computer wizards.

The RPS meeting is an excellent meeting. I was impressed at the level of interest of residents in some very complex issues. I highly recommend ORR's further collaboration.

Happenings

Cheryl Rucker Whitaker, M.D.: married, Saturday, Nov. 4, 1995.

Mike Syptak, M.D.: new dad of Caitlyn Marie Syptak, 11/2/95 7lb., 3 oz..

David Altman, M.D.: resigned AAMC, now at Lewin-VHI consulting in the Salsalito, CA office.

Vivian McClaine: new administrative assistant in the Division of Medical Education, joined 12/26/95.

Moving? Be sure to let us know about new address and phone information. Forward the vital statistics to Vivian McClaine 202/828-0408 or VMCCLAINE@AAMC.ORG

ORR Fast Contacts

Chair, Nicholas Gideonse, M.D.
Phone: 541 942-7805
E-Mail: NLGMD@AOL.COM

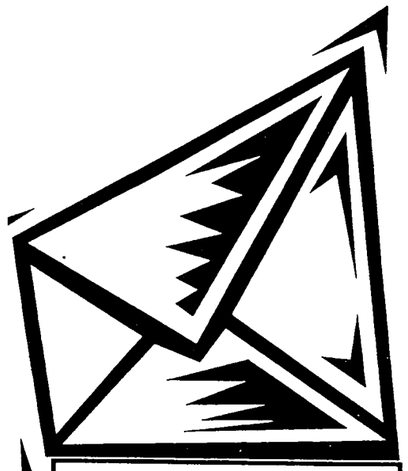
Chair-Elect, Cheryl Rucker Whitaker, M.D.
E-Mail: CRUCKER@ITSA.UCSF.EDU

Immediate Past Chair, Denise Dupras, M.D.
E-Mail: DUPERMD@AOL.COM

AAMC Staff, Alexis Ruffin
Phone: 202 828-0439
E-Mail: ALRUFFIN@AAMC.ORG

Coming Attractions

ORR LISTSERV
ORR WEB Page



Innovative programs that you spearhead or that differentiate your program are topics of interest to your colleagues and should be highlighted in the Residents' Report. We are interested in hearing about your **special projects or awards.** Please contact Alexis Ruffin, staff associate, Division of Medical Education, 202/828-0439 or ALRUFFIN@AAMC.ORG with details on initiatives or recognition activities that you are involved in.

Address Changes

Please be sure to let us know about changes in your vital statistics (address, phone, fax, e-mail) by contacting Vivian McClaine, administrative assistant, Division of Medical Education, 202/828-0408 or VMCCLAINE@AAMC.ORG.

ORR FAST CONTACTS

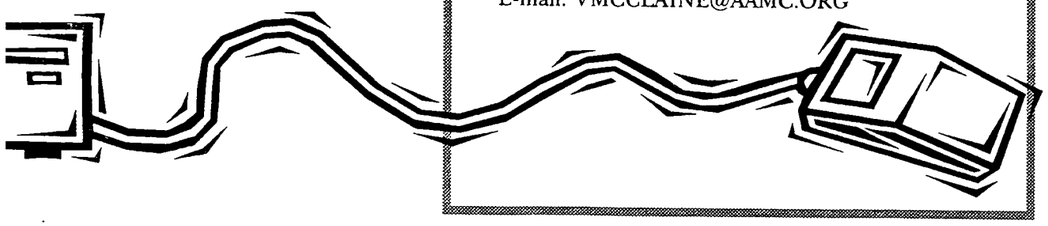
Nicholas Gideonse, M.D.
ORR Chair
Phone: 541/984-9869
E-Mail: NLGMD@AOL.COM

Cheryl Rucker Whitaker, M.D.
ORR Chair-elect
E-Mail: CRUCKER@ITSA.UCSF.EDU

Denise Dupras, M.D.
ORR Immediate-past Chair
E-Mail: DUPERMD@AOL.COM

Alexis Ruffin, AAMC Staff
Phone: 202/828-0439
E-Mail: ALRUFFIN@AAMC.ORG

Vivian McClaine, AAMC Staff
Phone: 202/828-0408
E-mail: VMCCLAINE@AAMC.ORG



The Residents' Report

Published For The AAMC Organization Of Resident Representatives

Spring, 1996 Volume 3, Number 2

Chair's Message

Nicholas Gideonse, M.D., ORR Chair

Greetings, ORR members, from not-so-sunny Oregon. I trust that everyone's Spring rotations went well, and that you are looking forward to the graduations, advancements, or at least the warm weather, that summer brings. And may all your new interns be able, caring and gungho!

ANNUAL MEETING UPDATE

Dates for the ORR-AAMC Annual Meeting are set. ORR activities will begin Friday, November 8 early afternoon with joint sessions with Women in Medicine and the Organization of Student Representatives, as well as reports from the Division of Health Care Affairs and the Office of Governmental Relations. The ORR business meeting will be held Saturday, November 9, 1996 and end noon Sunday, November 10, 1996. Look for preliminary registration materials in mid-to-late July, and please make your registration and hotel arrangements as soon as you receive the materials. Space fills up fast! Questions? Call Alexis Ruffin or Vivian McClaine, 202/828-0439 or 202/828-0408, respectively.

Of course, we all come to our residency education with varying skills and knowledge. And everyone of us needs a quality experience to become a trained practitioner in our chosen field. I've always felt that one of the ORR's best purposes is to advocate for the quality of the educational experience in graduate medical education; another is to prepare residents to be the best possible teachers that they can be.

With this in mind, I urge all ORR members to begin planning NOW for the next Annual Meeting to be held in San Francisco, November 8-10. It's not too early to check whether your rotations are compatible, or if your call schedule or personal schedule will need adjusting. ORR business will be held from late afternoon on Friday to early afternoon on Sunday. We'll be looking at a variety of topics, as well as conducting the business and elections of the Organization. We'll have a forum with students to discuss interactions between students and residents. We'll continue to discuss issues of quality in the context of new restrictions on graduate medical education, both access to patients and, in some places, decreasing program size. With much of the general AAMC programming occurring over the weekend (a scheduling anomaly), we will have greater opportunity to be involved in the plenary sessions and other highlights of the AAMC annual meeting this year. And for those of you interested in continuing in an academic career, attending other segments of the meeting can be quite stimulating. I'm sure that this will be especially true in this election year.

Meanwhile, the Administrative Board continues to work on refining the ORR's mission and structure. Continue to look for our messages and sign-up for the ORR LISTSERV when it becomes available. Please let us know if there are specific topics you would like to see addressed in the annual meeting programming and be on the lookout for the upcoming membership survey. This will be your opportunity to provide the Administrative Board with your feedback and direction. We hope that you will read and respond to this edition of the ORR newsletter by E-mail, post or phone. We enjoy hearing from you.

Report from the Council of Academic Societies Spring Meeting

Nick Gideonse, M.D., ORR Chair

The Council of Academic Societies (CAS) is the constituent body of the AAMC that represents the faculty of medical schools and teaching hospitals. The CAS and the ORR have had close ties since the ORR's inception, as ORR members are appointed by CAS member organizations. In addition, during past annual meetings, CAS and ORR have held

joint programming sessions.

The CAS holds an annual Spring Meeting to conduct business, and provide programming and networking among its members. Held this year February 29-March 3 outside Jacksonville, Florida, the meeting brought together some 70 CAS representatives, a dozen speakers, and AAMC staff. Overall, representation seemed slightly more uniform among basic science societies than among clinical science groups, and a number of chairs and program directors groups that appoint to the ORR were not present.

Plenary sessions focussed on the changing milieu for faculty of medical schools with quite a bit of optimism and positive realism, I thought. Dr. Lombardi, president of the University of Florida, humorously, but forcefully, pointed out that teachers of medicine are simply going to be a bit more like teachers of everything else of value. Dr. Arana of the Medical University of South Carolina discussed faculty management in much the same vein. Items from the business meeting included a new OB/GYN chairs' group on the CAS and discussion of CAS restructuring. The latter focussed on, for example, whether broader faculty representation could occur on a school by school basis without becoming too parallel to the Council of Deans.

I was able to discuss annual meeting programming ideas, as well as a future professional development conference for the ORR in conjunction with a CAS meeting. CAS leaders are quite receptive to both. Programming ideas included assessment of residency education, mid-level providers in the teaching setting, end of life issues, and population based medicine.

However the CAS is potentially restructured, it will remain an excellent ORR resource for faculty issues, both for mentoring academic medicine interest and for a direct link to those responsible for our education.

Report from the Liaison to The Advisory Panel on Strategic Positioning for Health Care Reform

Denise Dupras, M.D., Ph.D.
ORR Immediate-past Chair

The Advisory Panel on Strategic Positioning for Health Care Reform met March 6 in Washington, D.C. The morning began with a brainstorming session to generate a list of topics that are currently most problematic for academic medical centers. Not surprisingly, the Investigational Device Usage issue, teaching physician regulations, and issues related to Academic Medicine and managed care were discussed in great detail. A long list was generated that will serve to focus the efforts of the Advisory Panel and the AAMC.

At the February Executive Council meeting the document summarizing the Association's position on Physician Workforce was edited, which the Advisory Panel later reviewed. It was again recognized that the policies stated in this document are not embraced equally by all constituents of the Association.

Dr. Henry Demarais of Health Policy Alternatives, Inc. presented its study on the potential sources of financial support, and the related infrastructure for undergraduate and graduate medical education. This study evaluated the "equity, adequacy, collectability, and the effects and consequences" of each alternative. It became clear that there is no single best mechanism to provide the level of needed support.

Dr. Malcom Cox, Department of Medicine, University of Pennsylvania, presented the results of a study on Graduate Education Consortia. While the data analysis was not complete, the study provided some interesting insights. The study focused on 19 consortia formed before 1990. It was pointed out that the drivers for consortia present then might very well be different than those of 1996. While many of the potential educational goals of consortia were not met in those studied, there were benefits, including decreased administrative costs and organizational efficiency. While initially the interpretation of the study results were disappointing, the latter findings and interpretations were deemed by the Advisory Panel to indicate that there are benefits to consortia relationships.

Ingrid Philibert, staff associate, Division of Health Care Affairs, provided a demonstration of AAMC ACCESS (a piloted online survey and analysis dissemination system on timely topics in medical education) and the AAMC Web Page. The seventh and final question of the AAMC ACCESS pilot project has been sent out. Many members of the Advisory Panel participated in the pilot project and felt that it was useful. Concerns regarding the sensitivity of information provided through ACCESS and the audience of ACCESS, were raised. It was recognized that there are different levels of accessibility to information on the Web, and that some members would not want information available to competitors in their markets. Alternative models such as LISTSERV for small groups were discussed; however, there was concern that alternative formats would detract from the use and usefulness of ACCESS. Access

oncology, and diagnostic radiology). The second represented training disciplines where supply equaled demand or where only a minimal surplus was predicted (adult psychiatry, dermatology, emergency medicine, general internal medicine, obstetrics and gynecology, oral surgery, pediatric subspecialties, plastic surgery, thoracic surgery, and neurology). The third included specialties for which a greater demand is predicted in the coming years, which include child and adolescent psychiatry, primary care internal medicine and primary care pediatrics (the institution not have training programs in family practice). Based on this system, reductions were assigned (for example: 40 percent for anesthesiology; 15 percent for general surgery; and 20 percent for thoracic surgery). Follow-up mechanisms for assessing whether or not these reductions will adequately or appropriately correct trends towards physician surplus have not yet been defined.

At the meeting, the SRE Steering Committee authorized the formation of an SRE Work Group on GME Program Downsizing. The charge to this group is to develop materials to assist institutions interested in reducing the size of their GME programs. One of the most important challenges will involve definitions of criteria and approaches for determining how many and what types of positions should be reduced at a given institution. It will also be critical to establish mechanisms to audit the impact of reductions to adjust them, if necessary, to changing market demand.

The Sixth Report of the Council on Graduate Medical Education (CoGME), titled Managed Health Care: Implications for the Physician Workforce and Medical Education, noted that residents may receive insufficient training in managed care and HMO delivery systems and would favor the inclusion of curricula that would better prepare them for practice in managed care and prepaid settings. The meeting also featured a discussion of the impact of the Teaching Physician Regulations, which will become effective in July 1996, replacing the attending physician requirements under IL-372. There is some concern that resident education, specifically in the area of increasingly independent and responsible practice, may be impacted by the new requirements.

National Consortium of Resident Physician Organizations

Cheryl Rucker Whitaker, M.D., M.P.H.., ORR Chair-elect
Internal Medicine, University of California-San Francisco

The National Consortium of Resident Physician Organizations (NCRPO) was the brainchild of Dr. Fitzhugh Mullan, former Director of the Bureau of Health Professions currently editor of Health Affairs, and Dr. Bob Harmon, former Director of the Health Resources and Services Administration. Both of these men were activists in medical school and residency, having formed the American Medical Student Association (AMSA), a break-away group from the AMA-Medical Student Section. Through NCRPO, they were hoping to establish a vehicle whereby residents across all specialties could get together and discuss issues germane to graduate medical education.

The first several meetings were organizational in nature. It was decided that the consortium would be an informational body and not a policy making one. Actions on policy would be constrained by pending approval of the sponsoring organizations, and could potentially detract from the informational exchange between consortium representatives.

The meetings convene once a year, usually in September. The Executive Committee (on which I serve) plans the forum via monthly conference calls. Nationally recognized experts are chosen to address the residents on timely issues at the annual meeting. Last year's panel was on managed care. David Nash, M.D., Chief Medical Officer at Thomas Jefferson, and David Altman, formerly of the AAMC, were two of the speakers. It is usually a very lively and informative discussion. It is also a great chance to meet national leaders in other specialty groups.

There is typically a morning-long personal/professional development session on the second day. Last year the focus was on public speaking; this year the session will address teaching for residents.

More information will become available closer to the September meeting. Meanwhile, feel free to contact me with questions, as I am the ORR liaison to NCRPO, in addition to serving on the Executive Committee.

to AAMC ACCESS will continue to be limited.

Importance of Communication: Stay in Touch

David R. Jones, M.D.
Thoracic Surgery, University of North Carolina, Chapel Hill

Appointment to the ORR is made by members of the Council of Academic Societies (CAS) every two years. Each of us was designated an ORR representative in order to represent the interests of all residents, not the interests of our specific speciality society. With that said, however, it is important for us to keep in touch with the specialty society that made our appointment. One of the ways in which the ORR can be better served is for each of us to keep the CAS group which appointed us informed about what the ORR and/or you are doing with respect to graduate medical education (GME). It is our responsibility as the resident advocates for GME to keep deans, department chairs, and program directors up to date about our activities.

There are several ways to communicate with our parent organizations. One way is to write a brief letter telling them about ORR activities and your involvement. Information that may be important to them would include items from the AAMC STAT online newsletter, the ORR newsletter, or your specific activities in various AAMC committees or the Administrative Board. An alternative route of communication is to contribute a short piece to your specialty's newsletter, if they have one. Finally, a phone call or e-mail may be just the ticket for those of us on tight schedules.

Establishing effective communication with your CAS representative is imperative if we expect the leaders in Academic Medicine to be cognizant of the resident perspective on GME. Once this communication line is established, don't be surprised if you're invited to participate in the decision-making process for GME for your own speciality.

If you need information on your appropriate CAS contact, call Alexis Ruffin, staff associate, Division of Medical Education, 202/828-0439.

Report on CoGME and AMSA Spring Meetings

Cheryl Rucker Whitaker, M.D., M.P.H., ORR Chair-elect
Internal Medicine, University of California-San Francisco

I was able to spend a few days in March attending the Council on Graduate Medical Education (CoGME) and the American Medical Student Association's National Meeting. Alexis Ruffin, staff associate, Division of Medical Education, was also at the COGME meeting.

CoGME, mandated in 1986 by Congressional statute, is an advisory body to the Secretary of the Department of Health andHuman Services (DHSS), the Senate Committee on Labor and Human Resources, and the House of Representatives Committee on Commerce on issues related to graduate medical education. Past reports have included those on managed care and graduate medical education, physician workforce issues, and women's health. The issue most discussed at this meeting was physician workforce and oversupply, and International Medical Graduates (IMG). Several speakers were brought in to address the panel on issues around immigration, IMG practice, and related financial concerns. Also, representatives from the Immigra-tion and Naturalization Service were on hand to educate the CoGME panel about immigration and policies around the admission of physicians from other countries.

The latter half of the week was spent at the national meeting of the American Medical Student Association (AMSA). I served as the Graduate Advisor for their Generalist Physician in Training Initiative, attending the meeting in that capacity, as well as an old officer of AMSA.

The meeting was excellent and full of the energy that only medical students have. Dr. David Stevens from the Senate Labor Committee spoke on medical education reform in the era of managed care. Dr. Bernie Siegel gave a fabulous talk on Love, Medicine, and Miracles; he was as inspirational as his books and TV programs depict. Dr. Scott Hitt, Chair of the Presidential HIV/AIDS Advisory Council, addressed current national level AIDS policies. The programming was further enhanced by the multiple task forces and standing committees that AMSA had to address other issues around medicine.

Summary Report from the Liaison to the Section on Resident Education

Michael S. Mulligan, M.D.
Thoracic Surgery, University of Michigan

The Section on Resident Education (SRE), a Section of the AAMC's Group on Educational Affairs (GEA), held its annual professional development meeting March 30 -April 2, 1996 in New Orleans, Louisiana. A meeting of the SRE Steering Committee was held in conjunction. What follows is an overview of the key issues presented at the meeting and a summary of the activities of the SRE Steering Committee.

Presentations on the AAMC's activities in the area of health care policy noted that the Association is addressing policy concerns in an environment that is increasingly moving toward less federal and more state control of health care policy issues. Specific areas include the need to accommodate new financing and delivery systems for health care; likely impending changes in the size and composition of the physician work-force; the design of specific health services for selected segments of population; redefining research priorities; introduction of new technology; and the financing of the academic mission. An issue of significant concern is the size and composition of the nation's physician work-force. Two studies (J. Weiner and R. A. Cooper, both published in JAMA in 1994) have predicted surpluses ranging from of 25,000-150,000 physicians. When rated by specialty, the greatest predicted surplus is expected in Thoracic Surgery, where supply is expected to exceed demand in a managed care environment by 600 percent in 2010. Reductions are occurring in selected specialties, some of these through reduced fill rates in the National Residency Matching Program (NRMP). The number of family medicine residency positions has increased slightly, while most surgical subspecialties have not altered their numbers of positions offered.

Two physician workforce reports and several studies project a physician oversupply in the coming decades, accompanied by an imbalance between generalists and non-generalist specialists and subspecialists. A report by the Pew Health Professions Commission predicts that over the next 15 years up to 50 percent of hospitals and 60 percent of hospital beds will close, through increases in the numbers of patients served in ambulatory settings. The report also predicts a national oversupply of 100,000-150,000 physicians, 200,000-300,000 nurses and 40,000 pharmacists. It recommends that U.S. medical schools decrease their number of graduates by 20 - 25 percent. It also advocates tightening visa requirements for international medical graduates (IMGs) and forming partnerships with state governments to make sure that needs of populations are met. A Report by the Institute of Medicine also predicted a physician surplus and noted that the number of IMGs in residency or fellowship training increased 80% between 1988 and 1993, New York and New Jersey having the highest percentages of IMG housestaff. It added that IMGs often do not return to their home countries and that, while it is often assumed that IMGs practice in underserved areas, studies show that they are less likely to practice in rural areas and more commonly compete in urban areas.

The recently formulated AAMC's Policies and Positions on the Physician Supply advises against limiting the number of U. S. medical school positions until the number of medical school graduates is better aligned with the number of GME training positions available. Otherwise, any reductions in U.S. graduates would be offset by increases in the supply of IMGs. The Association also recommends that GME programs designed primarily to meet service needs, rather than accomplish educational goals, should be redesigned or eliminated. For training programs or positions eliminated, transition funding should be available to mitigate the negative impact of a loss of residents. Finally, incentives for increasing the size of GME programs should be eliminated, potentially through freezing the intern-and-resident-to-bed (IRB) ratio used in calculating the indirect medical education (IME) payment at 1995 levels.

Recognizing a surplus of physicians produced locally and nationally, the Massachusetts General Hospital opted to reduce the number of GME positions available through a voluntary institutional effort. The institution has initiated a phased 20 percent reduction in its number of trainees. Programs were assigned to three tiers, based on individual specialties' anticipated demand/supply ratio. The first tier represented specialties with the greatest predicted surplus (anesthesiology, cardiology, gastroenterology, neurosurgery, orthopaedics, pathology, radiation

SAVE THESE DATES!!

Friday, March 14- Sunday, March 16, 1997

"Considering Academics in a Managed Care World"

The Organization of Resident Representatives will be hosting a professional development conference in San Diego, CA in conjunction with the Council of Academic Societies. This conference will be an opportunity to bring together residents and leaders in academic medicine and should be of interest for those who intend to pursue a career in academic medicine, as well as those who would like to keep a toe in the academic world. Be on the lookout for more information. Travel funding will be available and all ORR members are encouraged to attend. Questions or comments should be directed to Alexis Ruffin, 202/828-0439 or <ALRUFFIN@AAMC.ORG>

AAMC ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW WASHINGTON, DC 20037
PHONE 202-828-0400 FAX 202-828-1125

The Residents' Report

Published For The AAMC Organization Of Resident Representatives

Fall, 1996

Volume 3, Number 3

Chair's Message:

Nicholas Gideonse, M.D., ORR Chair

I'd like to use this space to call for each and every one of you to consider taking a leadership role in the ORR. What better way to serve as an advocate for high quality, humane residency education? What better way to serve your fellow residents? What better way to gain insight into and experience within academic medicine?

As a small organization, nearly one fifth of our membership is needed to fill our administrative board and liaison positions. Every year we elect the following a chair-elect, six at-large board members, and liaisons to the Group on Resident Affairs, the Group on Educational Affairs, the Electronic Residency Application Service, as well as appointed members to serve on a variety of AAMC task forces and advisory boards. Officer responsibilities range from approximately 15 meeting days per year as Chair and a dozen as Chair-elect, to only four or five as a liaison. Ad Board members come to three, two-day meetings in February, June and September, in addition to attending the annual meeting.

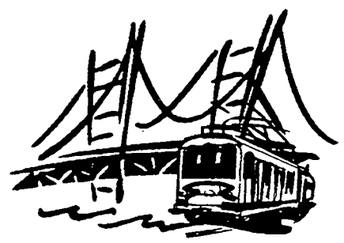
At these meetings you work with fellow ORR members and other AAMC members to advance medical education. The chance to work with leaders in academic medicine is outstanding: deans, teaching hospital CEO's, department chairs. The staff of the AAMC are incredible resources of information about our institutions, governmental affairs, and the nuts and bolts of making organizations work. But best of all is the chance to work with your fellow ORR members, a select and talented group. Though your expenses are paid, the time you give is well rewarded through the information and experience you bring back to your program, your education, and your career. So contemplate this opportunity carefully; now's your chance to get involved!

We've given ourselves more time at the annual meeting between nominations (Sunday early am) and the actual elections (Sunday midmorning) to consider candidates. While early nominations (self-nominations are customary) are appreciated, if you are at all interested, you can submit your name at time of the annual meeting. Be on the lookout in the mail for a call for CVs and statement of interest forms for those who know they want to run for office. For those who put forward their names before the annual meeting, their CVs and statements will be available for review by the general membership during the annual meeting. Nominations on-site will be added as they are submitted. Be sure to bring along your CV to the annual meeting in case you decide to run. Also, check in with your program director or coordinator; usually they are very supportive and encouraging, and are enthusiastic to support this leadership opportunity knowing it brings added value back to the program.

As always, feel free to contact me, ad board members, or staff with your questions and comments. And we'll see you in November!

Chair's recommendation

August 15, 1996 *New England Journal of Medicine* has a thoughtful editorial on "Redesigning Graduate Medical Education," by Jerome Kassirer, M.D.



1996 ORR Annual Meeting
San Francisco, CA

San Francisco Hilton and Towers

Friday, November 8, 1:00 pm through noon Sunday, November 10. Registration materials, call the ORR AAMC staff. Hotel reservations, call 1/800/632-0078. And be sure to make plane reservations early! See page five.

Report on the Advisory Panel of Strategic Positioning for Health Care Reform

Denise Dupras, M.D., Ph.D.
ORR Immediate-past Chair

The Advisory Panel of Strategic Positioning for Health Care Reform (APSPHCR) had identified faculty compensation/incentive systems as a topic of potential interest to the AAMC. Three institutions were invited to present their experiences at our recent meeting. John N. Evans, Ph.D. and James P. Reushel led off with a discussion of their experiences at the University of Vermont College of Medicine. They identified three main goals: 1) recruitment and retention of faculty, 2) linkage of compensation to performance, with rewards for excellence in the areas of education, research and practice, and 3) optimizing the number of faculty necessary for their school's mission. They discussed the process used to develop and explore these goals including an "open town meeting" forum, which allowed faculty input early in the process. Richard D. Krugman, M.D., dean of the University of Colorado School of Medicine and Lilly Marks followed with a description of their experiences at the University of Colorado. Their presentation focused on the process of garnering support for their faculty compensation system. Like the first presentation, they stressed that the open nature of the communication with the faculty was critical to the success of the acceptance or "buy in" of the other faculty members. Key components of the Colorado system also incorporate accountability of faculty for their performance and link compensation to that performance. The lively panel discussion explored barriers to both the process and outcomes. Overall, the panel felt the information was valuable to AAMC members and identified the topic as a potential future AAMC workshop.

David Podoff, chief economist of the US Senate Committee on Finance, and Laird Burnett, professional Senate staff, reviewed Senator Moynihan's Bill (S 1870), the "Medical Education Trust Fund Act of 1996," and answered questions for the panel. Briefly, S1870 provides for an estimated $17 billion payment to support the education mission of medical schools and graduate medical education. It is financed through a 1/5% tax on health insurance plans, Medicare, and an amount equal to 5% of acute care Medicaid. It provides for a nine member Medical Education Advisory Commission that will

continued on page 5

1996 National Primary Care Day, October 10th

Calling all residents who are interested in student activism and education! National Primary Care Day October 10, 1996 is a student organized national effort to educate medical students about generalism. Each allopathic and osteopathic medical school has a student coordinator who is responsible for programming local events around the theme of "Medical Students Caring for the Future." Though the focus is on primary care, some programming includes discussions between generalists and specialists on their roles and interactions. If you as a resident would like to share your experiences or help students in this effort, please contact the National Primary Care Clearinghouse at the AAMC at 202/828-0435 or check out the Web page at <http://www.aamc.org/~NPCD>. Student organizers would welcome your participation and expertise.

NATIONAL PRIMARY CARE DAY
MEDICAL STUDENTS CARING FOR THE FUTURE

continued from page 2

administer the Trust Fund. The panel provided input to Podoff and Burnett on the composition of the proposed panel, need for consideration of other groups such as the VA and Children's hospitals, and reaffirmed the AAMC position that the entities incurring the costs of the education should receive the funding. While it is recognized there is little likelihood of passage with the national elections so near, all agreed for the need to keep this on the "front burner," and to continue to educate our Congressional members on the nature of medical education as a public good requiring support by all users of the system.

A third major topic of discussion was a report from Tripp Umbach and Associates (a consultant group contracted by the AAMC) on the "Economic Impact of Academic Medicine." Simon Tripp presented data on the economic impact of 125 medical schools and 300 plus teaching hospitals in 47 states. The study did not measure the impact of research in medicine, education, or the impact on neighboring states. It was therefore felt to be an underestimate of the overall impact. Since the report was still in draft form, the data were not included in his brief report. However, the impact of academic medicine, as measured in this study, on local and state economics is significant.

Mary Beth Bresch White and Robert Dickler provided a legislative update on 1L372 and the ongoing activities of the Office of the Inspector General regarding audits. The new regulations are to take effect this summer, though HCFA has agreed to a future review of the regulations with the AAMC.

A brief discussion of the role of state initiatives and the APSPHCR ensued and will be taken up further at the next meeting.

I have indicated to the APSPHCR that I will no longer be able to serve as the ORR representative after the 1996 Annual Meeting, but that the ORR is still interested in designating a resident member to be part of the advisory panel.

AAMC 1996 ANNUAL MEETING
BUILDING A BRIDGE TO THE FUTURE

1996 Annual Meeting

Anyone receiving this newsletter should ALREADY be signed up for the Annual Meeting. Even more crucial, have you made hotel reservations yet? Do so NOW by calling the reservations "Hotline" at 1-800-632-0078! Note that our meeting begins Friday, November 8, at 1 PM. However, you might wish to hear Nina Totenberg's post-election political analysis at 11:30 AM. If you can't make it Friday, don't worry. Our ORR business meeting begins Saturday morning. We'll finish about noon on Sunday and can catch afternoon flights out of San Francisco; so see you there!

Alexis Ruffin <ALRUFFIN@AAMC.ORG> or 202/828-0439 is available to ask questions or give advice.

Annual Meeting of the National Medical Association

Cheryl Rucker Whitaker, M.D., M.P.H., ORR Chair-elect

I was fortunate to be able to attend the 101st meeting of the National Medical Association (NMA), the oldest and largest group of African-American physicians in the United States. Their resident group meets at the time of the NMA annual meeting, which I attended as a representative of the ORR-AAMC. In the spirit of networking with other resident organizations, the ORR was invited by their Resident Trustee. I hope that we'll continue to meet and identify other resident organizations so that we are able to support each other around common endeavors.

ORR Administrative Board Update

Nicholas Gideonse, M.D., ORR Chair

At the June ORR Administrative Board and Executive Council meetings, a broad range of issues were discussed; your Ad Board had a productive two days. We've spent more time with ourselves and our agenda, and dedicated considerable time to discussing and planning the 1996 Annual Meeting. We also had the opportunity to participate in a focus session of residents in support of the Medical School Objectives Project (MSOP), a major AAMC initiative out of the Division of Medical Education. There was a valuable update on the Requirements for Teaching Physicians/IL-372 in clear and direct terms. We also had the opportunity to network very nicely with the OSR Board at a joint dinner.

Our greatest efforts went into working on a mission statement for the ORR, annual meeting planning, and planning our organizational self-evaluation, which was mandated at the time the ORR was established. We find ourselves at the five year review period for the ORR and are evaluating our progress and successes thus far; particular attention has been paid to the representativeness of the ORR. You have all had the opportunity to participate in this evaluation process by completing the membership evaluation survey sent out in July and followed up with a fax to nonrespondents. We intentionally kept it short to encourage a high return. I hope that you all have forwarded your survey; if not, you can still send it in. We will be using the survey results to help inform our evaluation report, which will be submitted to the AAMC Executive Council in September and to the general ORR membership at the Annual Meeting.

A last general note, the ORR LISTSERV has been established. I encourage everyone who has e-mail access to sign on by sending an e-mail to ALRUFFIN@AAMC.ORG. This is a terrific opportunity to interact and share with your ORR colleagues. Look forward to hearing from you!

The Ad Board meets again in mid-September, and will no doubt have another productive and stimulating forty-eight hours together. If you have ideas, concerns, or suggestions, please forward them to me before September 17 so I can share them with the rest of the Ad Board.

1996 ORR Annual Meeting

Highlight on Joint Sessions

The ORR will be hosting two joint sessions at the 1996 annual meeting. Both will be held on Friday, November 8.

A joint session with the Women and Medicine group, Friday, November 8, 3:15 - 5:00 pm, entitled "Conflict Resolution: Personal and Institutional Strategies in Medical Education" will feature ORR Chair-elect Cheryl Rucker Whitaker, M.D., M.P.H., along with ombudspersons from Stanford and Yale.
From 6:00-7:30 pm on Friday, November 8 there will be a joint session with the Organization of Student Representatives. This will provide the ORR with an opportunity to explore with our sister organization the roles, expectations, and interactions residents and students have with each other. The session will be moderated by Joan Friedland, M.D., Baylor, Convener of the Residents' Teaching Skills Special Interest Group of the AAMC Group on Educational Affairs. The panel will include two residents, Denise Dupras, M.D., Ph.D., ORR Immediate-past Chair and Assistant Professor Internal Medicine at Mayo, and Chris Hanson, M.D., ORR Administrative Board, Pediatrics, as well as students Shamiram Feinglass, Emory, and Mike Tewfik, Oregon Health Sciences. Hope to see you there.

ORR Listserv

The ORR LISTSERV is up and running! Join your ORR colleagues in Internet exchanges. To subscribe to the ORR LISTSERV simply send a message to <MAJORDOMO@AAMCINFO.AAMC.ORG> In the text box, not the subject line, type "subscribe ORRLIST" You will receive a message notifying you that your subscription has been accepted and then you will be free to post and receive messages. Pretty simple way to stay in touch, huh?

A Primer on the Ins and Outs of Computers and E-mail

John Biglow, M.D.

With the ORR LISTSERV (ORRLIST) established the ORR Administrative Board wanted to do something to maximize participation. The first step of course is to get everyone the basics. To participate in e-mail you need a computer, a modem, and an Internet account. Below you will find an expansion on each of those things, and some helpful hints to get you going if you are missing some or all of those things. Good Luck, and I'll see you on the Internet!

This article is intended for those who do not have a computer, and, thus, are not using electronic mail, a.k.a. e-mail.

Basic advantages of e-mail are it's cheap, it's quick, and you can send a memo to multiple people, as many as you like, as easily as one. Basics on how to get on e-mail require a computer, a modem, and software that writes and reads e-mail.

E-mail requires relatively little in the way of a computer. You can even buy an used one under $400 that would be sufficient to get you using e-mail. Realistically, you will want at least a 486 33 MHZ. These are found more and more in the regular want-ads of your local newspaper. You can also contact your computer help desk at an affiliated university to ask them where used computers are advertised. You might also try looking under computers in the yellow pages. Look for a listing that advertises used computers.

What type of computer to get depends on your decision between two major types, IBM compatible (or PC) and Macintosh (Mac). Macs have a reputation for being easier to learn and better for graphics. IBMs have a reputation for being better for business and having a greater proportion of the market, though they probably require more self- teaching and are not as standardized as the Macs. Best is to have a friend who is willing to help you if you have questions, then get the type that they have. Macintosh are all pretty much the same, so any one would be a safe bet. Reputable IBM-PC brands include Compaq, IBM, Gateway, Toshiba, Hewlett Packard.

How much memory do you need? Software for e-mail is very small and does not require a lot of memory. I gave my parents my Macintosh computers from 1987 and they are proving to be plenty for e-mail, and even word processing and spread sheets. The bottom line is that whatever you find will likely have enough memory if it was made after 1987 for Macs and 1990 for IBMs.

A modem will probably have to be bought new and will be about $150 to $200. All you need to know is that it matches your computer type, either Mac or PC, and how fast it is. You will want one at 14,400 or 28,800, termed as 14-4 and 28-8, respectively. Again, it is likely that any modem you buy now will be fine, as long as it matches your computer type! How to get a modem? Check local computer stores, or computer catalogues such as PC or MacWarehouse at 1-800-255-6227.

Software companies are practically giving it away for free. Usually you get a one month free trial; after that it usually runs around $10 per month for the first 5 hours, which is plenty of time for sending and receiving all your e-mail. They should all allow you to read and write mail while you are not connected to their system ("off line"), and then send and receive it all with one quick call. That will reduce your charges. How to get the software? America-On-Line (AOL) is very popular and easy to learn (800-827-3338). Other good "servers" are Compuserve (800-336-6823), e-World for Macintosh (800-775-4556), and Prodigy (800-776-3449). All are about $10 per month after one free month. Physicians-On-Line (800-332-0009) is free to get and free to use, although has a more frequent "cut off" rate requiring that you re-dial in. It also has little advertisements on every page. These companies can be reached to request their software for free, although you may have to wait a bit on the phone and for the mail. They also have the advantage of allowing you to dial in to check your mail from anywhere in the country, if you have a lap top or a friend who has the same software on their computer.

A caution about using Microsoft's e-mail system on their Windows 95 is that when you log on through them, they will scan your computer for all of your software to see if any of it is pirated. This is supposedly for research purposes only.

There will always be questions. Remember that computers have little problems sometimes. Try to relax, recognize that it's probably the computer's fault (a "bug"), take your best guess and to try to figure a way around it; and call your friends who said they would help you!