

OSR ADMINISTRATIVE BOARD MEETING  
AGENDA

June 22, 12:00 - 5:00

June 23, 9:00 - 5:00

2nd floor conference room, One Dupont Circle

I. Call to Order	
II. Consideration of January and April Minutes. . . . .	.1
III. Chairperson's Report	
IV. ACTION ITEMS	
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B. Nomination of Student to LCME. . . . .	7
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VIII. New Business	
IX. Adjournment	

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

OSR ADMINISTRATIVE BOARD MINUTES

April 12, 1982  
AAMC HEADQUARTERS  
WASHINGTON, D. C.

Chairperson  
Chairperson-Elect  
Regional Chairpersons

--Grady Hughes  
--Ed Schwager  
--Pamelyn Close  
David Baum  
Ron Voorhees  
Paul Organ  
--Beth Fisher  
Michael Tom  
David Thom  
Linda McKibben  
--Janet Bickel  
Robert Boerner  
Mindy Hatton  
Joseph Isaacs  
Dario Prieto

Representatives-at-Large

AAMC Staff

- I. Mr. Hughes called the meeting to order at 9:15 a.m. and, after hearing reports on regional meeting plans, listed for the regional chairpersons all the items that need to be covered during the business sessions.
- II. OSR Survey on Ethical Behavior of Medical Students

The Board discussed the summary of the results of the pilot survey which was distributed at the 1981 Annual Meeting; 39 questionnaires were returned and the Board commended Steve Phillips for his work in tabulating the responses. Highlights from the results are that respondents felt that 1) the most problematic areas are refraining from presenting false data on medical records and during presentations and reporting peers seen behaving suspiciously and 2) the circumstances contributing most heavily to students' unethical behavior are pressure for grades, fears of failure, and volume of the workload. Sixty-seven percent of the respondents reported that an honor code is a useful means of instilling awareness of ethical responsibilities; the same percentage believe that students can be expected to abide by the agreements of an honor code, indicating skepticism about the utility of this method. An additional data source which the Board noted as they explored these issues is the AAMC Delphi Survey on Characteristics of Future Medical Students; one of the 15 most desirable predictions was more instruction in medical ethics; however, faculty respondents felt significantly less strongly about this need than did other categories of respondents.

The Board recognized the wisdom of treating separately questions related to the teaching of medical ethics and matters pertaining to attempts to be evaluated at a higher level than may be appropriate, i.e., cheating. With regard to the former, Mr. Organ expressed the view that this education be offered during the

clinical years when students can put it directly to use and when there will be less tendency to view such courses as 'soft'. Regarding different forms of cheating, students noted the likelihood that patterns probably form early and are shaped by the necessity to succeed and by looking to others instead of to oneself for evidence of excellence. It was also remarked that some forms of cheating, such as 'ballparking' test values are encouraged rather than punished and that, once you are rewarded for using such methods, you can no longer believe in the evaluation system. The whole system, predicated on normative curves and the 'publish or perish' ethos, is thought on the one hand to 'make the cream rise to the top' but on the other hand appears to condone a number of forms of unethical behavior.

In considering specifically what schools could do to encourage honorable behavior, the Board concurred that the twenties are such formative years that students need guidelines about what is and is not appropriate but that guidelines are useless unless reinforced and supported by positive incentives and faculty behaviors. It was also noted that the kinds of questions students have change as they progress in their education and that it is likely that not many schools' honor codes have been written with these in mind. It is also likely that not many schools have appointed an ombudsperson to deal with problems in faculty/student relations and ethical questions that may arise and that difficulties in these veins are swept under the rug in a way similar to physician and student impairment. The Board concluded that it is unknown whether schools would welcome the development of a set of model guidelines on ethical behavior in medical school and decided to postpone additional discussion until its June meeting with the hope that guidelines can be obtained from student affairs deans and students at the remaining regional meetings.

### III. Proposed AAMC Position on Health Planning

The Board with the help of Mr. Isaacs reviewed the recommendations of an ad hoc Committee on Health Planning. Its proposal states that the Association supports the concept of community-based health planning, calls for repeal of the former health planning legislation, and recommends that the new statute should encourage the continuation of local planning on a voluntary basis and mandate state level certificate of need (CON) review.

ACTION: The OSR Administrative Board recommended approval of the proposed AAMC position.

### IV. Update on Funding for Financial Aid Programs

Ms. Hatton, AAMC legislative analyst, informed the Board that the Administration's proposal to modify eligibility for the Guaranteed Student Loan (GSL) Program has generated enormous controversy on the Hill; it appears likely that Congress will not approve the proposal to eliminate medical students' eligibility but that some modifications in the program will be approved. She noted that this is a particularly volatile subject in an election year and that Congress will probably postpone action as long as possible. Once the Budget Committees' work is underway, if it looks as if their recommendations will be detrimental, students will be notified of the need to engage in additional lobbying.

Mr. Boerner explained the upcoming crisis regarding HPSL loan repayments. The Department of Health & Human Services' Bureau of Health Personnel Development and Service is proposing that, because the current HPSL default rate is felt to be

too high, new standards be implemented which would define delinquency as borrowers more than 30 days past due in repaying. If a school's delinquency rate is greater than 5% (of both borrowers and dollars) by June 30, 1983, the school would become ineligible to participate in the program. Mr. Boerner expressed the view that such regulations would be arbitrary and harsh and would kill the program because presently only 27 of the 126 medical schools are under 5% based upon 90 days delinquency according to the Bureau's own data. When the regulations are published, schools will need to deluge the Bureau with letters explaining why schools will have difficulties complying. Mr. Boerner also described the Administration's proposed ceiling on the Health Education Assistance Loan (HEAL) Program which will be too low even if students are allowed to continue to borrow under the GSLP. He reported, however, that the situation with regard to lender participation in the program looks brighter now that Sallie Mae has proposed making approximately \$200 million available FY 1982-83 through a Washington D.C. lender.

Mr. Boerner also noted that efforts to work with the private sector to generate student aid funds are continuing and that information being received from the schools via an extensive questionnaire about institutional activities are being collated and will be shared with the Board. He recommended that informed OSR members could serve as catalysts at their schools to stimulate exploration of innovative ways to assist students in the financing of their education.

The Board expressed the desire to be kept current on issues affecting student aid so that OSR members can be mobilized as appropriate to write additional letters. The Board commended Mr. Thom for his work in preparing the hand-outs which were mailed to the representatives to assist them in conducting letter-writing campaigns; it was noted that AMA-MSS borrowed extensively from the OSR generated materials in its campaign to inform its membership.

#### V. Report of the Chairperson

Mr. Hughes gave an overview of the GSA Steering Committee meeting he attended in March and of the GSA Annual Meeting plans. He summarized the most recent Consortium of Medical Student Groups meeting held in conjunction with the AMSA convention, noting that the present good feelings among all the officers represent a significant accomplishment and that OSR members could extend this achievement by working with other student leaders at their schools. At this meeting it was agreed that not only the officers but also the Boards of each group should receive mailings, and he alerted the Board to the likelihood of their receiving such materials. Mr. Hughes also commented on the existence of two new AMA-MSS committees, i.e., on the medical consequences of nuclear war and on financial aid, and on AMSA's Healthwatch which is attempting to document consequences of federal budget cuts on health care, especially to poor people. He noted that an area of particular concern to him continues to be negative publicity resulting from the Percy hearings on students' defaulting on their educational loans and recommended that OSR should be alert to ways to counteract this. He reported that he would be attending the April meeting of the advisory panel of the General Education of the Physician Project (GPEP). In this context, Ms. Bickel described the plans to convene beginning this summer the first three GPEP working groups; they will deal with 1) essential knowledge; 2) necessary skills; and 3) personal values and attitudes. Each of these will have a student member, and she will describe these positions at each of the OSR regional meetings. Finally, Mr. Hughes asked the Board for guidance in pursuing the OSR goal of seeking more active housestaff participation in AAMC affairs. Ms. Fisher noted the increasing timeliness of this effort; as residency programs are cutback and expected to justify their existence, a forum in which to air

this and related challenges is urgently needed and is one which AAMC can provide. It was also agreed that more resident input would strengthen the Association even if many organizational difficulties stand in the way of formation of a representative group of residents.

#### VI. OSR Report

The Board commended Ms. Bickel for her work in preparing the last two issues on physician and student impairment and on cost containment education. She suggested that the next issue be prepared by Board members who would write on topics of particular interest to them which they have researched; Mr. Hughes introductory section could provide an organizational framework for their presentations. Half of the Board members agreed to prepare brief papers, the first draft of which would be presented at the next Board meeting, June 23.

#### VII. 1982 OSR Annual Meeting Plans (November 5-9, Washington, D.C.)

The Board discussed the perennial problem of the majority of OSR members' having to leave the meeting on Sunday night in order to return to clinical rotations resulting in minimal participation in Monday programs and decided that expanding the OSR activities held on Friday was the only feasible option. In order to assure attendance on Friday, the Board decided to begin the business meeting and have the main program on that day. Mr. Organ suggested devoting the program to presentations on the responsibilities of physicians vis-a-vis nuclear armament and the Board enthusiastically concurred. In reviewing the perpetual catalogue of misunderstandings and inefficiencies resulting from the resolution-centered formats of the regional and business meetings, the Board requested Ms. Bickel to prepare a historical document, grouped by issue, on OSR resolutions passed over the last few years. Mr. Voorhees and Ms. McKibben related experiences with a different method of issue identification and problem-solving, and the Board decided to re-orient Saturday's activities based on these group process principles; after the membership prioritizes five or six issues (e.g., the role of the computer in patient management, time-management skills), students will choose one of these to focus on during the remainder of the day with opportunity for later feedback from and sharing with the whole group. Ms. Bickel will seek to engage an expert in group facilitating for the June Administrative Board meeting in order to educate Board members in these techniques. Working on the assumption that Sunday afternoon would be devoted to a joint plenary session with the AAMC Council of Academic Societies (CAS), the Board agreed to move the second business meeting to Sunday morning, during which election of offices and voting on any consensus statements emerging from Saturday's sessions will take place. (The schedule which appeared most workable appears as an attachment to the minutes).

The Board expressed the hope that the Friday activities will be included in the preliminary programs which is mailed in late summer. It also recommended that Dr. Cooper write a memo to medical school deans, describing the importance of OSR members attending the Annual Meeting in order for them to carry out their responsibilities at their institutions and within the AAMC; a number of students have reported that many faculty members do not view such attendance as legitimate activity. Noting the effectiveness of the letter from Dr. Cooper to their deans immediately following their election, Board members who will begin graduate medical education this summer requested that he write to program directors regarding their commitments during the Annual Meeting.

VIII. Universal Application Form for Residency Training Program

Due to program directors' disappointingly low acceptance rates of the AAMC-prepared Universal Application Form in lieu of their own (as reported by senior students at the last Annual Meeting), Mr. Hughes raised this topic with an eye toward activities which the OSR might initiate to increase usage of this time-saving device. Ms. Bickel reported that, pending NRMP approval of minor modifications of the form, quantities will once again be sent to student affairs deans in late spring for distribution to juniors. It was suggested that as program directors become accustomed to seeing the form, its acceptance will increase, and that OSR members could assist this process by communicating with program directors at local hospitals regarding the merits of students' completing one rather than numerous applications. It was also suggested that NRMP could publish a list of those programs using the form and that this idea be forwarded to Patricia Pellika (Mayo), the OSR-nominated student member of the NRMP Board of Directors.

- IX. The meeting was adjourned at 3:15 p.m. so that Board members could prepare for their subsequent meeting with the CAS Board.

1982 OSR ANNUAL MEETING SCHEDULE

FRIDAY, NOVEMBER 5

2:00 - 3:00 Administrative Board meeting  
3:00 - 4:30 Business meeting  
4:30 - 5:30 Regional meetings  
7:30 - 9:30 OSR Program

SATURDAY, NOVEMBER 6

8:30 - 9:30 Business meeting  
9:30 - 11:00 Discussion sessions  
11:00 - 12:00 Issue identification & prioritization  
1:30 - 3:00 Small group exploration of single issue  
3:00 - 4:00 Whole group reassessment  
4:30 - 6:00 Small group definition of work plan  
8:00 OSR Reception

SUNDAY, NOVEMBER 7

8:00 - 9:00 Candidates for OSR office session  
9:30 - 1:30 Business meeting (including small group reports and discussion)  
3:00 - 5:00 Joint OSR/CAS Plenary session  
5:00 - 6:00 Regional meetings  
6:00 - 7:00 CAS/OSR Reception

APPLICANTS FOR LCME STUDENT PARTICIPANT\*

Robert Berry '83	University of Virginia
Deborah Day '83	George Washington University
Charles Dimino '83	University of Connecticut
John Furcolow '84	University of Kentucky
Joseph Girone '83	New Jersey Medical
Timothy Herrick '83	Bowman Gray University
John Huston '83	Yale University
Ruth Keves-Cohen '83	Johns Hopkins University
Joel Lavine '84	U of California-San Diego
Barry Markovitz '83	University of Pennsylvania
Buckley ter Penning '84	Albert Einstein University
Wanda Whitten '83	Howard University

\*c.v.'s and support documents are attachments to agenda



## DIRECTIONS FOR OSR PROJECT ON ETHICAL BEHAVIOR OF MEDICAL STUDENTS

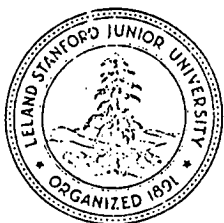
At each of the OSR regional meetings, some time was devoted to discussion of the results of the 1981 Annual Meeting pilot survey on ethical behavior (distributed in the April Administrative Board agenda). A summary follows of these discussions which may serve to guide the Administrative's Board determination of future directions.

The extent to which U.S. medical schools presently rely upon an honor code or some statement of ethical principles and practices as a part of their acknowledged expectations regarding student professional behavior is unknown; if the survey results are representative, about 70% have written statements. There are reports of schools' adopting a code subsequent to a well publicized case of student cheating and of schools' dropping codes that did not hold water in court cases. At some institutions, the document has not been referred to for so long that its existence is open to question. Three examples of existing codes are attached: 1) Stanford University's, which has been adopted by the medical school and is printed in a pamphlet published by the office of the president titled "Regulations Governing Student Conduct"; 2) University of Maryland's School of Medicine's recently developed approach to the monitoring of professional behavior; and 3) Southern Illinois University School of Medicine's statements on professional behavior and academic honesty from its handbook "Student Progress System." Students at schools with honor codes note that, even when published in the school catalogues and reviewed during orientation by the dean, many individuals find it easy to ignore the provisions; problems with enforcement, with students reluctance to judge other students and with the absence of a bill of rights/ protection for the accuser are also prevalent. Also frequently noted by students is confusion, particularly while on the wards, about what constitutes inappropriate behavior. It appears that most honor codes do not assist students in such determinations. Some students stated that they had never heard the term 'ethics' used while in medical school. They agreed that a forum was definitely needed for discussing questions/problems that arise about observed instances of suspicious conduct and about professional obligations, patient/physician interactions and faculty/student relationships. There is no consensus about the utility of having an honor code except to the extent that students feel it is better to have one on the books than not to have one.

The tentative recommendation forthcoming from the Administrative Board's April meeting was presented, that is, development of guidelines on ethical behavior to include an overview of the kinds of dilemmas which students face and principles to guide appropriate professional behavior. Attendees at the regional meetings had a difficult time envisioning such a set of model guidelines, particularly their level of specificity, and foresaw the possibility of their being ignored in the same way that honor codes frequently are. Nonetheless, OSR members expressed resolute encouragement to the Board to continue its efforts in this arena, recommending that any activity will be an improvement over the present state of confusion and silence. OSR members cited many discouraging examples from their schools of inappropriate student conduct and some examples of such conduct being brought to the attention of faculty/administration and no action taken. Another problem is that, where due process or judicial review provisions do exist, seldom is the accuser afforded any protection, compounding the inherent difficulties with students' judging one another and with convincing a student/observer to give testimony. OSR members identified as well complicating backdrops to considerations of students cheating 1) overlap with other types of student impairment and reporting and confidentiality related to these; 2) adversarial relations with faculty;

3) poor faculty and resident role models particularly with regard to peer review and helping each other; and 4) increasing competition for residencies which encourages students to find ways to make themselves look more attractive. Despite the complexity and elusiveness of these issues and the fact that there will always be some students who knowingly cheat and some who unknowingly show poor judgment, the representatives concluded that OSR should play a role in stimulating discussion of these problems.

At its meeting on June 8, the OSR Chairperson sought the recommendations of the GSA Steering Committee regarding appropriate OSR activity in this area. There was agreement that schools need help dealing with issues of student unethical behavior. One idea put forward was a brief survey asking student affairs deans about their present methods of 1) discouraging cheating and 2) handling reported cases and for an indication of level of satisfaction with their methods; descriptions of systems with good track records could then be shared. This proposal, along with others created by individual OSR Board members, will be considered toward the goal of determining what is the next step OSR may take.



## THE STANFORD UNIVERSITY HONOR CODE

- A. The Honor Code is an undertaking of the students, individually and collectively:
- (1) that they will not give or receive aid in examinations; that they will not give or receive unpermitted aid in class work, in the preparation of reports, or in any other work that is to be used by the instructor as the basis of grading;
  - (2) that they will do their share and take an active part in seeing to it that others as well as themselves uphold the spirit and letter of the Honor Code.
- B. The faculty on its part manifests its confidence in the honor of its students by refraining from proctoring examinations and from taking unusual and unreasonable precautions to prevent the forms of dishonesty mentioned above. The faculty will also avoid, as far as practicable, academic procedures that create temptations to violate the Honor Code.
- C. While the faculty alone has the right and obligation to set academic requirements, the students and faculty will work together to establish optimal conditions for honorable academic work.
- (c) It must be understood that the individual and collective responsibility of the students for upholding the Honor Code (including so-called third-party responsibility) was not imposed upon the students by the administration or the faculty but was assumed by the students at their own request. Without such student responsibility, the Honor Code cannot be effectively maintained.
- (d) In interpreting and applying the general provisions of the Honor Code, it should be kept in mind that although primary responsibility for making the Code effective rests with the students, faculty cooperation is essential, since the faculty sets the academic requirements which students are to meet. The faculty should endeavor to avoid academic requirements and procedures which place honorable and conscientious students at a disadvantage. The faculty also should be ready and willing to consult with students and should be responsive to their suggestions in these matters.

### 2. Specific Interpretations and Applications

#### (a) *Third-party responsibility*

A primary responsibility assumed by students is to discourage violations of the Honor Code by others. Various methods are possible. Drawing attention to a suspected violation may stop it. Moral suasion may be effective. Initiating formal procedures is a necessary and obligatory remedy when other methods are inappropriate or have failed. Faculty members have like responsibilities when suspected violations come to their attention.

#### (b) "Proctoring"

Proctoring means being present in the examination room for the purpose of preventing dishonesty. The prohibition against proctoring should not be construed to prohibit the instructor from visiting the examination room briefly to answer questions or to make announcements (e.g., about the time remaining for completion). Nor does it prohibit the instructor from visiting the examination room in response to specific prior reports from stu-

### INTERPRETATIONS AND APPLICATIONS OF THE HONOR CODE

#### 1. General

- (a) The Honor Code is agreed to by every student who registers at Stanford University and by every instructor who accepts an appointment.
- (b) The Honor Code provides a standard of honesty and declares that compliance with that standard is to be expected. It does not contemplate that the standard will be self-enforcing but calls on students, faculty, and administration to encourage compliance and to take reasonable steps to discourage violations. If violations occur, procedures are prescribed by the Legislative and Judicial Charter. However, the Honor Code depends for its effectiveness primarily on the individual and collective desire of all members of the community to prevent and deter violations rather than on proceedings to impose penalties after violations have occurred.

dents that cheating has been observed to investigate the basis for such reports.

(c) *"Unusual and unreasonable precautions"*

In interpreting and applying this provision, consideration should be given to standard procedures which are customary at Stanford and the need for cooperation between students and faculty in making the Honor Code effective. The following situations are cited as examples.

An instructor should not require students to identify themselves before being admitted to an examination room, or require students to submit in advance to being searched for notes or other materials, or maintain surveillance upon students who leave the examination room. Nor should the instructor take deliberate steps to invite dishonesty in order to entrap students. Procedures of this kind would be unusual and unreasonable.

On the other hand, an instructor may require copies of an examination or test to be returned after the examination. When possible, alternate seating should be provided and used for all examinations. To avoid controversy in any rereading or regrading of students' work, the instructor may take measures by which the original work may be clearly identified. An instructor who requires students to make up a missed test or examination may administer a different test or examination of equivalent range and difficulty. Such procedures are not to be construed as unusual or unreasonable.

(d) *"Procedures that create temptations to violate the Honor Code"*

Although students are expected to resist temptations to cheat, the faculty should en-

deavor to minimize inducements to dishonesty. Examples of undesirable procedures include the following: failure to give clear directions and instructions concerning course requirements; treating required work casually as if it were unimportant; carelessness or inconsistency in maintaining security of examinations or tests; reusing an examination which is neither kept secure from public exposure nor made available to all students. If take-home examinations are given, they should not be closed-book examinations, nor should there be a specified time limit less than the full period between the distribution of the examination and its due date. Such procedures place honorable and conscientious students in a difficult position and often at a disadvantage.

(e) *Penalty grading*

Under the Legislative and Judicial Charter, students are not to be penalized for violations of the Honor Code without notice, hearing, and adjudication, as therein provided. An instructor may not, therefore, lower a student's grade on the grounds of dishonesty in the absence of such formal proceedings unless the student is informed and gives consent. An instructor who suspects dishonesty may, with the student's consent, request that the work be redone and resubmitted, giving a grade on the resubmitted work.

(f) *Taking tests outside the examination room*

Provided that alternate seats are available, tests will be taken from the classroom only with the consent of the instructor. (Adopted by student referendum as an addition to the Honor Code in 1955.)

Preamble

The physician is entrusted by society with unique responsibilities: the alleviation of mental and physical pain, the treatment of disease, and the prolongation of life. The ethical and competent exercise of these responsibilities require the highest standards of compassion, knowledge, skill, and personal integrity. The milieu in which the physician receives his or her training has the responsibility of maintaining equally high standards in these same categories of human experience and endeavor. Thus, the medical school and hospital experience should not be limited to the rendering and acquisition of factual knowledge and skills but should also nurture and reinforce those characteristics which make the physician worthy of the trust of his or her patients, peers, and the larger society.

It is a responsibility of the academic community to insure the professional competence of, and to attest to, the personal qualities of each member to the extent that these qualities bear significantly on the member's function in the community. Our community is here defined as administrators, house staff, students, and faculty. By voluntarily joining this community we bind ourselves to the acceptance of agreed upon principles of behavior and to peer review processes evolved to monitor our professional behaviors. Each member of our community should assume the responsibility of learning about and acting in concert with our shared principles.

To facilitate these goals we here present a list of ethical principles and behaviors for the medical school community. Obviously, no statement of ethical principles can provide an explicit code of conduct covering all situations in which varying interpretations of ethical behavior might arise. Instead, the statement contained in this document is presented as a guide for thought, self-scrutiny, current use, and future modification.

Together with the responsibility of the community to provide for itself a statement of its principles is the responsibility also to establish procedures for peer review by due process. We, therefore, recognize establishment of a Judicial Review System whose working instrument is a Judicial Board (hereafter referred to as "Board"). The Board shall be composed of representatives of the community. It shall report to the Dean unless, in the Board's judgment, particular circumstances justify reporting to some other administrative official of the University.

The Board shall have original jurisdiction in all case involving alleged breaches of ethical principle except where such cases involve faculty in the care of patients; in these, the Medical Board of the Hospital shall retain jurisdiction. Any allegation against a student working in a clinical setting should be submitted to the Judicial Board; subsequent consultation between this Board and the Medical Board of the Hospital will determine appropriate jurisdiction.

I. Statement of Ethical Principles, Practices, and Behaviors for the Medical School Community.

1. Medical service will be rendered with full respect for the dignity of men and women.
2. Both students and physicians must merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.
3. Physicians should seek consultation upon request or initiate it whenever it appears that the quality of medical service may be enhanced thereby.
4. Students should seek consultation and supervision whenever their care of a patient may be inadequate because of lack of knowledge and/or experience..
5. A student may challenge an order or request special assistance in carrying out a procedure which is deemed beyond his or her level of competence.
6. Physicians, teachers, and students should be concerned with their own competence and strive to learn, integrate, and transmit knowledge at a level which transcends the accomplishment of minimal criteria.
7. Each member of the community, when acting as an evaluator of any other member, should recognize unprofessional personal bias and eliminate its effect on the evaluation.
8. The validity of examination-evaluation shall not be compromised by any departures from the advertised and/or generally understood rules of conduct during examinations.
9. Individual members of a group shall not be subjected to alterations in rules or procedures announced for the whole group on the basis of presumed violation of the ethical code.
10. Members of a group who are unaware of unethical actions by a member shall not be penalized for those actions.
11. Each member (or group) of the community should treat every other member (or group) with civility, independent of relative status of the individuals involved.
12. Each member of the community is obligated to carry out his or her designated responsibilities within the rules and governance structure adopted and agreed to by the community as a whole.

E. Failure to Achieve Objectives

When, after due consideration of the student's overall academic performance and any extenuating circumstances, remedial requirements are of sufficient magnitude to be deemed by the appropriate Student Progress Committee to be unachievable while keeping pace with the continuing curriculum, a student may be given Academic Warning, may be placed on Academic Probation, Leave of Absence, Special Student Status, or may be dismissed from the School of Medicine. A student who fails to meet the objectives of a Sequence may be required to repeat that same Sequence. It is not anticipated, except under extraordinary circumstances, that students will be retained in the School of Medicine if it is necessary for them to repeat the same Sequence more than once, or repeat subsequent Sequences. Unlimited opportunity to repeat curriculum units or Sequences is neither feasible or desirable.

Section 3-102 - Professional Behavior

Students of SIU School of Medicine must demonstrate proper conduct, personal integrity and ethical attitude of the caliber which their profession expects and demands.

- A. A medical student shall not demonstrate behavior which, by its nature or magnitude, is considered to render the student unfit for a career in medicine or which shall cast grave doubts upon the student's potential suitability or competence as a physician. Such inappropriate behavior includes, but is not limited to: the demonstration of poor judgment; lack of perception or personal insight; lack of motivation; lack of personal integrity; lack of personal accountability; lack of responsibility to patients; inability to recognize personal limitations; inability to function under pressure; or any other behavior that would have serious adverse effects upon the student's ability to practice medicine.
- B. A medical student is responsible for helping to meet a patient's emotional as well as physical needs and accordingly shall demonstrate sensitive and human consideration for patients by exhibiting, through behavior, manner, dress and grooming, the etiquette and maturity upon which patients depend for reassurance and confidence.
- C. A medical student occupies a position in which there is occasion to gain knowledge of confidential or privileged information. It shall be the responsibility of the medical student not to disclose such information inappropriately or unethically.
- D. A medical student shall have the continuing responsibility to comply with federal and state laws; the rules and regulations of the School of Medicine, affiliated hospitals and other medical institutions; and other applicable guidelines either stated or published.
- E. A medical student shall have the continuing responsibility to demonstrate behavior which is consistent with the highest standards of professional and personal honesty.

Section 3-103 - Academic Honesty

The following shall be considered violations of the standards of Academic Honesty:

- A. Plagiarism: representing the work of another as one's own work, or participation in plagiarism by preparing a writing with the knowledge that it is to be used by another as representing that person's own work.
- B. Cheating by any method or means.
- C. Knowingly and willfully falsifying or manufacturing scientific or educational data and representing the same to be the result of scientific or scholarly experiment or research.
- D. Knowingly and willfully falsifying by omission or commission any information pertinent to patient care.
- E. Furnishing false information to academic officers relative to academic matters.
- F. Knowingly and willfully restricting the use of material used in study in a manner prejudicial to the interest of other students.

DIVISION IV - GRADUATION

Graduation is recommended by the Student Progress Committee to the Dean and Provost upon the student's successfully complying with the Standards of Academic Conduct including Academic Performance, Professional Behavior and Academic Honesty previously enumerated. The Dean shall accept and act upon the recommendation of the SPC barring compelling reasons to the contrary.

DIVISION V - COMMITTEE STRUCTURE

Section 5-101 - Student Peer Review Committees

A. Definition

The Student Peer Review Committees (SPRC's) are elected student committees of the School of Medicine which are advisory to the Student Progress Committee/Carbondale (SPC/C) and the Student Progress Committee/Springfield (SPC/S).

B. Responsibilities and Jurisdiction

The SPRC's shall function under the Student Progress System as advisory bodies to the respective SPC's. Each SPRC shall have investigatory jurisdiction in matters of Academic Honesty and may be granted similar jurisdiction in matters of Professional Behavior by the chairperson of the respective SPC's. The SPRC's are responsible for conducting meetings and other proceedings in accordance with the procedures outlined in Division VI of this document.



## GUIDELINES FOR THE HEALTH PROFESSIONAL SCHOOL ADMISSION PROCESS

The Ethics Committee of the National Association of Advisors in the Health Professions has formulated a set of guidelines for personal and professional conduct in the admissions process. The Committee now requests any suggestions for improvement or criticism of the draft (which follows) particularly on the part of OSR or GSA. The OSR Administrative Board is therefore invited to consider and make recommendations regarding these guidelines.

GUIDELINES FOR THE HEALTH PROFESSIONAL SCHOOL ADMISSION PROCESS  
Initiated by NAAHP Ethics Committee 1982

PURPOSE:

This is an attempt to define guidelines for personal and professional conduct in the health professional school admissions process. We recognize that many of the decisions which must be made are difficult and subjective, and that there will be honest differences of opinion. If the best interests of society, professional schools, undergraduate schools and applicants are to be served, the highest professional standards must be observed on the part of all concerned. The following statements were prepared in an attempt to clarify the responsibilities of the various participants, to facilitate communication, and to serve as guidelines for making ethical decisions throughout the admissions process.

A. ADVISOR RESPONSIBILITIES

The advisor has a key role

- in counseling the student through undergraduate education and guiding the student through the mechanics of the admissions process,
- in providing a fair and accurate evaluation of the student in the letter of recommendation,
- in maintaining a reputation for honesty and reliability as a representative of the undergraduate school.

In fulfilling these sometimes conflicting roles, advisors should remember that their primary responsibility is to society, which deserves the most ethical and competent health professionals.

1. Role with Advisee

This role should be one of mutual trust, honesty and confidentiality. Advisees should be encouraged to make their own decisions based on solid information provided in part by the advisor and they should always be encouraged to develop their self confidence and seek solutions for their own problems. Confidential information pertaining to an advisee should not be revealed unless demanded by a higher ethic.

2. Role with other advisors and her or his own institution

As professionals, advisors should act with integrity, thus earning respect for themselves and their respective institutions. Statistics concerning acceptance to professional schools which are disseminated for recruitment purposes should be accurate and not misrepresented or misused.

## POSSIBLE OSR ACTIVITIES IN IMPROVING CAREER COUNSELING FOR MEDICAL STUDENTS

A long-standing and increasing concern of OSR is the quality of the counseling students receive regarding residency selection and career choice. Two issues of OSR Report have focused on improving organizational strategies for dealing with the residency selection process; an additional issue dealt with physician manpower inequalities. OSR has also chosen to devote numerous annual and regional meeting programs to discussion of these subjects. At its 1981 Business Meeting, OSR passed a resolution in support of improved data distribution, education and guidance for medical students in the area of future planning and career choice. Documenting this need, this resolution cites a paucity of available guidance, especially prior to the third year, and the changes occurring in manpower distribution and practice characteristics, information on which students have limited access to. At its January 1982 meeting, the OSR Administrative Board formulated a list of discussion questions to be used to gather perspectives on the state of the art at the OSR spring regional meetings and requested staff to summarize for the June meeting agenda these discussions as well as pertinent outcomes of the AMSA Career Development & Specialty Choice conference held in March. Accordingly, the following presentation is divided into three sections: summary of the most common general dilemmas students face vis-a-vis career planning and specialty choice; partial listing of what schools are offering by way of guidance; and suggestions of possible OSR activities. In formulating its recommendations, the OSR Board will also want to use as resources Norma Wagoner's paper titled "Residency Selection and the Match: The Nuts & Bolts" (distributed as a separate attachment) and the final report of the GSA ad hoc Committee on Professional Development and Advising (to be circulated at the meeting).

### Common Dilemmas

A few students enter medical school with definite ideas about what they want to become; and it is likely that they have a more relaxed and self-confident approach to their medical education because they have fewer questions about where they stand in relation to each discipline and fewer doubts about medicine as a career choice. The majority, however, do not enter with precise ideas or aspirations about their future practices but do experience a moribund internal and external pressures early on 'to announce'. In addition to quieting questions about priorities and what to study, other benefits of deciding early are decreased anxiety about the decision and more time to plan the residency selection process. Clearly, for many students, the deadline for submission of NRMP rank-order lists (January of the senior year) drives the specialty selection process. Certain specialties, such as ophthalmology, require even earlier decisions. Flexible first-year graduate programs are not considered a viable option to most because "they don't prepare you for anything". Even for those students who feel no inner drive to initiate the narrowing process, one unannounced function of core clerkships and electives is that, by necessity, they serve as specialty discriminators. Unfortunately, many clerkship experiences cannot be said to be representative of the variety of a given specialty; moreover, a poor evaluation or poor relationship with one attending or resident may unduly influence a student's view of a specialty. Off-campus senior electives offer welcome opportunities; these are arranged in order to evaluate residencies and to enhance one's chances of entrance.

Curricular choices are not all that are motivated by specialty and residency considerations. Residency programs vary a lot in terms of the qualifications one must present in order to be competitive; those students (whose numbers are increasing) who expect a lot of competition for their top choices must take care for their numerical profiles, i.e., class rank, NBME scores, number of honors. It is clear, then, that decisions about specialty and graduate medical education are rarely simple or clear-cut and are usually interwoven with questions which span the medical school experience about professional development in general and about how to focus one's energies.

This complex and conglomerate challenge called career planning evokes a wide range of responses, from denial that choices must be made to an irrational, compulsive search for a "career choice formula". Many students feel a stigma against asking for help in making career decisions and therefore any activity which legitimizes their inquiries is welcome. The types of questions students most frequently ask may be divided into five major categories:

- 1) Logistic, e.g., needing to apply for a graduate training position in a specialty before an elective in that area can be scheduled.
- 2) Gathering specific information about residency programs beyond that contained about the few variables published in directories, including applicant profiles since in many cases students are dealing with an admissions rather than a selection process.
- 3) Assessing practice and life-style characteristics of specialties and matching these with personal characteristics and goals.
- 4) Assessing "alternative" career opportunities, i.e., career types not represented in most academic medical centers; and
- 5) How or whether to take into account rumors and published information regarding overcrowding and undersupply in various geographic and specialty areas.

When asked to name the kinds of career planning assistance that would be most desirable, students frequently ask for: 1) "objective criteria" against which to compare their own evaluations of specialty characteristics and available opportunities; 2) help with what to do if no one specialty seems right; 3) more exposure to non-academic modes of care delivery; 4) a description and evaluation of the career decision making process; and 5) assistance with the transition from undergraduate to graduate medical education, especially with regard to financial management. There appears to be some disagreement about the optimal time to offer different kinds of assistance. Some students prefer that a whole array be described and available from the orientation period onward; others feel that for the first two years the less said about career planning the better. However, there seems to be a general consensus that assistance should be available to those first and second-year students who desire it, but that attempts should be made to avoid increasing pressure on students in these regards.

## Types of Assistance Offered by Schools

There is no appropriate measuring device for what constitutes successful career planning and counseling programs. Since by and large students remark upon too little assistance, it seems fair to assume that any organized assistance is better than none. The following activities are on-going at at least one school:

1. Series of workshops offered by student affairs office from December through March of the 3rd year, covering the gamut of concerns including personal needs assessment, selecting senior electives and meetings with program directors (Nevada).
2. One-hundred-plus page booklet called "Guide to Planning your Senior Year" distributed to juniors (Cincinnati).
3. Two-week summer institute offered to entering students, a portion of which is devoted to presentations by and informal contact with specialists. Individual in dean's office (job description includes arranging career guidance programs) who provides individual counseling as well as continuous small group workshops (spouse invited) according to student demand. Workshops include values and goal-clarification exercises and materials which assist in matching personal characteristics with specialty characteristics (Medical College of Virginia).
4. Administration of the Myers-Briggs Type Indicator and Medical Specialty Preference Inventory and free consultation on results (St. Louis U).
5. Before beginning of 3rd year, students offered a day's worth of activities devoted to one specialty (e.g., observe patients being examined); students may take up to five (Buffalo).
6. Maintain Physician Identification Groups (PIGs), i.e., a list of specialists whom student contact and then accompany at office, etc.; beginning in first year, introductory evening programs offered on all specialties and subspecialties (George Washington).
7. First-year students invited to accompany on the wards fourth year students and/or residents (Pittsburgh).
8. Alumni-sponsored small group discussions about specialty characteristics (Medical College of Pennsylvania).
9. Option of being assigned during entire first and second years to physician preceptor (Dartmouth); at Hershey this option enhanced by student being able to specify certain characteristics of preceptor, e.g., woman with children, and by learning physical diagnosis from the preceptor.
10. Presentations to 2nd year students from representatives of the major departments to help them in determining clerkship lottery decisions; on-going luncheon conferences with presentations on career planning topics.
11. Discussions presented by economists and practice management experts regarding differences in expectations and realities among specialties and practice types (Irvine)
12. To upgrade quality of faculty advising, Rush contracts with and pays faculty for a four-year term as counselor (student may keep same one throughout) and

Brown publishes a faculty advisors handbook.

13. Host meetings between local AOA chapters with 2nd year students to dispel myths and rumors about selection processes; have a junior/senior mixer right after Match.
14. Field trips to examine "alternative" careers in aerodynamics, industry, business, etc. (Miami).

#### Possible OSR Activities

The following options are presented for discussion by the Board with the hope that members will bring to the meeting additional ideas.

- 1) Jack Carow, Deputy Executive Vice President of the Council of Medical Specialty Societies, has agreed to place on the CMSS agenda an OSR/AAMC request for the assistance of its constituent colleges in providing some assistance in the area of medical student career planning. A draft of a letter to CMSS will be presented to the Board for its input.
- 2) OSR could sponsor in conjunction with an annual meeting or regional meetings a specialty choice conference as a model to be replicated by OSR members at their schools.
- 3) A listing and brief discussion of the types of assistance that schools are presently offering could be distributed to OSR and GSA members; it may be advisable to undertake a survey in order to offer more comprehensive descriptions than is currently possible based on the informal regional meeting discussions.

OSR 1982 ANNUAL MEETING PROGRAM

Friday, November 5

3:00 pm - 4:30 pm

Business Meeting

4:30 pm - 5:30 pm

Regional Meetings

7:30 pm - 9:30 pm

OSR Program

'Toto, I've a feeling we're not in Kansas anymore':  
Nuclear Weapons, Denial Psychology & Physicians'  
Responsibilities

H. Jack Geiger, M.D., Professor of Community Medicine  
City College of New York

Bruce B. Dan, M.D., former Deputy Chief at Center  
for Disease Control

Saturday, November 6

8:30 am - 9:30 am

Business Meeting

9:30 am - 11:30 am

Stimulus/Discussion Sessions

New Premises and New Tools in Medical Education  
Lawrence Weed, M.D., Professor, Univ of Vermont  
School of Medicine

Recreating the Joy of Medicine

John-Henry Pfifferling, Ph.D., Director, Center  
for the Well-Being of Health Professionals

11:00 am - 6:00 pm

Issue Assessment & Planning Sessions

8:00 pm - until

OSR Reception

Sunday, November 7

8:00 am - 9:00 am

Candidate for OSR Office Session

9:30 am - 1:30 pm

Business Meeting

2:30 pm - 5:00 pm

Joint OSR/CAS Plenary & Discussion Groups

General Education of the Physician Project:  
A Student/Faculty Colloquy

5:00 pm - 6:00 pm

Regional Meetings

6:00 pm - 7:00 pm

CAS/OSR Reception

Monday, November 8

12:00 - 2:00 pm

DISCUSSION SESSIONS

A Seminar for Third & Fourth Year Medical Students:  
How to Retain Your Humanism in the Face of the  
Technologic Explosion

Robert Lang, M.D., Associate Professor of Medicine  
Alan Kliger, M.D., Associate Professor of Medicine,  
Yale University School of Medicine

3:00 pm - 5:00 pm

Health Awareness Education for Medical Students

Joel Elkes, M.D., Professor, Department of Psychiatry  
& Behavioral Sciences

Leah Dickstein, M.D., Associate Dean for Student  
Affairs & Assistant Professor, Department of  
Psychiatry & Behavioral Sciences, University of  
Louisville School of Medicine



610 Fourth Street N.W.  
Rochester, Minnesota 55901  
May 22, 1982

Ms. Janet Bickel  
Staff Associate  
Association of American Medical Colleges  
Suite 200  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear Janet and Members of the OSR Administrative Board:

I attended the annual meeting of the NRMP Board of Directors held April 27 in Chicago at the O'Hare Hilton. Discussion concerned:

- 1) The delivery of results of the Match- Efforts will be continued in attempt to shorten the time span over which results are received- perhaps through the use of central repositories.
- 2) Premature disclosure of results to unmatched students-This occurred in at least 6 medical schools. The NRMP maintains that policing of the deans is not its responsibility but should be left to the AAMC.
- 3) 1983 Match- The Match will be simplified to consist of 2 programs: Categorical Programs, specialty programs which meet the Special Requirements for that specialty, and Transitional Programs, formerly Flex. A student may apply to either or both. The NRMP also provides Preliminary tracks for programs in Internal Medicine and General Surgery to provide 1 or 2 years of broad clinical experience, and Advanced Resident tracks.
- 4) Student representation on the Executive Committee of the NRMP Board- Because the 2 student members of the Executive Committee were not in attendance at the meeting, it was decided that student representation be decreased to 1. Students on the NRMP Board will rotate through the position- AMSA representative Ken Stone serving this year, and the OSR representative next year.
- 5) The practice of several programs which select residents to begin their first year at the second graduate level offering appointments to students prior to the match- In the past, when the number of PGY-1 positions was considerably greater than the number of applicants, early recruitment efforts by some program directors for PGY-2 positions was understandable. Currently, with an increasing number of applicants seeking a diminishing number of positions, less reason for early appointments is anticipated. This early selection is advantageous to students who are interested in competitive programs, e.g. ophthalmology, who if unable to obtain these positions would prefer something else, but disadvantageous to those students not yet completely decided on a specialty.

I would appreciate your opinions especially on this issue.

Your suggestion that the NRMP publish a list of programs using the Universal Application Form is excellent. Thank you for allowing me to represent the OSR at the meeting.

Sincerely yours,  
*Patricia Pellikka*  
Patricia Pellikka (Mayo Medical School)

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