association of american medical colleges

OSR ADMINISTRATIVE BOARD MEETING

January 18   12:00-5:00
January 19   9:00-3:00
(Conference Rm., AAMC Headquarters)
January 20   1:00-2:30
(Map Rm, Hilton Hotel, Joint Lunch)

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

OSR ADMINISTRATIVE BOARD MEETING
MINUTES
September 7 & 8, 1982
AAMC HEADQUARTERS
WASHINGTON, D. C.

Chairperson	--Grady Hughes, M.D.
Chairperson-Elect	--Ed Schwager
Regional Chairpersons	--Pamelyn Close
	--David Baum
	--Paul Organ, M.D.
	--Ron Voorhees, M.D.
Representatives-at-Large	--Michael Tom
	--David Thom
	--Linda McKibben, M.D.
AAMC Staff	--Janet Bickel
	--Robert Boerner
	--John A. D. Cooper, M.D.
	--Davis Johnson, Ph.D.
	--Maria Thomae-Forgues
	--Sally Osterling
	--August G. Swanson, M.D.

I.   The meeting was called to order at 1:00 pm. Ms. Bickel shared with the
     Board a number of informational items, e.g., 1982 Graduation Questionnaire
     results, evidence of additional uses of recent issues of <u>OSR Report</u>,
     suggestions for OSR member selection procedures that accompanied the OSR
     certification form mailed in August.

II. <u>Problems with Student Assistance Programs</u>

     Dr. Cooper told the Board that the Reagan Administration is not much concerned
     about opportunities for education; even the AMA leadership has stated that
     financial aid for medical students is not a problem. He described the need
     to assure the availability of sufficient funds under Health Education
     Assistance Loan (HEAL) which is in serious jeopardy due to instructions in
     the federal credit budget. Unless the Appropriation Subcommittee in both
     Chambers of Congress can be persuaded to override these instructions, the
     program will be reduced to one-third its current commitment of $225 million.
     Dr. Cooper said that he has notified OSR representatives to generate letters
     to Congress about the need for HEAL funds and has requested deans to provide
     AAMC   an estimate of the present level of borrowing under HEAL. Ms. Close
     asked how to stimulate students from schools with relatively low tuitions
     to write in support of HEAL. It was recommended that "we're-all-in-this-
     together" is an appropriate approach since sooner or later students at
     all schools will need this source of funds.

     Mr. Boerner reported that Guaranteed Student Loan (GSL) Program is currently
     static but it will probably be continually under attack for the foreseeable
     future. He noted that the Health Professions Student Loan (HPSL) Program
     default scandal resulting from Senator Percy's hearings has poisoned

the student loan well; now there is a general fear among members of Congress that physicians maybe poor risks. The campaign to collect past-due HPSL's has extended to tapping Medicare reimbursement monies. Mr. Boerner also noted that the long awaited notice of proposed rule-making to modify debt collection procedures for HPSLs was finally published in the August 31 Federal Register; the regulations are even more onerous than anticipated. The new definition of delinquency will undoubtedly result in schools' being closed out of participation in the program. OSR members therefore need to offer their assistance to financial aid officers in the campaign to reduce delinquency rates; for instance, students can write letter to alumni in default.

The Board discussed the feasibility of recommending to OSR members that they make appointments with their Congressmen for the week of the Annual Meeting (as suggested in a letter from Mark Schmalz, OSR representative from Minneapolis). Because November 2 is Election Day and so few Congressmen will be in D.C., it was decided not to stage visits for this year but undertake this next year instead. Dr. Organ noted the appropriateness of encouraging all the OSR members in Illinois to target Senator Percy with evidence of students' commitment to repay their loans. In all efforts to motivate students to write letters, parents of students should not be overlooked as an important source of additional letters and support.

III. Medical Student Organizations

Dr. Johnson, who is writing a book titled U.S. Medical Students, 1950-2000: Trends and Projections, met with the Board in order to gather their views. He noted that students have played a very important role in changing medical education for the better but that student activism may be on the wane for a variety of reasons, including the financial need to work in addition to attending school. Dr. Organ stated his belief that circumstances at many places had gotten so bad that previously immovable students were grouping to address them; he also added to Dr. Johnson's list of organizations Physicians for Social Responsibility which is becoming an important faculty/student group on many campuses where the threat of nuclear war is being taken seriously. Groups added by other Board members include: American Medical Women Student Association, expanding student chapters of county and state medical organizations (due to reduced membership fees), rise in religious groups some of which have faculty members, and groups formed to carry out projects within communities, for instance, at jails and inner-city clinics.

IV. Annual Meeting Plans

Dr. Hughes urged the Board to remind constituents at each opportunity about OSR activities beginning on Friday afternoon; the first business meeting will include reports from Dr. Cooper and leaders of other student groups and overviews on student financial aid and OSR projects. The Board reviewed again the group process format to be used following the Saturday discussion sessions, expressing the belief that students attending the meeting will have much greater opportunities to participate in discussions and action plans than has previously been the case. Drs. Voorhees and McKibben agreed to develop a timetable and guidelines for the use of the six small group leaders and their assistants. Group leaders for the Sunday discussion sessions with the Council of Academic Societies (CAS) were designated as follows: Drs. Organ, Voorhees, Fisher (Essential Knowledge); Drs. McKibben, Capaldini, Mr. Thom (Fundamental Skills): Ms. Close, Mr. Tom, Mr. Baum (Personal Qualities, Values and Attitudes).

V.   Statement on Status of Minority Students in Medical Education

Dr. Hughes noted that this reaffirmation of AAMC's commitment to equal
opportunity in education and to the provision of support for minority and
disadvantaged students is timely due to developments which threaten recent
progress, i.e., static minority applicant pool, rising tuitions, class size
reductions, financial aid cutbacks.

ACTION: The OSR Administrative Board endorsed the statement appearing in
         the Executive Council agenda.

VI.   General Professional Education of the Physician Project (GPEP)

Dr. Swanson cited evidence to the Board that the booklet containing the GPEP
working group charges (mailed this summer to over 3000 individuals including
all deans, professional societies holding AAMC/CAS membership, and OSR
members) has captured the imaginations of numerous medical educators. As of
September 1, 81 U.S. and Canadian medical school and 18 societies had agreed
to engage their faculty in discussions to parallel the endeavors of the
Working Groups on Essential Knowledge, Fundamental Skills and Personal
Qualities, Values and Attitudes. Dr. Hughes noted that he will recommend to
OSR members to contact 1) their institutional GPEP correspondent to assist
with activities that are being planned and 2) the student members on the
three working groups to offfer any creative thoughts. It was also suggested
that OSR members can identify who at their schools should be drawn into
discussions of various facets of the educational process and can make sure
those faculty receive a copy of the booklet mentioned above (available from
Mary Littlemeyer, GPEP Project Coordinator).

VII. OSR Career Counseling Project

Dr. Swanson also discussed with the Board the proposal to prepare for con-
sideration by the Council of Medical Specialty Societies (CMSS) an overview
of students' dilemmas regarding specialty choice. He suggested that while
the member colleges would probably not be good sources of information on
relative employment opportunities, they should be able to provide timely
overviews of their disciplines. Dr. Swanson noted also that the colleges
have genuinely altruistic motives to see students well-guided and well-
trained. Board members noted that many faculty have such biased and limited
understandings of the various specialties that students have a high need
for concise and balanced summaries which can correct false impressions and
present non-academic aspects of a field. Dr. Organ suggested gathering a
variety of well-known, accomplished physicians in each specialty to partici-
pate in a panel discussion to be video-taped for distribution to each school.
A proposal summarizing the Board's recommendations will be drafted. Also to
be prepared is a memo to deans of student affairs listing career decision
facilitation programs presently being offered at at least one school; a
slightly different version will go to OSR members who can accept responsi-
bility for initiating a number of activities. Finally it was suggested
that if the GSA Steering Committee, the OSR Administrative Board and CMSS
could work together, a future joint product might be a faculty advisors hand-
book on career decision-making.

VIII. OSR Ethical Behavior Project

The Board once again discussed the drawbacks of attempting to generate a model code or guidelines for student behavior. It decided that the most troublesome area is the widespread yet elusive unethical activities which students observe residents and attendings engaging in. With an eye toward producing a document which may help students sort through what they observe on the wards, Dr. Organ and Ms. Close agreed to write a number of typical scenarios; with an appropriate introduction these can be shared with OSR members. Mr. Schwager suggested that next year's regional meetings include panels comprised of faculty, residents and students to discuss a variety of topics related to faculty and student responsibilities and to the boundaries of professional ethical behavior.

IX. The minutes of the June meeting were approved.

X. The meeting was adjourned at 3:00 pm in order to prepare for the special joint session with CAS and COTH, a summary of which follows:

Graduate Medical Education: Portents of Changes in Opportunities

Dr. Swanson introduced the program by providing a few statistics which illustrate the importance of the changes occurring. Comparing data between 1966 and 1981, the number of U.S. graduates has increased 107% while the number of first-year residency positions has increased only 37%. The "jaws" are steadily closing: the number of graduates from U.S. schools continues to rise but, in 1982 for the first time in five years, the total number of positions offered in the Match was less than the previous year, producing a ratio of positions to graduates of 1.12. Moreover, the number of foreign medical graduates is also increasing: between 1981 and 1982 the number of USFM's participating in the Match increased from 785 to 1400 and alien FMGs from 1731 to 4000. However, at present these candidates are not displacing U.S. domestic graduates from the programs they aspire to enter. Dr. Jack Graettinger (NRMP Executive Vice President) reported that in the 1982 Match there were 1800 unfilled positions, representing the vacuum into which FMGs flow. He noted that, even though many schools offer required clerkships in these hospitals, the quality of clinical supervision in these programs is poor. Dr. Graettinger asked whether, given the closing jaws, U.S. graduates will be forced into these lower quality programs. He speculated as to whether there will be adequate numbers of residencies to accommodate all those desiring board eligibility.

Dr. John Gienapp (Secretary of the Accreditation Council for Graduate Medical Education (ACGME)) reported that Residency Review Committees (RRC) are now looking more critically at programs; 33% of the 100 surgery programs most recently surveyed received an adverse action. He noted, however, that mandated budget cuts and changes in reimbursement schemes which eliminate payments for educational costs will have a greater impact than accreditation decisions on program quality. Hospitals are now asking "how much education can we afford?"

Dr. Richard Reitemier (Vice Chairman, ACGME) offered a summary of manpower and training gaps abroad. In Great Britain, there is much greater competition for fellowship opportunities than in the U.S. Israel and Ireland are training many more physicians than needed by their people but intend to do nothing about

this situation. In Spain it is estimated that 6000 physicians are on the dole, and this number may represent only one-third of the actual total. Dr. Reitemier noted that nowhere is it considered the responsibility of graduate programs to increase educational opportunities based on rising numbers of M.D.s, especially given the budgetary restraints of hospitals. Accrediting bodies have also determined that it is not their responsibility to regulate numbers of entrants or graduates. He mentioned that osteopaths are facing a situation similar to medicine's, only accelerated--with the outcome that presently instead of 16 patients per intern, the ratio has decreased to 5 or 10 per intern. Dr. Reitemier concluded by saying that unless medical schools decrease the number or entrants, there will be many disappointed graduates unable to find satisfactory graduate medical education.

Following these presentations, a number of questions were discussed in an open-ended fashion. These included: who will decide which, if any, medical schools should close? How will schools makeup the income lost if they reduce class size? Should schools attempt to accept the responsibility to produce the resources needed by their graduates to complete their training?

NOMINATION OF STUDENT TO COMMITTEES

This year the only two committees for which it is appropriate
for the OSR Administrative Board to nominate students at this
time are:

1) <u>Flexner Award Committee</u> (Nominates to the Executive Council
an individual selected for "extraordinary contributions to medical
schools and to the medical education community")

2) <u>Women in Medicine Planning Committee</u> (Plans and evaluates
Annual Meeting activities offered by the Women in Medicine; will
meet once, probably in April).

As of January 5, no specific applications have been received for
the first of these, which was described in the Annual Meeting agenda
materials. Because of familiarity with Annual Meeting planning,
an OSR Board member has typically been nominated to the latter.

Friday, Nov. 5

3:00-4:30 pm	Business Meeting (A)	Georgetown West
4:30-5:30 pm	Regional Meetings	
	South	Hemisphere
	Northeast	Thoroughbred
	Central	Military
	West	Independence
7:30-9:30 pm	Program	
	"Toto, I have a feeling we're not in Kansas anymore": Nuclear Weapons, Denial Psychology & Physicians' Responsibilities	Georgetown West
	Bruce B. Dan, M.D.	
	H. Jack Geiger, M.D.	
	Tony Robbins, M.D.	
	moderator: Paul Organ, M.D.	

Saturday, Nov. 6

8:30-9:30 am	Business Meeting (B)	Jefferson West
9:30-11:00 am	Discussion Sessions	
	Re-creating the Joy of Medicine	
	John-Henry Pfifferling, Ph.D.	Caucus
	New Premises & New Tools in Medical Education	
	Lawrence Weed, M.D.	Map
11:00-noon	Issues Identification Session	Jefferson West
1:30-3:00 pm	Small Group Issue Exploration	Farragut
		Edison
		Dupont
		Chevy Chase
		Grant
		Hamilton
3:00-4:00 pm	Issues Assessment Session	Georgetown East & West
4:30-6:00 pm	Small Group Workplan Definition	(as above)
8:00-	OSR Reception	(to be announced)

Sunday, Nov. 7

8:00-9:00 am	Candidate for OSR Office Session	Georgetown East
9:30-1:30 pm	Business Meeting (C)	Monroe West & East
2:30	AAMC General Professional Education of the Physician Project: A Student/Faculty Colloquy	
	Plenary Session: Presentations by Working Group Chairmen	Conservatory
3:30-5:00 pm	Discussion Sessions	
	(three groups each: Essential Knowledge; Fundamental Skills; Personal Qualities, Values & Attitudes)	(to be assigned)

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5:00-6:00 pm	Regional Meetings	
	West	Hamilton
	Northeast	Independence
	Central	Caucus
	South	Map
6:00-	CAS/OSR Cocktail Reception	Lincoln East

Monday, Nov. 8

12:00-2:00 pm	A Seminar for Third & Fourth Year Medical Students: How to Retain your Humanism in the Face of Technologic Explosion	Hemisphere (attendance will be limited to 20)
	Robert Lang, M.D.	
	Alan Kliger, M.D.	
3:00-4:30 pm	Discussion Session Healthy Medical Students: Creating Self-Help Programs	Jefferson East
	Leah Dickstein, M.D.	
	Joel Elkes, M.D.	

OTHER AAMC SESSIONS HIGHLY RECOMMENDED TO STUDENTS

Sunday

7:30 pm	Women in Medicine General Session The Changing Environment: What's Ahead for Women	Jefferson East & West

Monday

9:00 am	Plenary Session Academic Values in a Changing Environment	Ballroom
12:30-2:00 pm	Student Financial Assistance: Status of Federal Programs	Jefferson East
2:30-4:30 pm	RIME Presentation of Papers	
	Attitudes & Patient Care	Map
	Professional Attitudes & Career Choice	Lincoln East
	Postgraduate Education Selection Process	Lincoln West
7:30-9:30 pm	Innovations in Student Financing	Lincoln East & West

Beginning at the bottom of this page appear the workplans which
the membership approved at the 1982 OSR Annual Meeting. These
were the products of day-long issue identification and assessment
sessions and cover the following topics: A) Housestaff Concerns;
B) Personal Growth and Development; C) Educational Issues;
D) Social Responsibility; E) Financial Aid; and F) Medical Use
of Information Systems.

The OSR Administrative Board will need to carefully consider
these outlines and refashion as is viewed advisable. Work has
already proceeded in two areas. Steve Hasley, the group leader
of the OSR members who focused on "Medical Use of Information
Systems" has prepared a paper titled "Micro Computers and Medical
Education" for the Administrative Board's consideration.
This paper as well as a pertinent article from "Business Report"
follows the workplans. The second area is the collation of the
"Personal Growth and Development" surveys collected at the meeting;
this will be provided at the Board meeting.

A.   HOUSESTAFF CONCERNS

The discussion group on Housestaff Concerns began their deliberations
by defining operational premises:

1. Medical students have a particular interest in the rights,
   responsibilities and concerns of residents for the follow-
   ing reasons:
   a. as students much of their "hands-on" experience
       (and often didactic education) is provided by
       residents;
   b. most medical students enter residency training programs
       after completing medical school.
2. The current state of housestaff programs in general is less
   than ideal; they do not maximize the creativity and producti-
   vity of residents, nor do they encourage humane and effective
   health care delivery.
3. There exists a multitude of interrelated factors which in-
   fluence the philosophy and functioning of residency training
   programs. Some of these factors include: competition for

increasingly fewer positions; the duality of health care delivery (especially the view that residents are "cheap labor"); and the lack of viable communication between residents, program directors, administrators and students.

4. The OSR occupies a unique role within the AAMC and has the resources and interested individuals with which to address the concerns of housestaff.

It is the recommendation of this discussion group that the Administrative Board of OSR form a Task Force on Housestaff Concerns with the following charges:

1. Review the pertinent literature and gather the necessary data to define (as accurately as possible) the current state of affairs of housestaff education.
2. Review the existing mechanisms for housestaff to represent their own interests within formal medical education channels, specifically AAMC and AMA.
3. Establish a network of former OSR reps currently in residency programs to be used as a resource base.
4. After an initial period of information gathering, reconvene and critically evaluate the charges of the Task Force with the specific goal of creating a representative and effective housestaff voice within AAMC.

The following issues may serve as "trigger points" for the Task Force's discussions:

1. The need for residents to receive high quality instruction and supervision from interested and competent instructors.
2. The need for residents to have an active and influential voice in the planning and evaluation of their programs.
3. The need for training programs to provide prospective and current residents with accurate, comprehensive and reasonable job descriptions.
4. The need for residents to be taught how to teach and to evaluate medical students.
5. The need for residency program directors to consider health and quality of life issues in the design and implementation of residency education.

It is felt that many of these objectives could be addressed in the formation of "Residents Bill of Rights" which could be assembled by OSR and distributed through the auspices of AAMC. It is further suggested that an interim project could involve the gathering of "Survival Hints in Residency" for distribution to OSR members. From the start it is recognized that this will be a difficult task involving the cooperation of many diverse "vested interests" within medical education. However, the unique resources of OSR and the difficulties of the transition from student to resident make this a critical issue with a reasonable possibility for constructive change.

B. PERSONAL GROWTH AND DEVELOPMENT

This group discussed the current trend toward a medical educational system designed to promote personal well being along with academic growth. It became apparent that a wide variety of appraches are being tried at different institutions with admirable success. In order that all may benefit from each other's experiences, it was decided to collect more data from OSR members about personal and community ventures. The need to assess ethical teaching during medical school was also evident. Therefore, a survey was designed and distributed with the following introduction:

> "We are excited by trends toward more humane medical education, dealing with the real issues of personal as well as academic growth. The variety and anecdotal nature of the information shared triggered the idea that this would make a creative, interesting and informative publication and would be useful to the OSR and the individual institutions and students. We need descriptive, anecdotal summaries of some of the most successful groups or methods of dealing with those issues at your school. Examples would include: support groups, peer counseling, impaired student programs, career choice and planning, time management in terms of life values and survival values, supports including significant others, recreation, and also any individual or organized "Great Escapes".
>
> We envision compiling responses into a humanistic, entertaining and informative booklet that will be distributed and shared among students at all of the schools with OSR representatives. Hopefully, this publication will stimulate the development of more participation in groups that facilitate helping attitudes and make our time spent in med school a more rewarding experience."

C. EDUCATIONAL ISSUES

In increasing numbers, medical students are indicting the present structure of medical education as an uncreative, demeaning and frustrating experience that poorly prepares them for future careers as healers. Students express the concern that the present system produces doctors unschooled in social issues and overly preoccupied with factual trivia. Specifically, the manner and educational atmosphere in which material is delivered fail to stimulate students to excel in their chosen profession. Professors are often ill-trained to adequately convey information and attitudes; research often takes precedence over teaching. Moreover, the lecture format causes students to suffer a sense of detachment from the educational milieu and is decried by most students to be a passive and uninteresting process. As a result, attentions wander and attendance declines. In addition, this acquisition of factual information by memorization remains a favored approach to education. This is encouraged by the misuse of the National Boards in promotion and grading criteria. Sacrificed is an emphasis on conceptual learning, problem solving and critical thinking.

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Students require a stimulating environment if they are best to learn, digest and sythesize the vast amount of information that is required to become effective physicians. Central to this is the role of the teaching faculty. The group devised some suggestions to improve the present situation in which many faculty are not fully undertaking their responsibilities resulting in less than optimal educational programs. Following is a suggested list of goals and resources:

1. Utilizable Resources:
   a) AAMC Group on Medical Education (GME)
   b) Student evaluations (which encourage student input through written forms and student/faculty committees)
   c) Research in teaching and education by individual faculty and staff members (this should be both encouraged and financed by medical institutions)

2. Products:
   a) Development of workshops for improving medical educational techniques and implemented locally with the aid of RIME (AAMC).
   b) Development of the following qualities in teaching faculty:
      -- knowledgeable in educational evaluation techniques
      -- using an organized approach, i.e., established learning objectives, effective communication skills
      -- fostering independent creative thinking by the students
      -- being motivated and enthusiastic about teaching
      -- having an approach that is broad enough to instruct at a basic level
      -- discussing social, economic and ethical concerns of the subject
      -- being free from the "publish or perish" syndrome
   c) Analyses of instructional modalities: comparison and and effective use of various formats, i.e., lectures, small groups, directed peer-group study.
   d) Student evaluations -- on both individual faculty teaching abilities and courses, to be used at the administrative and student levels. Needed are establishment of an administrative area responsible for utilizing these evaluations in the improvement of teaching abilities and course format and establishment of student bodies which also have access to summaries of these evaluations and which can monitor areas identified as needing improvement.

3. Creation of an environment to promote teaching excellence:
   a) Monetary rewards as incentive to faculty, e.g., "Golden Apple" awards for the faculty members judged by the students to be excellent teachers, establishment of a salaried position which is periodically rotated among interested faculty with the purpose of promoting teaching excellence and research in education.

b) Institutional efforts, e.g., require continued education credits of faculty, award continuing education credits to faculty participating in AAMC teaching-workshops, allow the option for faculty not to teach topics in which they have no interest.

In order to seek implementation of this program, OSR should create a task force to study the qualities that contribute to teaching excellence, to serve as a resource on programs for improving instruction methodology, to make recommendations to the GPEP working groups as appropriate, to act as the agent to advocate this program and any other recommendations they deem appropriate.

D. SOCIAL RESPONSIBILITY

Three subgroups addressed their image of the physician as a community-oriented professional. The three groups approached this goal from the viewpoint of the professional who is: ethically aware, understanding of the economics of health care, and competent as a positive leader in the community.

1) Ethics - This group formulated recommendations for the Ad Board which were to: a) develop a model program for a professional ethics presentation to be given at orientation in medical schools, b) promote to the GPEP group the possibility of undertaking a study of the development of personal values of physicians as it relates to undergraduate medical education, c) elicit the support and activity of the Consortium of Medical Student Groups, d) enlist the AAMC's support in creating an awareness of the problems and possible solutions within administrative and faculty populations, e) promote wherever possible the limiting of medical educational demands (physical, intellectual and emotional) to allow students to view problems from a human perspective.

2) Economics - These industrious OSR's created a curriculum for an 18 hour course for medical students to educate them about the needs of the indigent and economically disadvantaged. This curriculum description can be disseminated by the OSR Ad Board. It includes both clinical and didactic experiences.

3) Leadership - A task force was created to address ways to promote student-sponsored community projects as learning and motivating experiences. The primary way elected to accomplish this goal was to create a written collection of existing projects. Therefore, students who know of any student-sponsored community projects or organizations which involve medical students, were urged to write Coordinator, Douglas Borg (Apt. 3A/1503 Anthony/ Columbia, MO 65201 (314-442-0305). A one-to-two page description of the program as well as a list of resource persons to contact for more information are preferred.

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E. FINANCIAL AID FOR MEDICAL EDUCATION

The group discussing financial aid for medical education was composed
of students from public and private schools across the country who had
had a variety of personal experiences in financial aid. From its
discussion, the group identified the following goals:

Highest Priority:

1. To protect and foster government sources of financial aid.
   This goal includes improving the public image of the medical
   student loan recipient, increasing the number of non-military
   service contingent loan options, and increasing awareness
   among medical students and the public of the financial aid
   problems of medical students.

2. To increase private sources of financial aid.

3. To document the costs of medical education and the uses of
   tuition money. Such documentation would be used to provide
   a rational basis for determining the reasonableness of tuition
   costs and to evaluate claims that current tuition costs
   pay for only 1/4 or 1/3 of actual education costs.

Additional Goals:

1. To examine the effects of financial aid barriers and decreases
   in class sizes due to budget constraints on access to medical
   school for minority and low income applicants.

2. To increase the information and guidance available to students
   regarding debt management.

3. To develop more equitable methods of dividing financial aid
   resources at individual medical schools.

Forces affecting the three highest priority goals were analyzed and
specific actions suggested:

Goal #1: Positive Forces:

a) Student concern and the large number of students, parents of
   students and friends of students.

b) Public concern about decreased access to medical school for
   middle and lower class applicants and the increasing costs
   of health care which may, in part, be engendered by high
   physician debts.

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c) Desire by the public for a more equitable distribution of physicians, which may be hindered by post-graduate financial pressures on M.D.s to practice in more lucrative areas.

Negative Forces:

a) Poor public image of medical students as loan recipients.

b) Student time constraints

c) Current poor economic and political climate.

d) Lack of support from AMA, state and local medical societies and many current M.D.s.

Recommendations:

a) A letter writing information packet, similar to the one distributed by the Ad-Board this year, should be provided again this year to all representatives.

b) OSR representatives should explore the possibility at their school of writing a letter from concerned medical students to delinquent alumni borrowers, to be mailed via the office at their school which collects these loans.

c) OSR should seek greater press coverage of student financial aid issues, e.g. by inviting the press to a conference on such issues at the national meeting.

d) A mechanism should be instituted whereby financial aid information from other student groups (e.g., AMSA legislation alerts) could be available to OSR representatives.

e) Students at individual medical schools could contact local media, go on radio talk shows, create a presentation on medical student financial aid problems for presentation to community groups, etc.

f) OSR Administrative Board would write letters regarding student financial aid to NEJM, JAMA and other relevant publications.

g) Available information contradicting Senator Percy's findings regarding student delinquency rates should be compiled and made available to OSR Representatives.

Goal #2: Positive Forces:

a) Innovative methods and programs being instituted at individual medical schools to obtain private financial aid.

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b) Tax incentives available for private contributions to medical education.

c) Financial resources of current M.D.'s.

d) Concern of medical students and parents about rising medical school costs.

e) Community contacts of local M.D.'s which can be used to find local sources of financial aid.

Negative Forces:

a) Lack of communication among medical schools about ways of obtaining private financial aid money.

b) Competition with other educational programs for the same private money.

c) Lack of understanding, by private funding sources, of financial needs of medical students.

Recommendations:

a) OSR should compile a list of innovative financial aid programs at individual schools and provide this information to OSR representatives and to financial aid officers via GSA. Three examples of such programs provided by group members follow:

Dartmouth: Melco has provided money for student loans which are at 11% interest with graduated repayments beginning during residency.

St. Louis University: Each year, the 2nd year class contacts alumni by phone to solicit funds for student loans. The amount of money obtained by each class is used to make loan to members of that class in their senior year. When the loans are repaid, they are repaid to a general student loan fund in the financial aid office.

Loyola: Via the alumni association students held a phone-a-thon to solicit pledges which will be used for medical student financial aid.

b) Information on tax incentives for medical education contributions should be obtained and provided to OSR representatives and to financial aid officers via the GSA.

c) OSR should investigate the possibility of service contingent loans and scholarships from corporations/HMOs.

   d) A task force, composed of interested OSR representatives not
      serving on the Ad Board, should be formed to carry out many
      of these recommendations.

Goal #3: <u>Positive Forces</u>:

   a) Government and public belief in accountability for institutions,
      such as medical schools, which receive public funds.

   b) Student interest in the uses of their money.

   <u>Negative Forces</u>:

   a) The complex logistics of such documentation.

   b) Opposition by medical school administrators due to a perceived
      loss of autonomy.

   <u>Recommendations</u>:

   a) Encourage local OSR representatives to attempt to get deans
      to document medical education costs at their schools.

   b) Explore the possibility of LCME documenting medical education
      costs as part of the accreditation study.

   c) Construct a model medical education budget as a yardstick for
      evaluating current tuition levels.

F. <u>THE MEDICAL USE OF INFORMATION SYSTEMS</u>:

It is reasonable to expect that the tremendous advances in the field of
information systems will have a great impact on medical training and
health care delivery. The Annual OSR meeting offered an opportunity to
hear about some of the experimental applications of this technology.
Having noted a substantial interest in the pros and cons of these
developments, it was decided to form an Ad Hoc Committee for Study of
Information Systems. An initial report will be prepared identifying
areas that need to be addressed in order to become informed about these
systems. Areas to be discussed will include the specific pros and cons
of integrating computers into medical education; reviews of various
types of programs now in use for teaching medical students; and hope-
fully some inquiry into the impact that this new technology will have
on the way medicine is practiced. We will also try to explore ways to
improve medical students' access to computers, including Congressional
actions that could facilitate donations of computers to educational
institutions.

MICRO COMPUTERS AND MEDICAL EDUCATION

Prepared by Steve Hasley
OSR member, University of Pittsburgh
Chair, adhoc OSR Committee on Study of Information Systems

It seems likely that computer systems will have a increasingly important role in the future of medical education, as well as in medical practice. Micro computers will play an increasingly important role in these advances. They are at once sophisticated enough to act as self-contained units, yet flexible enough to be used to access national systems of educational programs and data bases. This paper will examine the various functions of micro-computers relating to medical education. The role of computers in medical education and possible directions for the AAMC/OSR to pursue will also be discussed.

To understand the functions of micros within a computer system, the system as a whole must first be understood. Computer systems consist of several parts. The hardware is the physical machine itself. Software is the programming that makes the machine work. Part of the software, the operating system, comes with the computer. Software may also be programmed in by the user or may be purchased as a commercial package. Micros can also "borrow" the software of other bigger computers via a MODEM, a piece of hardware that lets computers talk over the telephone.

An example of tieing into a larger system would be the interactive computer assisted education programs from the Massachusetts General Hospital. A student is presented with a short history, and by asking questions can examine, diagnose, and treat the "patient". As the student works through the case, the computer will offer suggestions, and even refuse to do some esoteric procedures until the student has assured the stabilization of the patient. All that is

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needed for a student to use this system is a micro (in this case being used as a terminal) a modem, and a phone. In addition the school must have signed up with MGH and have the necessary instruction books. No programming is required of either the school or the student.

An example of commercially available software would be a type of data base management system (DBMS). This type of program would enable a medical student to create a file of all the drugs he has learned, for example. A record of each drug could contain name, class, method of action, side effects, dosage, etc. The software would enable the student to create, fill, and search this file. He could list all the drugs with the side effect of pancreatitis or generate a cross-reference list of drug class interactions. In addition to teaching students how to organize information electronically, this function would help also to teach how an isolated fact is connected to the whole body of medical knowledge. DBMS are commercially available for several hundred dollars and can be used with a micro such as Apple II.

There are now some commercial software programs specifically geared for medical information. The Problem Knowledge Coupler (PKC, 9 N. Michigan Ave., Suite 1620, Chicago, IL, 60611) and the Microcomputer Diagnostic Indexing system (MDI, Box 5223, Boston, MA, 02206) are two systems that are specifically set up to store, retrieve and cross reference medical information. Currently these programs will not run on every available micro. MDI needs a 64K TRS 80 (Radio Shack computer with 64,000 bytes of memory); PKC uses a Northstar Advantage, also 64K. These programs can be adapted to run on any 64K micro; however, a knowledgeable programmer is needed. It seems likely that more medical oriented DBMS's will appear in the future and that they will be compatible with a wider range of micros.

The third component of a computer system is a data base, a collection of facts stored in a computer. These data bases can either be huge national com-

pendiums of information or ones created by the user for his own reference.
Micros can be used in both of these applications. National data bases include
MEDLINE, BIOSIS, and SCISEARCH. Access to these storehouses of information via
micro and modem reduces hours of searching the literature to seconds. Another
national data base is the AMA/GTE nationwide medical network. Currently this
system has data bases on Drug Information, Disease Information, Socioeconomic
Bibliographic Information, and Medical Procedures, Coding and Nomenclature.
Access to these National data bases is something all medical students could
benefit from.

The other type of data base would be one created by the user, as in the drug
example above. With the use of commercially available software, students could
constantly expand their medical knowledge; not only by adding new facts, but by
seeing how each new fact fits into the whole system of medical knowledge. Again,
no programming skills are necessary, just access to a micro, and a $300 program.

It is unfortunate that there are not more commercially available programs
specifically geared to medical information. One of the main reasons for this paucity
is that computer engineers do not understand the complexities and inter-
relationships of medical knowledge. The best new medical programs will come
from physicions who have learned to manipulate computers, not from engineers.
In order that this new software be expediently created, medical students need
access to computers.

While it is clear that medical students would greatly benefit from access
to computers, it is difficult to know what is the best path for OSR to pursue
to help this movement along. It may be advisable to contact computer companies
(which should be aware that most doctors will eventually own a computer) and
inquire about donations of computers to medical schools. Apple Computer Inc.
spent a great deal of effort last year trying to convince Congress to grant a
tax deduction to computer companies that donate computers to elementary and

secondary schools (see following article from "Business Report"). Clearly this idea is fraught with complications, but we should not consider the avenue closed. In addition, since the current information relating to medical applications of computers is somewhat diffuse, I would request that the AAMC/OSR support efforts to compile and review lists of relevant commercially available software, national data bases, computer assisted educational programs, and medical computer literature. Subsequently, this information could be shared in digested form with medical students and deans. The impact of computers on medical education, and medical information in general, requires that students have access to and information about this powerful set of tools.

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OSR ACTIVITIES TO INCREASE CAREER GUIDANCE RESOURCES

As described on page three of the September OSR Administrative Board meeting minutes, a proposal ("Overview of the Specialty Choice Dilemmas of Medical Students") was developed and sent to the Council of Medical Specialty Societies (CMSS). The CMSS Manpower Committee considered it at its November meeting; a copy of the disappointing response is included here as well as the proposal.

The mailing to the student affairs deans and OSR members, listing examples of innovative career guidance programs, is still in preparation. As an information item, a copy of the draft cover memorandum is included in the agenda.

Overview of the Specialty Choice Dilemmas

of Medical Students

Since its formation in 1971, the Organization of Student Representatives (OSR) of the AAMC has frequently expressed concern about medical students' unmet career counseling needs. With each passing year these needs have continued to increase while resources available and programs designed to address them, at most medical centers, have not. Escalating problems in this area prompted the OSR to devote a portion of its 1982 regional meetings to collecting perspectives from the representatives about students' career dilemmas. What follows is a summary, based on these sessions, of pressures surrounding the specialty selection process. This summary was prepared as a discussion item for the Council of Medical Specialty Societies in the hope that the Council may desire to play a role in addressing these challenges.

Depending on one's perspective, the present era is either one of expanding opportunities or compounding constraints in the practice of medicine. New technology, drugs, procedures are opening surprising frontiers in patient care. Graduates of medical schools today can pick from among 23 areas in which it is possible to obtain board certification, not to mention the greater-than-ever variety of practice modes and settings. For a large proportion of medical students, however, excitement about the broad range of possibilities is much less characteristic than anxiety and confusion about which direction to pursue. A national study conducted in 1976 showed that only 14% of U.S. graduates who

indicated a specific specialty at time of application to medical school chose the specialty of original interest four years later.[1] The remaining thousands of students must work within a rather narrow time period in arriving at a decision: residency program application deadlines occur in December of senior year (NRMP Match rank-ordering forms are due in January), and the majority of U.S. medical schools offer a 'split' curriculum such that during the first two years there is little clinical content and most teaching is provided by Ph.D.s. Logistical problems which arise are troublesome, e.g., the application deadline for ophthalmology programs comes before many students can complete an elective in that specialty. But more significant is the fact that students feel they do not receive broad enough exposure to even the major specialties to be able to assess confidently their own personal characteristics vis-a-vis each specialty's.

For better or for worse, clerkships represent the first important exposure to and a major source of information on the different specialties. The 'slice of life' which the student sees during his or her four-to-twelve weeks in a given place may or may not represent adequately the academic practice of that area; certainly students learn little about practice outside the hospital. Rural electives and other kinds of preceptorships are usually available so that students can broaden their images beyond the walls of the teaching hospital, but obtaining a balanced view remains an achievement. Another limiting factor is the paucity of individual attention medical students receive from attendings, i.e., potential role models. A great deal of the teaching is provided by harried

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[1]Cuca, J.M., *Career Choices of the 1976 graduates of U.S. Medical Schools,* Washington, D.C.: AAMC, 1977.

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residents who may not be well equipped to assist students in

weighing features of specialties. Students not only need help in

forming a picture of the 'typical' day of a specialist in terms of

pathology and procedures, they also are increasingly seeking indica-

tions about the future employment picture. Unsure about whether to

factor in the projections generated by GMENAC, students try

hard to believe that opportunities will exist in the specialty and

geographic area of their choosing.

Difficulties inherent in assessing present and predicting future

specialty characteristics are exacerbated for students unable to

assess their personal goals, values, strengths and weaknesses;

before a match can be sought, this side of the equation needs to be

filled in. Moreover, since students experience very early pressures

to 'declare' themselves, the inabilty to do so is accompanied by a

vague sense of guilt. Faculty and friends seem always to be

inquiring, orientation to medical school may include suggestions

about beginning the specialty selection process; and, most influ-

entially, the sooner a decision can be made, the more time to

develop a strategy for obtaining a desirable residency position.

With the still increasing number of applicants to residency programs

and the now decreasing number of slots, competition for entrance

into those programs which attract U.S. graduates is such that

students are reminded of the medical school application process.

Components of an application strategy include but are not limited

to: 1) thorough investigation of a cross-section of programs in the

chosen specialty (in the absence of any centralized source of the

most useful information about programs); 2) scheduling electives at

those medical centers to which one has applied and procuring loans
to finance these and interviewing trips; 3) decisions regarding how
much effort to expend preparing for the National Boards since many
programs require report of these scores. For many students, instead
of guided opportunities to continue their general professional
education, the senior year has come to resemble a mail campaign and
shopping expedition.

Even students who do not experience heavy internal or external
pressures to enter a particular graduate program and who do not
allow the application process to interfere greatly with their under-
graduate education feel the need for more guidance in choosing a
specialty than is generally available. Student affairs and academic
deans have numerous other responsibilities, including preparation of
the dean's letter to program directors and coordinating the NRMP
Match, and many have limited capacities to answer students' ques-
tions. Advising systems at most schools leave much to be desired,
with faculty tending to recruit or discourage as frequently as they
share their expertise. Many faculty who serve as advisors are
uncomfortable about not possessing up-to-date information of the
kind their students request.

The member organizations of CMSS could encourage their practicing
members to become advisor resources to local schools. Moreover,
member societies might consider compiling concise and balanced
summaries of the practice characteristics of their specialties
which could be used by faculty advisors and available in dean's
offices for students to read. A more vivid method would be to
video-tape a panel discussion (or presentation by one leading

representative) on the range of opportunities in and unique features of each specialty. It is hoped that CMSS members may have additional ideas on ways in which it might contribute to helping students formulate and assess career decisions.

CMSS

COUNCIL OF MEDICAL SPECIALTY SOCIETIES

P.O. Box 70, Lake Forest, Illinois 60045 • (312) 295-3456

December 29, 1982

Janet Bickel
Association of American Medical Colleges
One Dupont Circle
Washington, D.C. 20036

Dear Janet:

I am sorry for the delay in getting the information to you about the recent CMSS Manpower Committee discussion concerning the AAMC proposal for overview of medical student's specialty choice decisions.

The Committee at its November meeting reviewed the AAMC proposal suggesting that CMSS member societies consider ways to assist medical students in career choices. The Committee recalled earlier deliberations regarding this, including some of the administrative difficulties such as printing costs of career choice brochures, mailing costs, etc. The Committee therefore felt that the medical schools were best equipped to handle the problem at the local level. Further, the Committee encouraged specialty societies to cooperate within their available frameworks with the medical schools.

In view of this decision, I am enclosing a copy of the list of member organizations of CMSS. Several I know already have programs of the type you are interested in developing while others have indicated that they would be willing to develop a program. Please feel free to write directly to them. I personally feel that this approach will prove fruitful to AAMC should it be pursued.

With best wishes for the New Year.

Cordially,

L. Jack Carow III
Deputy Executive Vice President

cc: August Swanson, M.D.
     William F. Donaldson, M.D.
     Richard S. Wilbur, M.D.

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DRAFT

M E M O R A N D U M

TO: Deans of Student Affairs

FROM: Ed Schwager, Chairperson, Organization of Student Representatives
          Robert Keimowitz, M.D., Chairman, Group on Student Affairs

That medical students need more guidance in selecting a specialty than is
generally provided is the recommendation proceeding from a series of OSR-
sponsored regional discussions and a follow-up survey. The goal of these
efforts was to identify innovative programs on-going at schools which students
are finding useful in helping them through the specialty selection maze. It
is now time to share the results with you.

It is highly appropriate for OSR and GSA members to work together in increasing
opportunities for students to enhance career decision-making skills. What
emerged from the OSR survey is that students feel they are operating in such a
vaccum that every bit of assistance helps. The information provided in the
attachment is offered, therefore, not as an exhaustive overview or list of
possibilities but as suggestions which, it is hoped, may stimulate you to
explore, within the limits of institutional resources, what can be done to
improve the career-decision-making environment.

Perhaps you will want to share these materials with other deans and faculty.
We welcome responses, positive or negative; these might best be forwarded to
Janet Bickel (AAMC Division of Student Programs) who has been responsible
for coordinating this effort.

cc: OSR Members

Attachment