

6/26



# association of american medical colleges

## OSR ADMINISTRATIVE BOARD MEETING

June 13, 1984

8:30 am/5:00 pm

Second Floor Conference Room

- I. Call to Order & Chairperson's Report
- II. Consideration of April Meeting Minutes
- III. ACTION ITEM
  - A. Nomination of LCME Student Participant. . . . .1  
(Reference letters & c.v.s are separate attachment)
- IV. DISCUSSION ITEMS
  - A. Finalizing Annual Meeting Programs. . . . .2
  - B. Revising "Ethical Guidelines for the Clinical Years"
  - C. Draft of "Residency Interview Travel Tips"
  - D. Computer Networking Project
  - E. GPEP Report
- V. INFORMATION ITEMS
  - A. Financial Aid Update
  - B. MCAT Experimental Essay Program
  - C. Report from OSR designee to NRMP Board. . . . .3
- VI. Old Business
- VII. New Business
- VIII. Adjournment

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LCME APPLICANTS (6/84)

<u>NAME</u>	<u>SCHOOL</u>	<u>NAME OF REFEREE (S)</u>
Moises Arriaga, '85 Alois J. Binder	Brown University Louisiana State University School of Medicine in New Orleans	Stephen R. Smith, M.D. Paul F. Larson, M.D. and James T. Hamlin III, M.D.
Peggy S. Braasch, '85 Alan C. Braverman, '85 Sandra Brooks, '85 Sharon Burke, '85 William J. Burman, '85 John F. Coughlin, '85 Barbara Fleming, '86 Carrie Gamache, '85 Ann C. Jobe, '86	University of Pittsburgh University of Missouri-Kansas City Howard University Wayne State University Mayo Medical School Georgetown University University of Maryland St. Louis University University of Nevada	Donald F. Leon, M.D. Harry S. Jonas, M.D. Russell L. Miller, M.D. Sanford N. Cohen, M.D. R.S. Rogers III, M.D. Jon J. O'Brien, S.J., D.O. Bernice Sigman, M.D. William Stonemann III, M.D. Grant D. Miller, M.D. and Robert M. Daugherty, Jr., M.D. John P. Steward, M.D.
Michael Lemmers, '85 Carol Mangione, '85 David Scott Miller, '85 Elizabeth Ann Newsom, '85 Mary Margaret O'Neill, '85 Lennis L. Percy, '85 Geoffrey Davis Reiser, '84 Bob Sherrick, '85 Steven B. Spedale, '85 Eric Spitzberg, '85 Phillip Ashley Wackym, '85	Stanford University University of California, San Fran. The Pennsylvania State University University of California, Los Ang. Creighton University University of South Carolina Medical U. of South Carolina The George Washington University The University of Texas Sunny/Bufalo Vanderbilt University	Alan Goldfien, M.D. Cheston M. Berlin, M.D. Martin A. Pops, M.D. Matthew J. Severin, Ph.D. J. O'Neal Humphries, M.D. W. Marcus Newberry, M.D. L. Thompson Bowles, M.D., Ph.D. James A. Chappell, M.D. Frank Schimpfhauser, Ph.D. John E. Chapman, M.D. and George F. Gray, JR., M.D. William J. Reals, M.D. and D. Kay Clawson, M.D.
Dael M. Waxman, '85	University of Kansas	Charles L. Votaw, M.D., Ph.D. Major W. Bradshaw, M.D., F.A.C.P.
Elizabeth Anne Williams, '85 Charles Woods, '85	East Tennessee State University Baylor College of Medicine	

*at end of file*

306 Riverway, #10  
Boston, MA 02215  
April 26, 1984

Dear OSR Ad Board:

I represented the OSR at the annual National Resident Matching Program Board of Directors meeting on April 23 & 24. The following items may be of interest to you:

The 1983-84 Match program was carried out quite smoothly despite the major increase in applicants. Preliminary results indicate that the new couples paired-choice algorithm worked quite well. Delivery of Match results went very well with all but one school receiving result packages as anticipated on Monday, March 12. The mechanism for advanced programs for students operated successfully and it is hoped that this will reassure subspecialties who are currently using early, non-NRMP matches that the NRMP can meet their needs.

Independent applicant fees will be increased from \$40 to \$45. Because of the increased handling required for the delivery of information and results to these applicants, this seems justified.

A couples charge of \$10 per paired-choices rank order list will be added. The processing of couples requires several-fold more work than for single applicants. Approximately 30% of applications contained errors requiring editing before they could be submitted to the computer. Note that each partner may rank 10 different programs (not 10 pairs of programs) for the basic fee.

An ad hoc Chairmen's Advisory Panel to the Board of Directors of the NRMP consisting of representatives from each of the major academic chairmen's groups, including those who currently participate in the Colenbrander match will be established. This will allow opportunities for the specialties to express concerns and dissatisfactions with the Match.

The NRMP appreciates the efforts of the OSR to report violations of the Match agreement and will act on such evidence. Breaches of contract can only undermine the efforts of the Match to provide the most equitable means for the admissions process in graduate medical education.

I presume you are in the process of selecting a student to participate as an "observer" at the next meeting, then assume my position as a board member. I have been re-elected to the Executive Committee and will complete my term at the next meeting, April 30, 1985.

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PROGRAMS  
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MEDICAL COLLEGE

In my experience, the NRMP has been very receptive to student (and house-officer)input, and it has been a pleasure as well as a valuable learning experience to participate in the meetings. Thank you for allowing me to represent the OSR. Please keep me informed of the OSR's activities and ideas pertaining to the Match.

Sincerely yours,

*Patricia A. Pellikka*

Patricia A. Pellikka, M.D.

## EVALUATION OF ATTITUDINAL CHANGE IN MEDICAL EDUCATION

David H. Rosen, M.D., University of Rochester

The purpose of this symposium is to review research directed at understanding attitudinal change and to evaluate its significance in relation to medical education.

The topic is timely in that medicine watchers (Thomas, 1983) and medical educators (American Board of Internal Medicine, 1983) have become increasingly concerned about the deterioration of physicianly attitudes as medicine becomes more technological. This development is occurring in the context of mounting evidence that the experience of medical school has a negative impact on attitudes. It has been well documented that cynicism and detachment develop if attitudinal and interpersonal skills are not attended to during medical school (Eron, 1955 and Korsch, 1971). Some investigators have argued that it is the stress of medical school that causes the deterioration in attitudes (Becker and Geer, 1958). Regardless of stress being a causal factor, other researchers have noted that one's reaction to stress must be examined in light of the individual's attitudes towards stressful change as well as an assessment of one's ability to adapt to that change (Hinkle, 1974 and Brown, 1974).

A number of evaluative studies have shown that physicianly attitudes can be sustained and even enhanced by various educational interventions. The most effective educational experiences involve didactic (content) as well as behavioral (process) components (Rezler, 1974; Cooper et al., 1980; and Larson, et al., 1980).

The three panelists (Drs. Levenkron, Krackov, and Rosen) will address the following questions from their unique perspectives:

1. When evaluating medical education, why measure something as soft as attitudes?
2. Do changes in attitudes correlate positively with mastery of knowledge?
3. How does a didactic (cognitive) focus versus a process (behavioral or clinical) focus affect attitudinal change?

### Attitudinal Change for Health Promotion

Jeffrey C. Levenkron, Ph.D.

The attitudes held by physicians about health promotion and disease prevention have been viewed as important determinants of whether or not doctors make an effort to influence the health behaviors of their patients. The physicians' beliefs that certain behaviors affect health appears to be a necessary condition for putting health behavior change into clinical practice (Dismuke & Miller, 1983).

1. When evaluating medical education, why measure something as soft as attitudes?

Clearly our attitudes reflect our philosophy and the paradigm we use in caring for patients and in teaching medicine. Attitudes are "soft" in the sense that they are subjective but that does not detract from their importance or validity. One of the most serious drawbacks of English or American science is its over-reliance on "hard" data. We endorse the German version of science, the "Wissenschaft," that goes beyond objective English science and encompasses all of human experience including the intuitive and subjective (Weiss, 1978).

Attitudes related to the human experience of medicine are directly reflective of four guiding precepts: acceptance, empathy, conceptualization and competence (Reiser and Rosen, 1984). Acceptance and empathy are essential to developing a healing partnership with one's patients. Both stem from self-awareness, for it is difficult if not impossible to accept another human being if you have not first accepted yourself. Conceptualization, utilizing the biopsychosocial paradigm, is directly related to comprehensive medical care and also relates integrally to competence. It is noteworthy that the need for active caring with related attitudinal and behavioral features is being seen as central to the successful practice of clinical medicine (Burnam, 1979; American Board of Internal Medicine, 1979).

2. Do changes in attitudes correlate positively with mastery of knowledge?

Generally, the answer is no to this question. The critical variable is a behavioral experience that brings the mastery of knowledge to life. This may be why there is such an erosion of the idealistic and humanistic attitudes that entering medical students bring with them to medicine. The knowledge explosion and the resultant stuffing of factual information into the heads of medical students leaves little room for humanistic attitudes, interpersonal skills, and problem-solving abilities to flourish.

3. How does a content (knowledge) focus versus a process (clinical) focus affect attitudinal change?

We have found that a purely didactic approach to teaching psychosocial medicine has a negative impact on attitudes and related interpersonal and clinical skills. The key to sustaining and enhancing attitudes conducive to comprehensive and humanistic care is to teach by example, i.e., by modeling an integrative approach that combines content (knowledge which is essential) and process (a behavioral experience in caring for patients) and utilizes the new paradigm in medicine (Engel, 1980; Rosen & Blackwell, 1982; Reiser & Rosen, 1984).

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# MUST ANIMALS BE USED IN BIOMEDICAL RESEARCH?

**T**he Association of Professors of Medicine (APM) is the organization that represents the chairmen of departments of internal medicine in the nation's medical schools. In addition to teaching and patient care responsibilities, the individual members of APM have extensive personal involvement in the conduct of biomedical research.

**T**he scientific community is sensitive to public concerns regarding how and why animals are used in research. Through this brochure, the APM hopes to address these concerns and clarify the essential role of animals in the search for medical knowledge which will save lives and relieve human suffering.

## What role do animals play in biomedical research?

Animals are used as substitutes for humans in research regarding the diagnosis, treatment, and prevention of disease. Virtually every major advance in medical science has been predicated on knowledge gained through research involving animals. The benefits to mankind of these achievements are impossible to measure. A good case in point is the development of insulin for the treatment of diabetes. There are in the United States alone approximately 11 million diabetics, most of whom live normal lives with the aid of insulin injections. Previous treatment for diabetes consisted of starvation diet to delay, however briefly, the inevitable death of the patient. Another good example is the development of a vaccine against polio—a disease which previously victimized in this country alone approximately 30,000 people each year, most of them children. Discovery of the polio vaccine has resulted in the almost total eradication of the disease. These are just two examples of how research involving animals has enabled millions to lead longer, healthier lives. There are countless others including:

- Improved treatments for heart attacks such as pacemakers and coronary artery bypass surgery
- Improved management of high blood pressure
- Liver, kidney, heart, lung, and bone marrow transplantation procedures
- Kidney dialysis
- Artificial limbs and hip replacements
- Vaccines against a variety of diseases including smallpox, mumps, measles, rubella, diphtheria, and tetanus

The development of these innovations depended upon research involving animal subjects.

Of course, many questions regarding human illness remain unanswered. Biomedical researchers are currently seeking methods to prevent or improve the treatment of a wide range of diseases including leukemia and other forms of cancer, multiple sclerosis, muscular dystrophy, and diseases of the heart and kidney. As substitutes for humans, animals are essential to this research activity.

In addition, animals are used to test the safety and efficacy of drugs. In this way, the toxicity and the potential side effects of drugs are identified before they are administered to humans.

## Are there alternatives to using animals?

Knowledge obtained through research involving animals has been and will continue to be supplemented by information obtained through alternative methods. Wherever possible, scientists employ non-animal techniques—not only to spare the animals but also because they are very expensive to procure and maintain. In fact, the increased use of alternative methods has resulted in a 50% decline in the use of animals in research since 1968. It is obvious, however, that human organs and their functions cannot be replicated solely through these techniques. The flow of blood to and from the heart, the digestive process, and the function of the brain and nervous system cannot be simulated in a test tube or through use of a computer. Improvements in medical care will of necessity continue to rely—at least in part—on the use of animals.

It is important to note that the development of alternative methods cannot be viewed as a separate science. Non-animal methods are developed in the course of research on substantive objectives. An important part of the scientific process is the continual improvement of research techniques—including methods which use fewer or no animals.

## Are laboratory animals treated humanely?

There has been considerable publicity and misinformation surrounding some isolated incidents of mistreatment of laboratory animals. In reality, the humane treatment of animals is almost always assured by:

- 1) **The Scientist:** Along with the general public, research scientists are appalled by the abuse of animals whether in a scientific, industrial, or sporting environment. Researchers themselves assure

that laboratory animals receive proper care for humanitarian reasons as well as in the interest of scientific quality. Important knowledge cannot be obtained from experiments involving poorly maintained or abused animals.

- 2) **The Institution:** Universities and medical schools have committees which inspect animal care facilities and actively oversee the use of animals in research.
- 3) **External Controls:** The Federal government has established standards for the care of laboratory animals. Animals must be housed in sufficiently large cages which are kept clean and adequately ventilated. Anesthesia must be used in the performance of potentially painful procedures. Animal care facilities are inspected by the Animal and Plant Health Inspection Service of the U.S. Department of Agriculture. In addition, many facilities are accredited by the American Association for the Accreditation of Laboratory Animal Care.

## Why is the use of animals in research so controversial?

All of us have personally benefitted from the abilities of modern medicine to prevent and treat many devastating diseases. Yet there are those who fail to understand or accept the fact that the improvement of health care depends upon research involving animals. These individuals mistakenly insist that the use of animals in research is inhumane and unnecessary.

Unfortunately, this public confusion has been exacerbated by the misguided efforts of certain well-intentioned animal rights groups. Many of us support organizations dedicated to the provision of shelter for homeless animals and the preservation of endangered species. However, there is an important distinction between these groups and those which seek to limit—if not totally eliminate—the use of animals in research. These organizations attempt to accomplish this goal in a variety of ways. Many have raised large sums of money to lobby for Federal and local legislation which would inhibit or ban

research involving animals. Some have successfully advocated the repeal of local laws which permit laboratories to obtain unwanted animals from shelters—facilities which last year alone had to destroy approximately 13 million homeless dogs and cats. Some of the more radical organizations have orchestrated demonstrations or break-ins at research facilities to “liberate” laboratory animals. Others go so far as to suggest that the use of prisoners or elderly patients as research subjects would be preferable to the use of animals.

For obvious reasons, there is sharp disagreement between these organizations and research scientists who are dedicated to the relief of human suffering. It is difficult for the biomedical community to comprehend that some would oppose research using animals—even rats and mice—which might lead to a vaccine or cure for a disease such as muscular dystrophy which strikes an average of 4,000 children each year. In addition to ignoring the benefits of such research to mankind, it is ironic that these organizations also fail to recognize its positive impact on the quality of veterinary care. Research using animals has also resulted in the development of vaccines which prevent disease in pets and livestock.

The Association of Professors of Medicine hopes this brochure clarifies the essential role of animals in biomedical research and testing. Additional copies may be obtained by writing to:

Association of Professors of Medicine  
One Dupont Circle, N.W.  
Suite 250  
Washington, D.C. 20036



June 15, 1984

Ms. Pam Close, M.D.  
Chairperson, Organization of Student Representatives  
AAMC  
Suite 200  
One Cupont Circle, N.W.  
Washington, D.C. 20036

Dear Pam,

First I want to thank you and the OSR for the privilege of serving on the Committee on Financial Assistance. The state of financial aid has been a long standing interest of mine. Participating in this capacity gives me a chance to impart a student's perspective and to broaden my own understanding. I am eager for input and information you or anyone in the OSR would like me to see.

This year I have attended two meetings, the first on January 30, and the second on May 23. I understand that you receive copies of the minutes of the Committee on Financial Aid meetings so repeating the detail of these reports seems pointless. Instead I will comment briefly on the activities and interests of the committee. To begin, I must say that this is among the busiest, well organized, and efficiently directed working groups on which I have served. By perusing the minutes you will see that much is considered in only one day. The committee directs its interests in three broad areas. These are national legislation, financial aid concerns of the local school office for student aid, and the student and financial aid.

Perhaps the committee's most effective and far reaching activities revolve around legislation. Two staff legal assistants monitor and summarize the status of pertinent bills and proposals on Capitol Hill. Based on these reports the committee discusses and recommends priorities for action and lobbying. Current bills concern all federal financial aid programs for medical students. Please see the minutes for detail. Also the issues of financial independence/dependence for students is in discussion but there will likely be no change. Another busy area concerns the payback of loans and costs associated with collection and default. Don't look for improvements in federal assistance. Loan levels may rise, but they will continue to be more regulated and more expensive to obtain. The alarming implications of increasing student indebtedness are not as politically pressing as budget cutting and the perception that there will be too many doctors out there making plenty of money to pay off those loans. The committee has made recommendations to the AAMC to press for increasing the yearly Guaranteed Student Loan to \$10,000, and to increase the total GSL aggregate. The committee advises that the independence/dependence issue be left as is. Generally it is urged that funding levels for all programs rise, that loan consolidation be expanded and encouraged, and that the excessively costly programs such as HEAL be made more affordable for students. Many other legislative rules and requirements are considered

and dealt with which may cause problems for financial aid offices.

The other two foci of interest are the local financial aid office and the individual student. Programs are given at regional and national meetings by members. Committee members now are working on recommendations for computerizing a financial aid office. A recent publication, Financial Planning and Management Manual for U.S. Medical Students, which I am sure Bob Boerner has forwarded you is of special import and merit. It is by far the most succinct and useful booklet concerning financial aid and the student. Any and all publicity you can generate for this booklet which is available through the AAMC is needed. One school plans to buy copies for its students. Others have suggested contacting drug reps about providing the booklet. School bookstores could be asked to carry it, and local Financial Aid Offices and student governments could be encouraged to spread the word on the value of this publication for students planning now and after graduation.

The committee itself is made up mostly of financial aid administrators representing all regions of the country. Student affairs Deans also have a representative, and there are various other guests and officials in attendance. The committee's first priority is the goal to ensure that students with the greatest need receive the most and best help. This goal guides the decisions and recommendations more than any other consideration. Special interest therefore centers around minority and underprivileged access to funds.

Thankyou again for the honor of serving the OSR on this committee. I look forward to participating further this next year. I'd like to know what people think and need in the different regions and schools. Please feel free to contact me with issues and ideas which might concern my work on the Committee on Financial Assistance.

Sincerely,

*Leslie E. Smith Jr., Univ. of Tenn.*

Leslie E. Smith Jr.  
1899 Poplar Avenue #68  
Memphis, Tennessee 38104



# association of american medical colleges

## MCAT Experimental Essay Project Guidelines for the Development of Essay Questions

The following information is provided to serve as guidelines for the development of essay questions for the Medical College Admission Test (MCAT) Experimental Essay Project.

- I. Questions are to be designed to provide the opportunity for the writer to demonstrate the following skills in the organization, composition and expression of the answer to the question:
  1. Ability to synthesize concepts/ideas
  2. Sequential thinking - reasoning
  3. Ability to develop alternative hypotheses
  4. Cohesiveness of presentation
  5. Ability to separate relevant information from irrelevant information
  6. Definition of central idea
  
- II. Question writers must consider the following factors when developing questions:
  1. Questions should have no relationship to the medical school application process or the candidate's reasons for the choice of career, i.e., Why I want to become a physician?: Why I am your best applicant?
  2. Questions should not relate to health care issues.
  3. Questions should not relate to religion or religious issues.
  4. Questions are to avoid social issues (subjects) that may result in judgemental statements/opinions of the writer and/or evaluator of the essay.
  5. Questions must be developed from sources (subject or content areas) that do not hinder the ability of any candidate to respond fully because of differences in social, ethnic and geographical background and experiences. Question writers must be sensitive to the background and experiential differences between the majority and minority student populations.
  6. Questions must not use the content of biology, chemistry or physics as a source area for questions.



# association of american medical colleges

## MCAT Experimental Essay Project Research Issues

1. Impact on writing preparation of students
  - identify baseline of performance today in medical school.
  - relationship of clinical clerk performance on essay to usual performance information.
2. Impact on admissions decisions
  - with and without essay information
  - Is information useful?
  - same or different people selected?
  - How used? What point in admissions process?  
Placement and use of essay at the various stages of the admission process--case study.
  - on disadvantaged and minority student admissions
  - changes in medical school requirements?
  - shift in majors of applicant population?
3. Impact on college/university undergraduate curriculum
  - Impact on choice of courses, e.g., kind and number.
4. Correlational studies with other admissions criteria and performance criteria (MCAT, Board scores, etc.)
5. Attitudinal change
  - a. students
  - b. admission committee
  - c. advisors (change in advisor demographics)
  - d. medical school faculty
6. Scoring/non-scoring/sample scoring
  - If local scoring, the kind of scoring support provided
  - comparing central scoring with no scoring
  - Comparing local scoring with no scoring
  - Importance attached to small performance differences
  - Form of score reports to minimize abuses
  - Variations in reporting scores (pass-fail, bands, etc.)
7. Modeling of various uses of essay and impact on applicant characteristics.
8. Score of thinking skill?
  - of communication skill?

March 1984, DEMR/Essay Committee

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

PROPOSAL FOR COMPUTER TELECOMMUNICATIONS NETWORKING  
FOR USE IN AAMC/OSR PROJECT DEVELOPMENT

A perennial and significantly limiting problem encountered by widely dispersed professional and educational associations such as the OSR, or any of the constituent bodies and groups of the AAMC, is the difficulty individual members of the organization have in collectively working to develop programs, projects, etc. The current method usually entails the interested individuals meeting in person at a regional or national meeting, and then attempting to follow-up with further in-person meetings or through the mails. Unless the qualified and interested individuals live in the same city (as is usually not the case in the AAMC) personal meetings are expensive. Follow-up by mail involves considerable delays and the possibility of losing material with each revision, as well as delays in responding to revisions causing considerable incoordination in the work effort. The resulting attenuation frequently results in a less than maximal result with the actual input into the project from the 2-3 people with the best communication, or else in no project at all.

As a solution to this basic functional problem of a national organization with only a few members in any single location, the OSR proposes to establish a telecommunications network based on a mainframe computer with a central location. Authorized individuals developing the project would be able to immediately access a word processing program in which there would be each individual's current concept of, and version of the project, as well as the collected edited version. Each individual would need a computer module with a telephone modem, and would incur telephone cost to edit his version, or review others. Each individual could also leave messages in the program files for other contributing members of the group, and be sure they would receive them the next time they accessed the program. This would eliminate the attenuation inherent in the repeated mailing process, as well as introduce an element of accountability by making it impossible to hide from messages or behind the mails. Finally, each contributor's input would be equally and constantly available, regardless of their geographic separation or secretarial support.

Specifically, we are requesting memory space and telephone access to the AAMC mainframe computer for use in developing this project development system. Our needs would be for a maximum of 10 participating individuals with 10,000 sectors of memory each - a total of 100,000 sectors. In addition, we would need a telephone link access to these 100,000 sectors only, with a program design that would make it impossible for anyone to use this access to enter the AAMC's sensitive files, or any other AAMC data beyond the specified 100,000 sectors. This system will also require each contributor to have a computer module with a modem compatible with the mainframe's program, however, these are widely available at the individual medical schools. Finally, funding for the incurred telephone costs will be necessary; however, we believe we will be able to develop outside funding once we have a workable system in place.

The OSR national meeting is an extraordinarily fruitful place for the expression of ideas that could be developed by the interested students, as well as faculty, administrators and AAMC staff into worthwhile projects for the advancement of medical education. It is our hope to instigate a system to facilitate the development of the most worthwhile of these ideas by the most interested and qualified members of the AAMC. We hope this may be available by the next national meeting.

QUOTATIONS FROM THE REPORT OF THE  
AAMC COMMISSION ON MEDICAL EDUCATION

Published in 1932

The Commission has believed from the beginning that an emphasis on educational principles in medical training and licensure can be secured only by modifying the point of view and broadening the interests of those responsible for medical education and licensure, not by recommendations, statistics, new regulations, further legislation, or manipulation of the curriculum.

The present concept aims to develop sound habits as well as methods of independent study and thought which will equip the student to continue his self-education throughout life. This can be brought about only by freeing medical education from some of its present rigidity, uniformity, and overcrowding and by articulating it more closely with the educational needs of the student. These considerations are very likely to modify in some degree the selection of medical students and what is expected of premedical education.

The medical course can not produce a physician. It can only provide the opportunities for a student to secure an elementary knowledge of the medical sciences and their application to health problems, a training in the methods and spirit of scientific inquiry, and the inspiration and point of view which come from association with those who are devoting themselves to education, research, and practice.

Medicine must be learned by the student, for only a fraction of it can be taught by the faculty. The latter makes the essential contributions of guidance, inspiration, and leadership in learning. The student and the teacher, not the curriculum, are the crucial elements in the educational program.

...the almost frantic attempts to put into the medical course teaching in all phases of scientific and medical knowledge, and the tenacity with which traditional features of teaching are retained have been responsible for great rigidity, overcrowding, and a lack of proper balance in the training. Attempts to correct the difficulties have been largely directed toward rearrangements of the curriculum.

In medical education, as in other forms of education, attention should be directed more to the development of the individual student than to details of the curriculum.

Inasmuch as medical education is primarily concerned with the qualifications and preparation of students to practice medicine, it is highly important that the training be permeated with an understanding of the larger social and economic problems and trends with which medicine must deal, and which are likely to influence the form and opportunities of practice in the future.

There has been a tendency in recent years to attempt to provide instruction in the medical course in the various special fields of practice. This has been responsible in part for the great overburdening of the curriculum and the confusion regarding the purposes of the basic training.

The medical course, partly because of the requirements for licensure, has been concerned more with the factual matter a student had memorized at the time of graduation than with the development of intellectual resourcefulness and sound habits and methods of study. Too great an emphasis has been placed on description and the memorizing of many details and facts which, though they are of little permanent significance, are of immediate value in passing the examinations and in meeting the requirements of licensure to practice.

Premedical education should be general, not preprofessional education. A sound general training is of more value as a preparation for the study of medicine than a narrow, technical training limited largely to the premedical sciences.

If the premedical period is intended for the purposes of general education, it should be permitted to serve these purposes. The tendency of medical schools and regulatory bodies to define in detail the amount and character of premedical education is contrary to the spirit of real education, the unit of which is the student, not the courses or the curriculum.

There has been a tendency on the part of individual medical schools to increase the premedical requirements, particularly in chemistry. In a few instances these requirements are formidable. It is quite likely that the medical profession is losing men and women of high native ability and character who desire to study medicine and who have not been able to meet the specific premedical requirements in the usual college course. The number of semester hours is unimportant, because it is not more but a different type of science teaching which is required for the purposes of both general and premedical education. The particular problem is that of shifting the point of view in the college courses and providing the student with a grasp of the fundamental principles of the sciences rather than with a mass of information and technical procedures, now largely taught by "cook-book" methods.

More attention should be given to the total science preparation rather than to specific hour requirements of individual subjects. The underlying principles and philosophy of the scientific method are far more important than the facts the student may learn. Reasonable substitutions in the science subjects and liberality in the interpretation of premedical education will improve, not impair, the quality of students going into medicine.

It is probably true that a considerable number of very well qualified and desirable students are lost to medicine each year through the insistence upon the letter rather than the spirit of the regulations regarding premedical education. The character, personality, ability, and promise of the student rather than specific courses and credit hours in prescribed subjects are the important factors to be considered.

The chief criticisms expressed by a group of recent graduates may be summarized as follows:

1. There is overcrowding throughout the medical course.
2. Much of the teaching in the science courses in both laboratory and theoretical work does not contribute to a sufficient understanding of these basic sciences. There is an undue emphasis upon laboratory work.
3. Too much of the clinical teaching is from the standpoint of the specialist and on rare diseases. Insufficient attention is given to the ordinary needs of most patients.



4. The divided responsibility for the care of patients and the impersonal attitude so frequently taken toward patients in the hospital and clinics handicap the preparation of students for the assumption of individual responsibility required in practice, and for dealing with the emotional and psychological factors seen in many illnesses.

Although medical students have been exposed to a period of college and university education, most of them are quite incapable of pursuing their medical training independently as graduate students in the strict sense of the word. Furthermore, they are in a new field of endeavor quite foreign to their previous college preparation and it can not be assumed that the earlier training prepares them to make intelligent choice of electives or to use their free time profitably. Only after they have obtained some appreciation of the field of medical education can they be expected to have much of an idea about the relative values of individual courses or special fields of study.

The chief criticism of the training in the medical sciences are directed against the presentation too early of too many details, often of temporary, miscellaneous, and inconsequential value, the overemphasis on the technical procedures of laboratory work, and the artificial segregation of the subjects.

Medical students, however, should not be considered as students successively of physiology, anatomy, or biochemistry, but as students of medicine. The training in the medical sciences should not be considered as preliminary to advanced work in these respective sciences, but rather as an introduction and experience which establishes a foundation for medicine.

Students should be made to realize from the beginning of their clinical studies that the diagnosis in a large majority of illnesses can be made on the basis of a searching history, a thorough physical examination, relatively simple laboratory determinations, and the thoughtful consideration of the problem presented.

Unless the student is required from the beginning to study his patients carefully and in detail, he is liable to develop habits of superficial examination, treatment, and thinking which may be a serious handicap later.

If clinical teaching is to attract and hold teachers of the caliber and ability which it requires, and provide a corps of younger instructors from which the senior members of the staff may be recruited, there must be a fuller recognition of the freedom and dignity which such work should command. Teachers of clinical medicine should not be subject to any restrictions or regulations beyond those imposed upon teachers in other fields of academic work, so far as their university relationships are concerned. The responsibilities for the care and treatment of patients in the hospital and clinics introduce features unknown in other university fields, and place heavy demands upon the clinical teachers, in addition to those which the university position imposes.

At the present time it is probably true that mastery of the clinical subjects and ability to teach are not sufficiently considered in the selection of the personnel of some faculties, and little attention is paid to the preparation of medical teachers in the art of teaching. The great emphasis in selection is placed upon ability and interest in, or willingness to do, research, in which outstanding ability is rare. Too much emphasis is placed upon this single requirement, important as it is.

Properly conducted examinations which are designed to test the student's knowledge and grasp of the principles of medicine are an invaluable method of education to which more attention should be given.

The present system of detailed subject examinations, which rely so largely upon memory and which are still popular in secondary schools and some colleges, tends to defeat the major purposes of the training, which are not the collection of facts but the intelligent and discriminating use of knowledge which is applicable to a given problem.

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**association of american  
medical colleges**

16 July 1984

To Whom It May Concern

RE: OSR June Meeting Agenda

Because so many Board members were unable to attend the regularly scheduled June meeting, an informal meeting was held earlier without the benefit of an Executive Council agenda. Minutes of the April meeting were not written because staff was not present and the tapes were unintelligible.

A handwritten signature in cursive script that reads "Janet Bickel".

Janet Bickel  
Staff Associate  
Div. of Student Programs