



association of american medical colleges

OSR ADMINISTRATIVE BOARD MEETING

September 11, 1:00 - 5:00 p.m.
One Dupont Circle
Basement Conference Room (1B-29)

September 12, 9:00 - 12:00 a.m.
Washington Hilton Hotel
Grant Room

- I. Call to Order
- II. Consideration of June Meeting Minutes.1
- III. ACTION ITEMS (from Executive Council Agenda)
 - A. Modifying the Medicare Payment System (p. 57)
 - B. Matching Medical Students for Advanced Residency Positions (p. 69)
 - C. Report of the Project Panel on the GPEP (p. 70)
- IV. DISCUSSION ITEMS
 - A. Preparation of GPEP Report Discussion Items. 8
 - B. Organization of Annual Meeting Issue Identification and
Discussion Sessions.13
 - C. Revised Ethical Guidelines for the Clinical Years
(to be provided at meeting)
 - D. Financial Aid Program Developments (to be provided at meeting)
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Students Association27
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- VI. Old Business
- VII. New Business
- VIII. Adjournment

DRAFT

**ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES**

MINUTES

June 13, 1984

AAMC Conference Room
Washington, D.C.

Pamelyn Close M.D., Chairperson
Ricardo Sanchez, Chairperson-Elect
Ed Schwager, M.D. Immediate-Past Chairperson

AAMC Staff
Robert Beran, Ph.D.*
Janet Bickel
Robert Boerner*
Brendan Cassidy*
John A.D. Cooper, M.D.*
Lynn Morrison*
August Swanson, M.D.*

Regional Chairpersons:

Pat Hennessey (South Alabama)
Dan Cooper (Colorado)
Roger Hardy (Cincinnati)
Tim Brewer (N.Y. Medical)

Representatives-at-Large:

Mark Schmalz, M.D. (Minneapolis)
Steve Hasley, M.D. (Pittsburgh)

I. Ms. Close called the meeting to order at 8:30 a.m.

II. Review of 1984 Annual Meeting Plans (See attached to minutes)

For the Friday night program, with Drs. Quentin Young and Robert Petersdorf speaking on physicians' social responsibilities, Dr. Close requested Dr. Hasley to serve as moderator. The Board also decided to send special invitations to the AMA-MSS Governing Board about this program. For the discussion groups following Saturday's issues identification session, the Board agreed to solicit co-moderators from the membership; stimulus documents can be mailed with the agenda prior to the meeting on topics which are likely to be one of the seven identified. Ms. Bickel asked the Board for suggestions to convey to the nurses at the University of Chicago who will be participating in the Saturday afternoon OSR program on working with nurses and other health professionals. Mr. Hennessey suggested that the program begin with a brief, open-ended role-played scenario and end with an upbeat one illustrating a well-functioning patient-centered health care team. The Board agreed that the nurses would be best at identifying the most salient problem areas but that the ones addressed should include: the transient nature of medical students' involvement on wards, that attendings and residents with poor interactional practices are often students' role models, why students receive no education regarding the role of nurses, the importance of viewing nurses as educators, and the difficulty students frequently have in admitting they don't know something. Names of some OSR members who are R.N.'s were offered who can be contacted to participate; Mr. Cooper asked that all participants describe their background at the beginning of the program.

The Board discussed the benefits of holding the Saturday night reception outside the hotel and, since Ms. Bickel received no response from the Chicago OSR members about finding a location, Mr. Hardy accepted this responsibility. Board members noted that, because of the high cost of downtown Chicago hotels, it should recommend to OSR members to select the most economical from the list which will appear in the preliminary program to be mailed in August.

Dr. Close recommended that the Sunday discussion groups devoted to GPEP (the General Professional Education of the Physician Project) should have the goal of giving students a realistic background for going back to their schools and working for needed change. The Board provisionally decided to divide the discussion topic areas into three as follows: 1) Baccalaureate Education/Acquiring Learning Skills, 2) Clinical Education, 3) Faculty Involvement. Dr. Close noted that the Monday workshop on the NRMP Match will include a packet with suggestions on scheduling electives and creating a filing system. Ms. Bickel circulated to the Board copies of the preface to the prepublication manuscript of Medicine as a Human Experience by Drs. David Reiser and David Rosen and suggested a program designed by these individuals in place of the previously scheduled workshop on developing teaching skills. While Mr. Hennessey preferred to retain this workshop, recognizing the difficulty of designing a teaching skills program that could be more specific than the one offered last year, the other Board members agreed to ask Drs. Reiser and Rosen to design a program for this Monday time slot.

III. Report of the General Professional Education of the Physician Project (GPEP) Panel

Dr. Swanson explained that the report of the 18-member GPEP Panel was being distributed to the four Administrative Boards and Executive Council for information. The report will be formally released in mid-September; all constituents will be able to read it prior to the AAMC Annual Meeting which will focus on medical student education. He noted that GPEP never intended to design a national curriculum but that the message has come through strongly that present strategies for educating physicians, e.g. many faculty limiting their responsibilities to lecture presentation, are not adequate. He mentioned the 1932 Rappleye Report, the conclusions of which do not differ radically from those of the GPEP panel. The key to improvement is the willingness of deans and faculty to become risk-takers on behalf of medical students.

In response to questions from the Board about the dampening effect that the Liaison Committee on Medical Education (LCME) has on risk-taking, he said that bodies like the LCME are by nature conservative but that its new guidelines represent an improvement; Dr. Swanson expressed optimism that the LCME will be less critical of experimentation than it has in the past. Mr. Cooper suggested that AAMC could play a more aggressive role by serving as an information clearinghouse to highlight the activities of the risk-takers in

medical education. Dr. Swanson recommended that one activity OSR members could help with is making sure every one of their deans and department chairpersons reads the report which will be mailed in September; it is purposely short and students could visit these person's offices and offer reasons for pulling the report to the top of the pile.

In view of the importance of this report to students, Dr. Close asked that each Board member send to Ms. Bickel by mid-August reactions and comments to the report's conclusions and recommendations; hopefully the composite document will serve to guide the OSR discussion of strategies for change via GPEP at the Annual Meeting.

IV. Graduate Medical Education Issues

Dr. Swanson explained that, with the advent of TEFRA and the Medicare Prospective Payment System, many of the traditional "givens" for reimbursement in a teaching hospital setting can no longer be taken for granted. That there is widespread, and often uninformed, discussion about appropriate methods for financing graduate medical education is illustrated by the recent action of the Social Security Advisory Council which has called for a three-year study of medical education financing. Debate on that recommendation revealed an opinion among the Advisory Council that "an orderly withdrawal of Medicare funds from training support" should occur. The debate also revealed a great deal of misunderstanding about the direct and indirect medical education payments. Other organizations are beginning to address the issue of financing graduate medical education, and since most GME occurs in AAMC member institutions, it is appropriate that the Association's constituency have a principal role in any discussions about financing graduate medical education. Dr. Swanson said that, therefore, a special joint session of the Administrative Boards is being scheduled for September, at which time plenary session speakers and small group discussions would be held to initiate Association review of the issues related to financing graduate medical education.

Dr. Swanson expressed the hope that the OSR Administrative Board could re-schedule its September activities in order to attend this session. The Board noted the sensitivity and the underplaying of issues related to the services that house officers provide in discussions of financing medical education.

V. Educational Efforts on the Use of Animals in Biomedical Research

Ms. Morrison told the Board about the efforts of the Association of Professors of Medicine (APM) to educate Congress, medical school deans and department chairs, and other health care organizations regarding the need to use animals in biomedical research and about the focus now on educating the lay public. Animal protection and anti-vivisectionist groups are increasingly vocal and well-funded, and many researchers have

trouble articulating clearly the issues to persons who do not understand the use of animals in testing and who do not appreciate the link between this use and the availability of vaccines and improved treatments for countless human ailments. Ms. Morrison distributed copies of the APM pamphlet "Must Animals Be Used in Biomedical Research?" which was mailed to OSR members last year and suggested to the Board that copies in sufficient numbers to give one to each medical student be sent along with the next issue of OSR Report (if support for this effort can be obtained). She stated that, even though this issue cannot be given top priority, medical students are in a unique position to get across the points outlined in the pamphlet to the public and that it is important that this encouragement come from OSR. Dr. Schwager suggested that basic science faculty need to use physiology experiments to help educate medical students about the role of animals in research as well as in teaching and that The New Physician staff at AMSA should be contacted about writing on this issue because of the large number of medical student it reaches. Mr. Hardy noted that the antivivisectionist organizations active in Cincinnati are powerful and that many faculty do a poor job of taking their charges seriously and therefore do not respond appropriately, believing that this threat to their work will pass. He therefore recommended that APM work harder at persuading faculty that the threat is serious; he agreed to write a commentary to be included in the Fall issue of OSR Report which will serve as an adjunct to the APM pamphlet.

VI. Residency Interview Travel Tips

Dr. Close distributed a rough draft of the "tips" and instructed Board members to send comments to Ms. Bickel. She noted that she had received the approval of the GSA Steering Committee to contact student affairs deans for local information to be included in a composite document which is envisioned to be targeted at fourth-year students via student deans and amenable to update, for instance, in a three-ring binder.

VII. Remarks from Dr. Cooper

Dr. Cooper outlined for the Board some of the concerns of the Association regarding the federal government's implementation of Diagnosis-Related Groups (DRGs) which fix prices under Medicare in advance on a cost-per-case basis. He also reviewed some of the problems associated with the funding of graduate medical education. In response to a question from the Board regarding the lack of resident participation in AAMC program and policy development, Dr. Cooper said that, while residents are the focus of much of what is being debated, the line responsibilities in these areas belong to hospital administrators and deans. He stated, however, that these financing issues would continue to be a major focus of each of the AAMC's governing bodies.

After Dr. Cooper was called to his office for a phone call, Dr. Close reported to the Board that she had

received a letter from him in April responding to the OSR's request that the AAMC formally consider the issue of housestaff representation in the Association. The letter conveyed the Executive Committee's consensus that the Association's current practice of involving housestaff on committees and convening periodic issue-related conferences was working most satisfactorily and that nothing further be done in this area. Dr. Close expressed her dismay at this response, and other Board members noted that housestaff are being viewed functionally as senior students without challenges setting them apart from medical students. The Board agreed that it is unfortunate that the AAMC is missing a chance to be proactive on the numerous issues with potential to cause friction between residents and attendings when cooperation is urgently needed.

VIII. OSR Nominations for LCME Student Participant

The Board carefully reviewed the 26 applications received for the position of student participant on the LCME.

ACTION: The OSR Administrative Board voted to submit its nominations to the AAMC Chairman as follows: "Of the candidates reviewed, the OSR Administrative Board finds the following four students to be the most outstanding:

Peggy S. Braasch '85, U. of Pittsburgh

John F. Coughlin '85, Georgetown U.

Ann C. Jobe '86, U. of Nevada

Carol Mangione '85, U. of California, San Francisco"

IX. OSR Proposal for Computer Telecommunications Networking

Dr. Schmalz distributed a proposal requesting memory space on and telephone access to the AAMC mainframe computer for use in improving OSR Administrative Board members' communicating with each other and in producing projects which require numerous drafts and the ability of members to comment on each other's contributions. The fact that Board members do not have secretaries and cannot keep regular hours because of unpredictable commitments at the hospital lessens their ability to use their year effectively; this limitation could be significantly lessened by the availability of an electric bulletin board. Mr. Cassidy, Director of Computer Services, explained that, while sufficient sectors are available, for security reasons Dr. Cooper has decided against allowing access to non-AAMC staff persons. He noted that even with four levels of security (after the phone number), an intruder once did violate the database. Mr. Cassidy discussed with the Board Stanford's federally subsidized bulletin board, and Mr. Cooper agreed to contact the person in charge. Board members noted the difficulty of creating a proposal requesting funds to underwrite the OSR Board's communication network, given remaining problems in each member's having access to a terminal and modem and the need to generate evidence that a network will significantly enhance the Board's functioning.

Beyond the Southern region's impaired student project and the Board's response to the GPEP report, Mr. Cooper asked Board members to give him additional ideas and examples for how the network would work.

X. MCAT Experimental Essay Project

Dr. Beran distributed guidelines for the development of essay questions and the research issues identified by the Essay Committee and stressed the experimental nature of the project to the Board. He described some of the concerns that have arisen, e.g. that students will flock to writing courses, even though the main goal is to assess ability to organize thoughts and synthesize concepts. Moreover, difficult questions must be faced about whether or not to score the essays; testing experts have advised that the possibility for abuse is greater if the essays are not scored, but the AAMC is resisting this evaluation method. Dr. Beran promised to share examples of the vignettes that are being considered by the Essay Committee with the OSR Board in September.

XI. Financial Aid Update

Mr. Boerner reported that Congress is not going to take action this year on the Higher Education Act Reauthorization Proposal, which means that those student assistance programs such as Guaranteed Student Loans and College Work-Study will be automatically reauthorized. Bills to renew the Health Manpower authorities are expected to go to the floors for vote within the next two weeks; the major AAMC effort to influence this legislation will probably occur when the two bills are conferenced. Efforts are being made to get HEAL included in Senator Robert Stafford's (R-Vermont) Loan Consolidation proposal; Mr. Boerner noted that, again, the push will occur during the conference when OSR members may be asked to generate support for the AAMC position. He mentioned that 2000 of the Financial Planning & Management manuals which were distributed to financial aid officers this spring have been sold. He noted complaints about the high price of the manual and that he has proposed another discounting scheme which he hopes will be accepted.

XII. Proposal to Change OSR Membership Requirements

Seeking a means whereby schools such as the Charles R. Drew Postgraduate Medical School in Los Angeles may have its own OSR member, Dr. Schmalz proposed that under Section 3 ("Membership") of the Rules & Regulations of OSR, the first sentence of "A" be replaced with the following language: "Members of the OSR shall be representatives designated by each Institutional Member that is a member of the Council of Deans. In addition, OSR membership may be granted to students from any Provisional Institutional Member of the AAMC or any geographically distinct medical school campus upon request by the Administration of the campus and its associated Institutional Member and approval of the OSR Administrative Board.

Representatives should be selected from the student body by a process appropriate to the governance of the institution." This proposal was seconded, and the Board agreed to table it for further discussion in September.

XIII. Adjournment

The meeting was adjourned at 4:45 p.m.

PREPARATION OF GPEP REPORT
DISCUSSION ITEMS

At the June OSR Administrative Board meeting, Dr. Close asked Board members to prepare in writing their reactions to the GPEP Report by mid-August. The two responses received follow. The goal is to create a document representing the thoughts of the Administrative Board which will facilitate the OSR's Annual Meeting discussion sessions devoted to GPEP (see schedule, Sunday morning). Especially those new to OSR, but all discussion participants and the three AAMC staff members serving as co-leaders, could use a series of stimulus questions and issues in approaching a report of this magnitude. Helping students to define and carry out a role in working for change at their schools should probably be the idea behind most of the questions/issues arrived at by the OSR Board.

TO: OSR Board/Janet

FROM: Mary Smith

Enclosed are a few of my musings of the GPEP summary. All in all, I found it a concise, to the point, document. The one major flaw as far as I could see was how specific it is in addressing knowledge and learning skills and, in contrast, how vaguely the development of values and attitudes was approached. With the exception of the introductory remarks, which placed a major emphasis on attitudes of commitment to patients and dedication to serving others and the society and the mention of "ethical sensitivity and moral integrity", these aspects of the General Professional Education of the Physician are not addressed. There is a necessary amount of study needed to become logical and consistent in one's rationale and to be able to explore all possible ethical alternatives before deciding on one appropriate course of action. The ability to defend one's rationale is not inherent nor is the ability to rise out of one's own frame of reference to understand the situation another person may face. And while I strongly agree with the position taken to encourage a liberal arts study during the college years, a formal course of training in looking objectively at the thinking process, specifically within the area of medicine, should be encouraged.

I. Recommendation 1.3 - Adapting to Changes in Health & Health Care:

In addition to making students aware of changes, students should also be made aware of how to study population needs and how to isolate and implement changes in health care. It is only by training physicians in the legislative process and increasing their understanding of this process that their participation is increased.

II. Recommendation 2.6 - Improving Communication:

Just as the AAMC/GPEP report suggest medical schools follow their graduates' long-term progress to judge the effectiveness of their education, colleges may need to be challenged to follow their graduates who enter medical school and deduce which students and with what particular undergraduate courses were accepted and fared well in medical school. They could then use these studies to aid in counseling prospective medical school applicants.

III. Recommendation 3.1 - Evaluating the Ability to Learn Independently:

There is a need to re-address the purpose of evaluations as viewed by both students and faculty. As medicine is a cooperative endeavor and should not be a competitive field in which withholding information or "one-ups-manship" may endanger the patient, evaluations of those in medicine should be a co-operative effort. It is not the purpose of evaluations to single-out individuals but to reinforce and direct students' learning. It should be an opportunity for the student to open himself up and actively seek constructive criticism in order that he may improve his capabilities as a physician.

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IV. Recommendation 5.1 - Organizing Responsibility:

I am very surprised that after all of the student input called for and received by the GPEP project, in the formation of curriculum review committees, their role is not even suggested!

V. Recommendation 5.4 - Expanding Teaching Capabilities:

Again, this section addressed "challenging medical students to learn independently". Some suggestion needs to be made as to methods to reinforce this method of learning. National Board - type examinations actually serve to negate this type of learning.

Dear OSR Boardmember,

The following is my disjointed response to GPEP. I tried to stick to those proposals I thought were important and where we may have some influence. I also wanted this response to be short; hence it seems to be jumpy. This paper basically follows the order of the report. I look forward to discussing the report in more detail at the next meeting.

Section 1

The limitation of factual information for memorization should be stressed. Working with curriculum committees and departmental chairmen may help achieve this goal.

Though I believe that residents have more than "limited responsibility for patient care," I do not see us as having much influence with residency directors.

Recommendation 1.3 lists some of the changes influencing medicine, but it does not offer any suggestions. Should courses concerning economic and demographic changes be included in the curriculum?

The physician as a public health advisor is logical, but how do we integrate this idea into our education?

Section 2

GPEP wrongly blames colleges for allowing "the pre-med syndrome" to exist by not requiring a broad baccalaureate education of their students. The fault lies with medical school admission policies. People are premed nerds because it works; they get accepted to medical school. The obvious way to increase the percentage of diversely educated individuals in medicine is to begin admitting those well rounded people who apply.

The report also glosses over the MCAT. Are MCATs predictive when it comes to clinical skills, problem solving abilities and other crucial traits? As stated in recommendation 2.5, these scores should not be used to differentiate among qualified candidates.

Section 3

Developing teaching methods that encourage independent learning is one area where we need to be strong advocates for change.

Clinical clerkships are an ideal opportunity to introduce problem solving into instruction methods. This style of teaching may be less suited for the basic science years.

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I agree that subjective evaluations have a place in assessing a student's ability.

Basic research on the use of computers is not needed as much as computers are.

The need for student support and guidance cannot be over emphasized.

Section 4

The skills to be acquired during a clerkship should be clearly delineated. When specific goals are set, evaluation becomes easier. Early evaluations with feedback to the students helps them chart their progress. Supervision during clerkships antecedes evaluation, and will make evaluations easier.

GPEP states that fourth year students make "rational" use of their electives, though they may not be properly augmenting their general education. Possibly, the problem is with the residency selection process, not with the elective system.

Section 5

Encouraging closer relationships with the faculty is a concrete recommendation we can act on.

Other Considerations

Changing the Board's scoring system to pass/fail would bring effective and quick results. The exception to this reporting should be made for students who fail. A breakdown of which sections they had difficulty with (available only to the student and Dean?) may help them identify and strengthen areas where they need help.

Take care,

Tim Brewer

Organization of Annual Meeting
Issue Identification & Discussion Session

When the OSR Administrative Board discussed experiences at the 1983 Annual Meeting, it agreed that OSR members needed more guidance in participating in Group Process as a method of focusing on selected issues. Following are pages from E. Schindler-Rainman's book Taking Your Meetings Out Of The Doldrums which Board members should review with the goal of adapting into an introduction which can be provided to OSR Members prior to Saturday's "Issue Identification" and "Small Group Discussion" sessions. Other ideas and guidelines not mentioned in this book could also be incorporated.

Board members need to look over as well the minutes of the 1983 Business Meeting which contain reports from last year's small groups (following the pages from the Schindler-Rainman book). In particular, the goals of the small group exercises should be discussed. If the main purpose is to energize and provide food for thought to representatives, then the group reports need not be considered part of an OSR "action agenda". But if the goal extends to directing the OSR officers on priorities, then the reports must be prepared with this in mind and must be limited and feasible in scope instead of asking for "moons". OSR Board discussion and communication to the membership about the functions of this part of the Annual Meeting program will help to eliminate misunderstandings such as occurred at the end of last year's business session.

TOOL KIT D: GETTING IDEAS OUT AND SHARED

There are many ways to help group participants "uncork" and share their ideas. We share here a few that we have found particularly useful in a wide variety of situations. Included are: brainstorming, small group techniques, self-inquiry method, and exchange of successful practices.

1. Brainstorming!

The purpose of this method is to get out as many ideas, on a given question or problem, as possible, utilizing all the resources of the group without stopping to discuss or judge the worth of any of the ideas during the actual brainstorm session. The time required varies from 10 to 20 minutes depending on the size of the group and the complexity of the question.

The size of the group we find best is between 3 and 15 persons. One person can brainstorm alone and sometimes 2 people can do well if this seems necessary or desirable.

Recording the ideas is very important. One person can do this or the responsibility can be shared. It helps to have large sheets of flip chart paper and a broad tip felt pen, so that the ideas can be seen going on the sheet and can be easily read afterward.

The question to be brainstormed about must be one to which all the participants can speak. e.g.,

- all the ways to recruit volunteers
- all the ways to improve our meetings
- all the ways to give information other than through speakers, etc.

There are 4 rules that help group members to do productive brainstorming. Have these rules available to the group through a verbal listing and/or posting them in easily seeable written form:

1. List all the ideas anyone has
2. Do not discuss
3. Do not judge - all ideas are go!
4. Repetitions are O.K. (just put the idea down again)

A helpful hint is to say to the group that if they hit a plateau or silent periods: "Just enjoy your silences because often the best ideas come after the silence."

After the brainstorm it is possible to do a variety of things with the product(s). For instance:

1. Encourage group members to look over their list and star the 4 or 5 priority items and report those.
2. If several groups are brainstorming the same question, put the lists on the wall with masking tape and have participants mill and read each other's and mark on each other's sheets those they find most exciting or feel are priorities.
3. Or have them check all the items they feel they could do easily (such as ways to improve their meetings)
4. You'll find other uses.

Just be sure that there is a use made of the brainstorm product(s). Most people love to brainstorm and enjoy seeing their ideas recognized and utilized. It is one of the best ways to help non-participants become active.

Self-Inquiry; Anticipations and Predictions

As you look around the circle of your group, which is about to begin working together, please reflect on and jot down ideas on the 2 questions below:

1. What are some of the factors which you feel exist in a new group like this that will block free and open communication?
2. What initiatives might a member like yourself take to help the group begin removing such blocks to communication?
3. Please share some of your self-inquiry reflections with fellow group members for a few minutes.

2. Small Group Techniques

Buzz Groups - here 2 or 3 persons "buzz" - talk for a short period of time in response to an instruction from the leader like:

- List: - Your questions about what you've just heard
- Your ideas on how to help shy people participate
- Your ideas on how we can improve our group's productivity

Small Work Groups vary in size from 3 to 7 or 8 persons. Members are requested verbally and/or in written instructions to do a particular task or set of tasks. For example:

- Members are asked to list their goals for this meeting and then to mark priorities on their list
- Each work group has a different question to answer or problem to solve (e.g.,
 - ways to recruit volunteers
 - ways to train volunteers
 - ways to keep volunteers happy
- Sometimes each work group is asked to brainstorm something (e.g., all the things a good leader does to help the group; all the ways to design our annual meeting, etc.)

3. Self-Inquiry Method

This is a way to help participants to work by themselves and to focus on some particular item of content. The purpose may be to help them think through something before discussing it in a group (see the following self-inquiry sheets as exam-

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Internal Society – (another type of self inquiry)

The purpose may be to give the participant a chance to think about how she/he feels about something, to give insight. An example of this is the "Internal Society" and "Invisible Committee" notions. (Following is an example)

Our "Internal Society" and Our "Invisible Committee"

Whenever we face a decision to try something new, there is an internal dialog which starts up inside us (parts of our selves that feel and think one way and other parts of us that feel and think differently). Also, we become aware that there are other persons in our lives who are influential reactors to our ideas and actions. As you think about changes you want to make, it will be helpful to do these two internal inquiries for a few minutes:

Internal Dialog

What do the various voices inside you say about your new change ideas, pro and con?

Invisible Committee Reactions

Who are the persons and groups who you can visualize as supporting or questioning or rejecting your new ideas? What are they saying?

4. Sharing and Integrating Ideas

When a group is divided into subgroups to do work, there is usually a need to report the results of each group's work and ideas. There are a variety of ways to do this. Here are some:

1. Each group reports out verbally their 2 favorite or best ideas. When each group has had a chance to do this other ideas can be added.
2. Reports are written out on newsprint and hung on the wall for the others to read. This makes for a useful "break" time since people can pick up a cup of coffee, go to the lavatory, etc., in addition to milling and reading.
3. Verbal reporting from each group, with one person recording the ideas on a large sheet of paper or on a transparency on an overhead projector for all to see.
4. Put reports on ditto masters and reproduce enough copies for every participant.
5. Give the reports to a summarizing committee who will integrate and summarize all the ideas.
6. Ask each group to make a non-verbal report of their best idea.
7. Report out and share results via a picture, collage or paper bag puppets.

It is important to remember that the reporting, sharing and integrating activities should be brief, varied, interesting and useful.

5. Exchange of Practices

The invention of useful social practices is not unusual. New ways to greet or group people, ideas for motivating the apathetic, a novel room arrangement, etc., are all social inventions that should be useful to more people than just the inventor. Yet such practices are rarely shared in a way that the next person can really adopt or adapt them.

Non-sharing is due to many reasons, ranging from lack of knowing how to do so, to modesty about one's own ideas, to possessiveness, fear of rejection, to high competitiveness.

We have found that people like to share new ideas when they are given some help to do a productive job of it. Here is a format to guide you; you will want to adapt it to your needs.

Usually each person in the group is given the interview form. Then the leader asks each person to share one practice that has worked for him/her on some agreed-upon topic (e.g., "ways I've motivated people to participate in meetings," or "ways I've helped kids learn" etc.). Everyone who has a successful practice on this topic mentions what it is. Someone writes the topic with the contributor's name on a large sheet of paper. After everyone who wants to contribute an idea has done so, the group votes on the priority ones they want to hear about in detail. These are starred and then the first exchange-of-practice interview begins. Questions are asked in the order on the form. One person records the answers and has them duplicated as soon as each interview is finished.

It is possible to record the answers directly on a ditto master and ditto enough copies for everyone. Or, a Xerox machine can be used. When neither of these are available, everyone takes his/her own notes on the form that has been provided to each person.

These are just a few ideas. You can adapt these to your own needs and invent new ones that help you share your designs and hopes for outcomes into a fun meeting.

EXCHANGE OF PRACTICES INTERVIEW FORM

Name of "Inventor" _____

Address of "Inventor" _____

Telephone _____

1. What is the practice?
2. Describe it so the listeners can see it in their mind's eye (give steps involved in doing it)
3. Where and with whom can it be used?
4. Facilities needed
5. Costs
6. Problems to watch for
7. Any evaluation of it? What?
8. Adaptations? (Of the practitioner or anyone else in the group)

TOOL KIT E. GOAL SETTING AND ACTION PLANNING

Setting long range and short range goals is one of the important agenda items in many groups and their meetings. And just as important as a good process of choosing goals, is the planning to take the best actions to implement these goals. From where do we get our goals? Here are eight sources of ideas for goals that we have identified:

1. Eight Sources of Goals

Goal Source #1: From those being served

The needs, expectations, confrontations of those we are trying to serve through our educational efforts, i.e., the students, are a very important source of good ideas. What are signs of discontent and boredom? How are they feeling about learning? What growth are they showing or not showing?

Goal Source #2: From Significant Others:

The organization is surrounded by other systems and persons who make up its environment - e.g., the economic system of business and taxpayers, the political system of voters, liberals and conservatives, youth with their ideas, the parents with their expectations, hopes, concerns; people serving agencies that can offer or withhold collaboration. They have important ideas to be considered.

Goal Source #3: From the Successful goals of others 19

Agencies and groups of all kinds are also continuously projecting goals and trying to achieve them. Some have had very exciting success experiences that have relevance for us. What are they?

Goal Source #4: From policy-practice discrepancies

We have previously set goals and policies. What are the discrepancies between these intentions and what we are actually doing? Closing some of these gaps could be important goals.

Goal Source #5: From listing our Current Problems

From such a list we select the priorities on which to work.

Goal Source #6: From predictions about the future (See Futurist Magazine listed in Bibliography)

Many predictions and projections of the future are being made by futurists and long-range planners. What implications do these predictions have for our goal setting?

Goal Source #7: From our Images of Potential

What would the best programs we can imagine look like in action? Do we agree on these?

Goal Source #8: From Our Own National Leadership

What ideas for goals and plans are in the minds of the leadership of our systems? Have they been set down in writing? How much commitment is there?

2. Discovering and Choosing Goals by Images of Potentiality¹

¹From *The Humanized-Future: Some New Images*, by R. Fox,

A typical way that most groups set goals is to list the problems they want to do something about and to decide what the "problems" are.

An analysis of this approach has uncovered several interesting facts that led us to develop another approach:

1. We discovered that when a group is listing its problems, the voices became more and more depressed.
2. And more and more comments indicate a sense of impotence or futility about action-taking and problem solving.
3. And there are more and more comments that attribute the causes of problems to "outside forces we can't do anything about."
4. As we listened to a wide variety of groups setting goals and priorities after such a "problem census" we noted that their goal selections were oriented toward "getting away from pain (problems)" rather than "going toward some positive image of desired achievement."

As a result of this analysis we have developed a future oriented approach to selecting action goals.

Taking a Goal-Setting Image Trip Into the Future

Your work group (or committee) will be making this trip together. You need a large sheet of newsprint and a person to act as recorder who will jot down your images as you report them.

You are projecting yourselves ahead in time — a year — and making observations of what you see going on in your setting, speaking in the present tense, — you are there! Be concrete in reporting what you are seeing that pleases you with what is going on.

You are not predicting what you think will or will not happen. And you are not expressing unreal fantasies. You are observing desired developments which have a sense of reality-feasibility of highly desirable future. Be creative. Use imagination. But be realistic. O.K., here are some instructions for the trip — the focus for your observations.

Suggestions for Your Observations

It is one year hence and you are looking down from your helicopter. You are pleased with what you see. You are seeing your group working together, and the various things you have caused to happen. Describe in the present tense how your group is functioning and what is happening, because of your efforts, that please you. Write down all the things that you are pleased about and you can see happening. Be as concrete as possible.

Selecting a Priority Image

After your group has listed all the images of potentiality they can project, you are ready to return to the present, and in the present, review the list of potential images. The job now is to select a priority image (or possibly two) which the group agrees is the most important to achieve and which they want to plan to start work toward. If the group is as large as, e.g., 7-15, you will have the resources to select two priorities and divide into two subgroups for planning. You will probably use a number of criteria for choosing your priority image(s), e.g., program importance, feasibility, sense of commitment by the members of your groups, etc.

Translating Your Priority Image Into a Goal Statement

Your desired image of the future new needs to be formulated as a goal. It is important to make your goal as clear, concise and specific as possible. To do this try to state it in such a way that you can know when it has been achieved; that is, the goal must be measurable and do-able. Also, it is important to set a beginning and ending time for accomplishing this goal. Most of all, the goal should be realistic. It should be something which you feel you stand a good chance of achieving. If it would be pushing your luck, or would be something very difficult to achieve in the time allotted for it, perhaps you should amend it, trim it down, clarify it further, or choose a different goal.

Two examples of a goal statement which meet these qualifications might be: to get a program started of teen volunteers helping lead activities of youngsters; or, to have a program of recruitment and training of the teens started by this time next year.

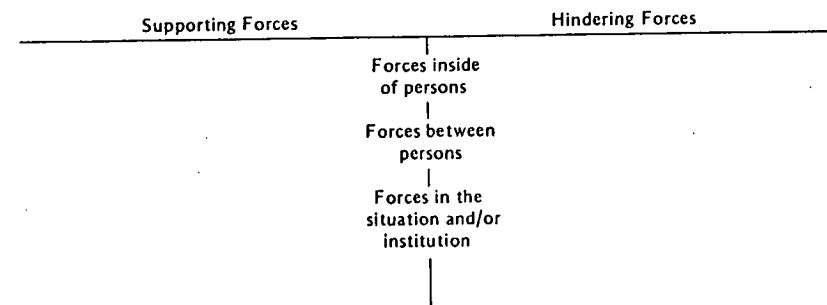
3. A Sequence of Action-Planning

Diagnosis of Helps and Hindrances

(an adaptation from Kurt Lewin's Force Field Analysis)

With your goal statement at the top of a large sheet, make a chart as illustrated below, to list all the factors (forces) you can think of that will help, support, push toward the goal (lefthand list) and all the factors (forces) that might block or hinder movement toward the goal.

GOAL STATEMENT: _____



Please note we have suggested a way to clarify your forces as you list them on the chart:

1. Some forces will be factors inside yourselves and other persons (e.g., lack of skill, ambivalence, enthusiasm, or bias about importance of goal)
2. Other forces will be generated by the relations between people or the style of the group (e.g., norms against trying anything new, consensus about importance, etc.)
3. Other forces will come from the characteristics of the large environment and institutions, such as lack of resources, budget, supportive policy.

Make as complete a list of factors as you can, realizing you may not have the data to be sure how strong some of them are — but make the best guesses you can.

Brainstorming Removal of Hindrances and Mobilization of Supports

Brainstorm #1: (see brainstorm rules on page 78)

Now brainstorm all the ways to remove the hindrances you have listed.

Brainstorm #2:

Next brainstorm all the ways to mobilize the supports you have listed

Selecting Feasible Action Priorities

Look at each of the two brainstorm lists you have just produced. Discuss each list and select from each the three, four, or five items you consider priorities for action for you. Star or circle these items so that they are easily identifiable.

Steps of Implementation

You are now ready to move to actual action step planning. It is suggested you include the following:

- a. List who besides you is needed to work on the priorities you have selected.
- b. How will you recruit these persons and who will do it, when?
- c. How do you begin on the action steps? What do you need to do?
- d. Who will do what to get started?
- e. Where to start?
- f. When will the group report to each other on progress?
- g. Who will convene the next meeting?

Planning for Follow Through

It is important to have follow up meetings to support each other; to change plans or re-group; to report progress, or lack of it; to make new or additional plans. This follow-through can be done through face to face total group meetings; through subgroup meetings; and/or through telephone conference calls.

Try it! You might enjoy this way of working on goals and seeing your own progress on reaching them.

1983 BUSINESS MEETING MINUTES

XIV. Small Group Reports

Dr. Schwager asked one of the leaders of each of the preceding morning's issues assessment groups to present a summary of the conclusions and recommendations.

A. Ethical Guidelines for the Clinical Years

Ms. Mary Smith reported on the outcome of the Saturday morning discussion group held with the Society for Health & Human Values which had devoted itself to students' needs for specific behavioral guidelines which go beyond that contained in most codes of ethics. She distributed to the membership a copy of such guidelines which could be referred to when up-dating or creating a code of ethics for medical students. Their primary thrust is to assist students to develop a sense of moral commitment to present and future patients.

B. Medical Ethics

Ms. Carol Mangione stated that her group recommended that the spring 1983 issue of OSR Report be devoted to medical ethics. The following is a suggested outline of topics: (1) Development of guidelines for the clinical years, such as those noted above; (2) Working definition of medical ethics including consideration of the goals of ethics in medical education (i.e., can ethics be 'taught?'); (3) Raising ethical questions in the clinical setting: a) Use of assertiveness training as a help in raising ethical questions in a non-threatening way; b) Curriculum formats which allow discussions of ethical issues (e.g., ethics rounds on the wards, support groups involving residents); c) Evaluations vs. ethical behavior (dealing with conflicts of interests between

behaving ethically and pleasing residents, d) How to represent yourself to patients (i.e., your level of competence, calling yourself doctor, etc.)?

This group also suggested the following steps: (1) Contact AMSA and AMA-MSS regarding work they are doing and a possible cooperative effort; (2) Heighten awareness of housestaff, possibly via AAMC Council of Teaching Hospitals, of the student issues in medical ethics as delineated above; (3) Explore questions related to those characteristics of residency training which foster unethical behavior.

C. Financial Aid

Mr. Jesse Wardlow stated that, considering declining federal funding, his group recommended that OSR commend those far-sighted deans and medical colleges which have adopted a long-term perspective and taken active and creative steps to develop new resources for student financial aid and programs to assist students in debt management. The following specific programs were identified as worthy of replication: (1) the floating of bonds to generate funds (for example at Dartmouth Medical School and being considered by legislatures in Illinois and Massachusetts); (2) the U. of South Alabama Medical School Job Search Program which seeks out jobs in the medical center appropriate for students; (3) the Yale Medical School Student Finance & Repayment Software, a computer program which allows financial aid officers to project specific student repayment schedules; and (4) in addition, continued involvement in strategies, such as letter writing to Congress, by which students can assist in lowering default rates and maximizing revolving loan funds available to students.

The following areas were identified as OSR priorities for 1983-84: (1) To investigate longer deferment and longer repayment schedules for GSL loans; (2) To increase the per annum and cumulative limit on GSL loans; (3) To reauthorize the Sallie Mae Loan Consolidation Program and to consider how the HEAL program can be incorporated into it; (4) To support and promote the creation of avenues and programs for service repayment options on loans as well as for grant support on the model of NHSC and the Armed Forces scholarship program; (5) To increase the opportunity for medical students to have access to College Work-Study funds for support and encourage medical schools to review policies regarding the criteria for students' working part-time; and (6) To increase student involvement on financial aid committees.

D. Housestaff Concerns

Mr. Ricardo Sanchez reported that OSR members attending this session discussed progress in OSR's bringing before the AAMC senior staff and Councils the need for greater housestaff involvement in the Association. The consensus of the participants was that this issue continues to be of great importance and that the Executive Council should continue to explore the conceptual and practical aspects of achieving more

frequent input. The participants also suggested that the OSR Administrative Board urge the membership to take an active role at their institutions by informing deans and program directors of their concerns and interest regarding the potential establishment of a housestaff liaison group.

E. Teaching Skills

Mr. Steve Erban stated that this group had divided the topic of teaching skills into three areas, as follows: (1) Abilities: a) Basic Science faculty should enhance their skills with formal training, show enthusiasm for their subjects, and remember that first year medical students are not graduate students; b) Clinical instructors should establish rapport with students early in the clerkship, state goals for the clerkship at the beginning, and give mid-course evaluations; c) Housestaff should be made more aware of their teaching responsibilities from the time of application to the program and should be given undivided time to teach as well as support and formal training. (2) Process: a) Students should be taught how to think rather than how to react to key words; b) Basic sciences should also be taught during the last two years when this material has increased relevance to students by including basic scientists on rounds and by offering mini-courses in the sciences; c) Examinations should be structured to give students feedback on their performance and to motivate students to learn rather than just to achieve good grades. (3) Content: a) Periodic redefinition of what constitutes core basic science material, inclusion of clinical material during its presentation, and greater emphasis on teaching people how to teach themselves are all needed; b) Definition of goals for each clinical rotation and patient-oriented exams are also necessary.

Suggestions for remedies included the following: (1) Improve teaching by offering formal systems of educating teachers and by greater utilization of student evaluations; (2) Institute a two-track tenure system such that teachers receive recognition and rewards on a par with researchers; (3) Improve communication between departments and course directors regarding course content, methods of instruction and evaluation techniques; (4) Restructure residency programs to allow more time for teaching and more rewards for teaching excellence.

F. NRMP/Career Decision Issues

Dr. David Thom reported on several areas of interest and concern to the participants in this group. (1) Separate specialty matches: Some participants felt strongly that the current system is untenable because: a) it requires separate application processes, usually with separate sets of interview trips and letters of recommendation, b) it requires earlier specialty decisions, and c) it is confusing, especially in specialties such as orthopedics. On the other hand, for a specialty such as ophthalmology, a separate match before the NRMP means that a student can arrange NRMP choices accordingly. Clearly the best arrangement is to have

specialty programs matching at the PGY2 level in an NRMP-administered Match before the regular match, thus allowing students to rank their PGY1 choices based on the results of the previous specialty match. (2) Early timing of career decisions, especially in specialties such as orthopedics and ophthalmology that require a strong commitment by the junior year in order to properly arrange electives, research experiences, Dean's letters, etc. (3) Decreasing ratio of positions available per applicant: Particular concern was expressed that the resulting "buyers' market" will encourage program directors to go outside, or stay outside, the NRMP Match, if more convenient for them, since they will have little concern over not filling their slots. Also voiced were concerns that program directors will rely more heavily on dubious criteria such as MCAT and National Board scores and ignore students from less prestigious schools. (4) Pressure to do extramural rotations: As competition for desirable residency positions increases it will be increasingly difficult for students to match in a first-choice program. Many students feel that doing an extramural clerkship at a program they desire will help them in this endeavor. Clerkships are also a valuable method for a student to evaluate a program or community and provide a break from medical school and a chance to learn medicine in a novel setting. However, clerkships away can be expensive and personally disruptive and may result in a poor use of medical education time. (5) Lack of career counseling information on specialties: One suggestion to improve these deficiencies was to offer career days with representatives from various specialties. The importance of faculty involvement in providing career guidance and the availability of workshop tools and self-assessment kits were described.

G. Social Responsibilities

Mr. John Dietz provided a summary of this group's discussion: (1) Health Care Policy Issues: It was suggested that AAMC define its position on important health issues; this discussion centered largely on the role of the OSR relative to the AAMC and the accountability of the Administrative Board in reflecting the views of students. The effects of social programs on and the responsibility for care of the medically indigent population were also discussed. Studies should be undertaken of the health effects of DRG's and other such cost containment programs. It was felt that physicians and medical institutions (both private and public) share a moral obligation for the care of indigent patients and that medical education should directly address this obligation. This group requested more specific guidelines from the Administrative Board for OSR reps to use in their school activities. One suggested format was to design activities on various social issues with clear "how to" directions from which the OSR rep could choose; there was strong agreement that OSR Report should be expanded to quarterly or bimonthly publications on a regular schedule and should discuss such issues and guidelines for action.

(2) Social Awareness Among Medical Students: Social awareness and responsibility should be fostered in medical school and sought in applicants. Admissions committees should clarify and emphasize such criteria, and pre-medical advisors should encourage involvement in social issues. The Administrative Board should suggest opportunities at the national level (e.g., with legislators and on the local scene), with specific guidelines on "how to" for OSR reps. The Administrative Board should also deal with this topic in more depth at subsequent meetings. The residency selection procedure was seen as an obstacle to fostering greater social awareness in medical students, since most program directors are uninterested in students outside of transcripts and publications. Substance abuse among medical students was considered as an example of a problem which may respond to improved social awareness; an Administrative Board project on this topic is suggested. (3) Minority Groups: The moral obligation of physicians and medical students in improving educational opportunities for minorities was reaffirmed. The focus for long term effort was seen to be educational opportunities in grade school, junior and senior high school. Programs within medical school aimed at assuring minority students' competitive equality for residency programs and licensure were suggested to be an important short term approach. (4) Other: Identified as very important but not discussed were: a) Physician's responsibilities in avoiding thermonuclear war; b) The moral obligation of the physician/student in counselling the dying patient and family and the need for instruction on this topic; c) The use of animals in medical instruction.

H. Curricula Innovation

Ms. Nora Zorich reported the following goals and directives which emerged from this group: (1) Goals: a) Integration of basic and clinical science instructional activities, particularly by mixing medical students at different academic levels in interactive teaching situations; also insuring the quality of this type of learning by finding adequate support among faculty. b) Improvement of the quality of physical examination instruction by increasing peer instruction and mandating adequate supervision and evaluation by qualified people. Also increasing the amount of patient-specific preparation that first- and second-year students have before doing physical exams. c) Emphasis on learning skills, particularly literature assessment and computer literacy, by addressing in a formalized manner from the beginning of medical school. d) Emphasis on problem-solving skills development, including student-initiated advocacy of this as a primary learning modality. e) Establishment of a serious, effective, ongoing curriculum evaluation process including significant student input and mechanisms to guarantee feedback to the faculty. (2) Directives: a) To encourage AAMC to evaluate the cost-effectiveness of student involvement in teaching their peers (i.e., availability of students for teaching; advantages of student involvement; model programs elaborated upon in OSR Report and also made available for presentation to deans). b) To demonstrate interactive learning systems, teaching skills techniques and problem-solving learning modalities on an ongoing basis to OSR

members and to encourage them to create similar programs at their schools. c) To encourage the use of alternative evaluation methods such as essay, oral, and interactive computer-based exams. d) To increase networking among OSR members, e.g., by encouraging all persons attending AAMC conventions to meet at the school and evaluate actions possible at their schools chosen from among presentations at the annual meeting. e) To encourage the OSR Administrative Board to increase the credibility of OSR among faculty, students and administration by direct communications.

XV. Dr. Schwager requested a motion that these group reports be accepted for the record for the purpose of guiding the deliberations of the OSR Administrative Board during the coming year.

ORGANIZATION OF
STUDENT REPRESENTATIVES

Friday, October 26

- 3:30-
4:30 pm Regional Meetings
ERIE -- Western
PRIVATE ROOM 3 -- Southern
PRIVATE ROOM 4 -- Northeast
MICHIGAN -- Central
- 4:30-
5:30 pm BELAIR
Program: "Becoming an Effective Change
Agent and OSR Member at Your School"
Mary E. Smith, M.D.
- 7:30-
9:00 pm BELAIR
Program: "The Physician as Health Advocate:
Responsibilities and Barriers"
Moderator: Steve Hasley, M.D.
Speakers: Quentin Young, M.D.
Robert G. Petersdorf, M.D.

Saturday, October 27

- 8:30-
10:00 am PRIVATE ROOM 2
Business Meeting
- 10:15-
11:30 am PRIVATE ROOM 2
Issue Identification Session
- 1:30-
3:15 pm Small Group Discussions of Issues
PRIVATE ROOMS 3, 4, 10, MICHIGAN
SUPERIOR A, BEVERLY, ASTORIA
- 3:30-
5:00 pm BEVERLY
Program: "Working with Nurses and Other
Health Professionals: Issues and Assumptions"
Ruth Purtilo, P.T., Ph.D.
Ann Lee Zercher, R.N.
Ann C. Jobe
- ASTORIA
Program: "Skills for Success in Medicine"
John-Henry Pfifferling, Ph.D.

Sunday, October 28

- 8:30-
9:30 am PRIVATE ROOM 2
Candidate for OSR Office Session

10:00-
11:30 am Discussion Groups: "Leadership and Change:
Putting GPEP to Work at Your School"

PRIVATE ROOM 3
Baccalaureate Education/Acquiring Learning
Skills
James Erdmann, Ph.D.
Richard Peters

ROOM 418
Clinical Education
Xenia Tonesk, Ph.D.
Ed Schwager, M.D.

ROOM 419
Faculty Involvement
August Swanson, M.D.
Ricardo Sanchez

1:00-
4:00 pm CONTINENTAL
Business Meeting

4:00-
5:30 pm Regional Meetings
PRIVATE ROOM 5 -- Western
SUPERIOR A -- Southern
419 -- Northeast
MICHIGAN -- Central

Monday, October 29

1:30-
3:00 pm ROOM 414
Workshop: "National Resident Matching
Programs; The Nuts and Bolts"
Martin A. Popps, M.D.
Pamelyn Close, M.D.

2:30-
4:30 pm ROOM 415
Workshop: "Medicine as a Human Experience"
David H. Rosen, M.D.
David E. Reiser, M.D.



association of american medical colleges

August 27, 1984

Nadine Loewen
Senior CFMS Representative
Manitoba Medical Students Assoc.
Faculty of Medicine
University of Manitoba
S204-750 Bannatyne Avenue
Winnipeg, Manitoba, CANADA R3E 0W3

Dear Ms. Loewen:

Thank you for your letter. As staff to the OSR, I would like to provide you with some introductory materials and then share this correspondence with the OSR Administrative Board at its September meeting, which may generate an additional response from OSR Chairperson, Pamelyn Close, M.D.

Since you evidently attended our last national meeting in Washington, D.C., you will understand why we invite a representative of your organization to attend the next one, which is on October 26-29 in Chicago; registration materials are enclosed (please let me know if you need additional copies). I've also enclosed a copy of the minutes of the November 1983 meeting (yellow) and an OSR Orientation Handbook which answers most of the basic questions about the nature of OSR and its parent, AAMC.

You may be interested to know of the informal association of U.S. medical student groups, known as the Consortium; I've enclosed a mailing list of participating organizations. The Consortium of Medical Student Groups meets in conjunction with the annual meetings of OSR, American Medical Association - Medical Student Section, and American Medical Student Association. Its next meeting is in the Conrad Hilton Hotel in Chicago at noon on October 29. Any representative from your organization is welcome.

Finally, I've enclosed a few copies of the most recent issue of the OSR Report, which is distributed via OSR members to all U.S. medical students. Extra copies of this issue are available and could be shipped to some Canadian schools, if desired.

More than likely, Dr. Close will be writing you during the end of September. However, please feel free to contact me in the interim.

Sincerely,

Janet Bickel
Staff Associate
Division of Student Programs

Enc.

Manitoba Medical Students Association
Faculty of Medicine
University of Manitoba
S204- 750 Bannatyne Avenue
Winnipeg, Manitoba
CANADA
R3E 0W3
August 4, 1984

Organization of Student Representatives
Association of American Medical Colleges
One Dupont Circle
Washington, D.C.
20036

Dear Fellow Medical Students:

For some time now the members of the Canadian Federation of Medical Students have discussed among themselves the possibility of establishing communication between our group and a comparable group of medical student representatives in the United States. Therefore on behalf of the CFMS I would like to request some information as to the goals and activities of your student organization. In addition, we would appreciate information as to the nature of any other student groups that may exist. In particular the name and address of a contact person would be appreciated.

We look forward to hearing from you and trust that your group will be as interested in a liaison with its geographical neighbor as we are.

Sincerely,

Nadine Loewen

Nadine Loewen
Senior CFMS Representative
Manitoba Medical Students Association

MANITOBA MEDICAL STUDENTS ASSOCIATION

FACULTY OF MEDICINE
UNIVERSITY OF MANITOBA
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REPORT FROM THE WESTERN REGIONAL MEETING OF THE CANADIAN FEDERATION OF MEDICAL STUDENTS (CFMS) Feb. /84

The Western Regional Meeting of the Canadian Federation of Medical Schools (CFMS) was held at the University of Calgary February 18 and 19. Present at this meeting were CFMS representatives from UBC, U of A, U of C, U of S and U of M. The proceedings were chaired by the Western Regional Director, Mary-Jane Seager, from the U of M.

CFMS President Marc-Andre Bergeron (U of C) brought the representatives up to date on several issues. The CMA Task Force on Primary Care which has been comparing the products of Family Practice Residencies and rotating internships plus two years of office experience may present its findings as early as March although the deadline is not until the fall of 1984. Further regarding the CMS- With an 87% return rate in its Manpower Study the purpose of which was to determine where the physicians of Canada are located and what they are doing it is expected that valuable information will be forthcoming. It is hoped that the results of this Study will help define the physician situation as it exists in Canada today.

The CMA is presently reviewing the criteria that are used in the process of accreditation of undergraduate programs of medical schools. No details were available.

Presently under investigation by the CMS is the status of career choice assistance and counselling in medical schools. The CFMS is assisting in this study. Each medical school, through its CFMS reps, is reporting its resources.

Marc-Andre announced that the Canadian Association of Interns and Residents (CAIR) had conducted a survey of the Family Medicine Programs across Canada the results of which are to appear in the next issue of CAIR's "House Staff". All final year students are to receive a copy.

Problems were reported with receiving sufficient articles for Mediscan, the student publication. If you have an opinion on a topic of interest to medical students write out your thoughts and submit them to Mediscan via your CFMS Rep.

MANITOBA MEDICAL STUDENTS ASSOCIATION

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UNIVERSITY OF MANITOBA
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Each school gave a report to the group the highlights of which follow:

UBC

1. The number of post-graduate positions (85 rotating internships and 15 family practice positions) is still less than the size of the graduating class (120)
2. Tuition fees are being raised by 33% per year so that within three years the tuition will be \$3,000, double what it is today.
3. Bill 24 which would regulate billing numbers for the medical service plan and thereby control who will practice in B.C. and where in the province they will practice is expected to be presented in a modified form in the present legislative session and is causing a great deal of concern for medical students regarding their career choices.

U of A

1. Dr. Donald Wilson, presently a nephrologist at the U of T, will become the Dean of Medicine on July 1.
2. There was a sense of relief that only 4 of the approximately 120 graduating students were unmatched after the February 15 CIMS Match. The goal of the U of A is to have all of the Edmonton hospitals in the Match for the 85/86 internship year.

U of C

1. Sparked by a tragic accident involving a U of C medical student a Medical Student Emergency Fund has been established. The purpose of this Fund is to provide financial assistance in extraordinary circumstances.
2. LMCC preparation classes are conducted once a week.

U of S

1. Dr. Ian McDonald, former head of Psychiatry at U of S, is the newly-appointed Dean of Medicine.
2. There is some concern regarding the March meeting of the accreditation team.

Several issues of concern to medical students were discussed.

Information arising from these discussions included the following:

1. CIMS Match- Early reports indicate that the Match turned out more favorably than some had feared. The 1984-85 Match will be computerized with a resulting increase in fairness of the exercise. A standardized application form is being tested in Ontario and may be introduced into general use sometime in the future.
2. Housing Registry- Sensing a need for a Housing-Exchange Program CFMS has set up the Housing Registry and encourages students to contact their Housing Representative who will be the Junior CFMS Rep at each school.

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3. Posters- Informational posters regarding the CFMS Organization are being printed and will be distributed to all the schools.
4. Information Package- The material for these packages has at long last been collected and each student should be a recipient of such a package soon.
5. Career Choice Survey- The surveys will be arriving in the near future. It is expected that a sample of students will be surveyed. Should you be one of the people whose opinion is requested we would appreciate your co-operation.
6. IFMSA- The question of whether the CFMS should upgrade its Corresponding status to a Full Member Status in the International Federation of Medical Schools (IFMSA) was discussed. The concensus agreed with the decision arrived at at the Annual General Meeting in the fall of 1983. Cost and politics were two major reasons for the negative decision. However, \$200 has been made available to a student who would be willing to represent the CFMS at the annual IFMSA meeting in Portugal in August.
7. The Canada Health Act- Concern was expressed over the loss of professional freedom that could follow passage of the proposed Canada Health Act which does not address the present practices of Quebec and the anticipated changes in B.C. A C.A.I.R. ammendment to ensure physician freedoms with the health care system was discussed and supported. CFMS will present its concerns in the form of a brief to the Standing Committee in Ottawa presently meeting to hear concerns from citizens regarding this proposed Act.
8. Organization of Student Representatives (O.S.R.)- The Organization of Student Representatives, one of the American counterparts to CFMS, held their annual meeting in Washington, D.C. this past November. Nadine Loewen reported on the meeting noting that several concerns were shared by both student groups. It was believed that the O.S.R. represents a valuable source of resource material. There was some question as to exactly who the O.S.R. represented and it was decided that CFMS would attempt to learn about the other student groups in the United States. This information will be presented at the next Annual General Meeting at which point there will be further discussion about establishing contact with an American group of medical students.
9. Cost-Sharing- All travel expenses for the Western Regional Meeting of CFMS were evenly shared by all schools at the meeting according to the number of representatives that each school sent. Total travel costs were \$1003.40 and there were eight representatives at the meeting. This worked out to a cost of \$125.43 per delegate.
10. Next Annual General Meeting of the CFMS- The next AGM will be in Ottawa in October of 1984. Attending this meeting will be the Senior and Junior Representatives from the U of M who will represent this medical school and Mary-Jane Seager who will attend as the out-going CFMS Treasurer and Western Director.

How The Match Works

(For the OSR Board's information, Dr. Graettinger provided a copy of this new description, which will appear in the October NRMP Directory and which has been sent to student affairs deans)

How The Match Works

The Match carries out the traditional admissions process with a computer program that requires only a few minutes to accomplish a series of decisions that would require hours of time for both students and program directors. The final outcome is that each student is matched to the hospital highest on the student's Rank Order List that has offered the student a position. In the process, the hospitals' Rank Order Lists are searched repeatedly. Positions are offered to students ranked within the quota

of available positions on the hospital's lists. Students are removed from a hospital's roster of filled positions if a match to a hospital more preferable to the student becomes available. As a hospital's positions open, candidates that have ranked the hospital and have not yet been matched are placed in the positions that become available. Hospitals thus offer positions "down" their Rank Order Lists until they fill their positions or have no more applicants. Students accept positions "up" their Rank

Order Lists until they are matched to the most preferred programs that offered them positions. Hospitals usually rank considerably more candidates than the number of positions they have available to try to assure that they will fill all of them.

The following example illustrates how both students and hospitals may best use the National Resident Matching Program.

Students' Rank Order Lists:

Anderson	Brown	Carpenter	Davis	Eastman	Ford	Goodman	Higgins
1. County	1. County 2. Mercy	1. Mercy 2. County 3. City 4. Memorial	1. Mercy 2. County 3. City 4. Memorial	1. County 2. Mercy 3. Memorial 4. City	1. County 2. City 3. Mercy 4. Memorial	1. County 2. Mercy 3. Memorial 4. City	1. Memorial 2. County 3. Mercy 4. City

Eight students are applying to four hospitals. After considering the relative desirability of each hospital, the

students submit the following Rank Order List to the National Resident Matching Program.

Hospitals' Rank Order Lists:

Mercy	County	City	Memorial
1. Carpenter 2. Goodman	1. Goodman 2. Higgins 3. Eastman 4. Anderson 5. Brown 6. Carpenter 7. Davis 8. Ford	1. Brown 2. Eastman 3. Higgins 4. Anderson 5. Carpenter 6. Davis 7. Goodman	1. Brown 2. Eastman 3. Anderson 4. Carpenter 5. Higgins 6. Ford 7. Davis 8. Goodman

Two positions are available at each hospital. The four hospitals, having determined their preferences for the

eight students, also submit Rank Order Lists to the National Resident Matching Program.

Student Anderson makes only a single choice, County, because he accepted remarks made by the program director that he would be ranked number one and he had in turn assured the director that he would rank County number one. This student is too gullible.

Student Brown ranks only the two hospitals that were desired by every student, Mercy and County, because as a junior AOA he feels that he is a most desirable applicant. He is too confident.

Student Ford would be very pleased to be at Memorial where she had several clerkships and feels that they will rank her high on their list. Although she doesn't think she has much of a chance, she prefers Mercy,

County, or City, so she ranks them higher and ranks her secure choice, Memorial, fourth. She is using the Match to maximum advantage.

Student Higgins is equally sure he will be offered a position at Memorial, but he also prefers the other hospitals. He ranks Memorial first because he is afraid that Memorial might fill its positions with others if he does not place it first on his list. He does not understand how the Match works.

The program director at Mercy ranks only two applicants, Carpenter and Goodman, for his two positions, although several more are acceptable. He has insisted that all applicants tell him exactly how they will rank his program and both of these students

have assured him that his program is their first choice. He delights in telling his peers at national meetings that he never has to "go far down his Rank Order List" to fill his positions. He will regret his overconfidence.

The program director at Memorial feels that his program is not the most desirable to most of the candidates, but that he has a good chance of matching Ford and Higgins. Instead of ranking these two applicants at the top of his list, however, he ranks more desired candidates higher. He also ranks all of the applicants to his program. He is using the Match well.

The final outcome of the Match was as follows:

Outcome of the Match:

	Rankings	
	By Student	By Hospital
Mercy		
Carpenter	1	1
Unfilled	-	-
County		
Goodman	1	1
Eastman	1	3
City		
Davis	3	6
Unfilled	-	-
Memorial		
Higgins	1	5
Ford	4	6

Unmatched Students:

Anderson ranked only County Hospital
Brown ranked only two hospitals, County and Mercy

The sequential steps in the matching process that led to this outcome were:

- Mercy had ranked only two candidates—Carpenter, who had also ranked it first, and Goodman, who had ranked it second. Since Mercy was Carpenter's first choice, he was firmly matched, but Goodman was only tentatively matched.
- County had ranked Goodman first and Higgins second. Since County was Goodman's first choice, she was removed from Mercy's list and firmly matched at County. Higgins ranked County second, so Higgins was tentatively matched into a position at County.
- Mercy thus had an empty position, but since it submitted only two candidates on its list, the second position could not be filled.
- City ranked Brown first and Eastman second. However, Brown did not rank City at all, so he could not be matched to a position at that institution. For Eastman, City was ranked as his fourth choice. He was tentatively matched to one of the two positions at City. Davis was matched to the other position at City through the following sequence. Higgins, who ranked City fourth, was already tentatively matched to his second choice, County. Anderson had not ranked City and Carpenter was firmly matched with Mercy. Davis, who had ranked City third, was tentatively matched with City, who had ranked him sixth.
- Memorial had listed Brown and Eastman for its first and second choices, but Brown had not ranked Memorial. Eastman, who had tentatively been matched to his fourth choice, City, was moved to a tentative match with Memorial, his third choice. Proceeding down Memorial's Rank Order List, Anderson, who was third, could not be matched because he didn't rank Memorial. Carpenter, who was fourth, had been firmly matched to his first choice, Mercy. Fifth ranked Higgins, who had ranked Memorial first, was moved from a tentative match with County to a firm match with Memorial.
- County thus had an open position and, since Eastman, who had ranked County first, was third ranked by County, he was moved from a tentative match with Memorial to a firm match with County. The position thus opened at Memorial was filled by matching Ford, who had ranked Memorial as her fourth choice, but had not been ranked sufficiently high by the other institutions to attain a more preferred choice.
- Mercy, who ranked only two candidates, and City, who ranked seven out of eight, had unfilled positions. City could have matched with Ford, who had ranked it second, had she been on their Rank Order List.
- Anderson and Brown went unmatched because they listed too few choices.
- Higgins could have matched at County had he ranked his choices in order of preference.

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