



**association of american
medical colleges**

**AGENDA
FOR
ORGANIZATION OF
STUDENT REPRESENTATIVES**

**ADMINISTRATIVE BOARD MEETING
June 18, 1986**

AAMC Headquarters



association of american medical colleges

OSR ADMINISTRATIVE BOARD MEETING

June 18, 1986 8:30 am--5:00 pm

AGENDA

- I. Call to Order
- II. ACTION ITEMS
 - A. Consideration of April Minutes.1
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 - 2. Report from Committee on Graduate Medical Education and the Transition from Medical School to Residency
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- III. DISCUSSION ITEMS
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 - D. Executive Council Agenda Items
 - 1. Applicant Pool
 - 2. COD Spring Meeting Resolutions

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IV. INFORMATION ITEMS

- A. Report on GSA Steering Committee Meeting
- B. Report on GSA Committee on Student Financial Assistance Meeting
- C. Legislative Update from David Baime
- D. Regional Chairpersons' Reports on OSR Spring Meetings
- E. Executive Council Agenda Items

V. Old Business

VI. New Business

VII. Adjournment

* * * * *

At 6:00 pm begins a reception and dinner for Dr. Cooper in the Lincoln Room of the Washington Hilton.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ORGANIZATION OF STUDENT REPRESENTATIVES
ADMINISTRATIVE BOARD MEETING MINUTES

April 9, 1986
AAMC Headquarters
Washington, D.C.

Rick Peters, Chairperson
Vicki Darrow, Chairperson-Elect
Ricardo L. Sanchez, M.D., M.P.H., Immediate-past Chairperson

Regional Chairpersons:

Joann Elmore
Joanne Fruth
Dan Schlager
Jim Stout

AAMC Staff:

David Baime*
Robert Beran, Ph.D.
Janet Bickel
John A.D. Cooper, M.D., Ph.D.*
Joseph Keyes*
Nancy Seline*
August Swanson, M.D.*

Representatives-at-Large:

Kim Dunn
Vietta Johnson
Kirk Murphy
Robert Welch

*Present for part of the meeting.

I. Mr. Rick Peters called the meeting to order at 8:45 a.m. Before approving the January meeting minutes, the Administrative Board requested the following amendments a) under the list of meeting attendees, the addition of Representatives-at-Large Kim Dunn, Vietta Johnson, John DeJong and Robert Welch; b) substitution of "apprehension" for "paranoia" in the penultimate paragraph on page six; and c) on page seven, substitution of "OSR" for "ATPM" in designing the evaluation form.

Next, Mr. Peters offered the Board some background on the advisability of asking a subcommittee of the OSR Board to review the applications for the Liaison Committee on Medical Education (LCME) student participant position. Ms. Vicki Darrow and Mr. Robert Welch volunteered to complete this work and to make recommendations to the Board later in the day.

II. Revision of Essentials of Approved Residencies

In hopes of helping Board members to target their questions, Mr. Peters quickly reviewed with the Board five of the Executive Council agenda items. The first of these, revision of the General Requirements Section of the Essentials of Accredited Residencies, requested the Executive Council to ratify the following additions: "Further, adequate financial support for residents' stipends is an essential component of graduate medical education" and "Instruction in medical ethics in the

socio-economics of health care, and in the importance of cost containment should be part of all programs." The OSR Board approved this recommendation.

III. Changes in Graduate Medical Education Training Requirements

Dr. August Swanson summarized for the students the history of the American Board of Medical Specialties (ABMS) and explained that the individual boards have carefully guarded their rights to set board certification requirements; these rights are now causing difficulties. He reviewed last year's decision by the American Board of Pathology to require an additional year of clinical training and AAMC's introduction of the following amendment to ABMS bylaws (which was rejected): "Changes that alter the resources that must be provided by teaching hospitals for their graduate programs or changes that impinge on the resources of educational programs in other specialties shall be submitted to the ABMS for approval prior to their implementation. Specifically, changes that lengthen the duration of training or that require a portion of the training period to be spent in an accredited program of another specialty shall be submitted for approval." This issue appears again before the Executive Council because in February the Anesthesiology Residency Review Committee requested Accreditation Council on Graduate Medical Education (ACGME) approval of changes that will lengthen anesthesia training programs.

Dr. Swanson recommended considering separately the issue of board autonomy and the request; anesthesiology he noted changes which have occurred in recent years in the practice of anesthesiology lending support to alteration of training requirements. Members of the OSR Board expressed the view that the fourth option presented in the Executive Council agenda could be considered antagonistic, i.e., "prepare and issue a public statement that members of the Council of Deans and Council of Teaching Hospitals will not consider changes in training requirements that require additional resources be provided by medical schools or teaching hospitals to be binding unless approved by the AAMC Assembly." The OSR Board responded more favorably to the fifth option: "require that changes in special requirements be ratified unanimously by the five sponsoring organizations of the ACGME."

IV. OSR "Critical Issues in Medical Education" Paper

Dr. Swanson also discussed his decision that the "Critical Issues" paper not become an issue of OSR Report. He said that the reviews conducted by the three AAMC Councils received no broader distribution than the OSR's review already has achieved and that, even after severe editing, he remained skeptical of producing a paper of sufficient quality to merit the cost of printing 66,000 copies. Dr. Ricardo Sanchez responded that the OSR and others has already had many opportunities to get something out of this paper but that, in the name of medical education and improved communications among AAMC bodies, it is important for the OSR Board to learn of the specific concerns about the paper. Dr. Swanson concurred and asked also that OSR take up the goal of helping to stimulate faculty to create the necessary strategies at their schools to implement the General Professional Education of the Physician (GPEP)

Panel's recommendations, because without student pressure the GPEP recommendations are not likely to go far. He mentioned two pieces of his that address these questions and said that copies would be given to the Board for its consideration: "Corporate Responsibility for Medical Students' Education" and "Learning Medicine as a Discipline: A Changing Emphasis for the Future".

Members of the Board asked whether a revised version of the OSR paper couldn't be published as part of an OSR Report, and the Board engaged in a discussion of the mechanism of deciding who should write OSR Report. Dr. Swanson explained that the AAMC staff is responsible for the quality of AAMC publications; therefore, however an OSR Report is written, AAMC staff will complete the job of editing it. Mr. Peters concurred but requested that any final drafts be shared with the Board so that no papers are published under the OSR name without its approval. The Board supported the importance of OSR's helping to keep GPEP alive, and Dr. Swanson agreed to review the OSR paper again and discuss specifics of it with the Board in June. In response to Board members' questions about feedback staff received, Dr. Swanson, Dr. Robert Beran and Ms. Janet Bickel noted that they had received no positive feedback. Dr. Beran explained that its iconoclastic tone limited its value and that, if the paper is meant to be critical, its lack of documentation and references also limit its utility here. He suggested that issues identified and stated in a positive manner provide a better basis for critical discussion and problem-solving. Dr. Swanson provided examples of the importance of citing data whenever possible on students' views of their education, e.g., from the AAMC Graduate Questionnaire.

V. Proposal on Problem-Based Curricula

Ms. Kim Dunn reported that, subsequent to the January Board meeting, a subcommittee including Ms. Vietta Johnson and Mr. John DeJong had met with Ms. Brownie Anderson, to work on the proposal to compare problem-based and traditional curricula. Ms. Anderson summarized the goal as follows: Invite a student, resident, faculty and academic dean from six "traditional" medical schools to experience certain aspects of the problem-based approach to medical education; these individuals would then evaluate the merits of this method for their own institutions. A paper would be written on the results of this symposium. She suggested Southern Illinois University (SIU) School of Medicine as a good choice for the symposium site and noted that the Annual Meeting plenary session of the AAMC Group on Medical Education would be evaluating graduating students' competencies, with which SIU also has solid experience. The Board discussed which other schools to invite, and Mr. Peters asked that a subcommittee of the Board assist Ms. Dunn and Ms. Anderson in the final selection. In closing, Ms. Anderson distributed an announcement on the Innovations in Medical Education (IME) Exhibits held during the Annual Meeting and encouraged OSR to apply (application deadline: July 1). She said that last year the Exhibit hours were extended to accommodate student attendance and that students originated three of the most popular exhibits.

VI. Issues Related to National Resident Matching Program (NRMP)

Ms. Bickel explained that Mr. David Resch, the AAMC/OSR appointee to the NRMP Board of Directors had requested the Board's guidance on issues of concern. Dr. John Cooper stated that the AAMC and the NRMP were attempting to engage representatives of the specialties in continuing dialogue to see what could be done to bring all the specialties into the NRMP and to stem premature requests for dean's letters. Dr. Cooper also described the monitoring program whereby students who know of program directors' violating NRMP guidelines are supposed to contact him; he would in turn, as NRMP President, without identifying the student in any way, reprimand the violator. Dr. Cooper asked that OSR and the Group on Student Affairs (GSA) do more to publicize this monitoring system. Members of the OSR Board suggested that the terms of the NRMP commitment and the specifics of what constitutes a violation should be more visible, perhaps appearing on the inside cover of the NRMP Directory. Mr. Peters noted that the universal application form needs to be updated, and Dr. Beran responded that at the Group on Student Affairs (GSA) meetings he is seeking a sense of the usage of and modifications necessary on this form.

Dr. Cooper closed by expressing his concerns about the future support of graduate medical education, as Congress and the Administration continue to look at how much money they can remove without considering the results of such actions.

VII. Outlines of Articles for OSR Report

Mr. Jim Stout presented an outline of an article on malpractice that would largely focus on why malpractice has increased and would include sections on expanding technology, the media's contribution, the litigious climate, insurance companies, peer review and tort reform ideas. He referred the Board to an article by Dr. Miriam Shuchman, former OSR Administrative Board member, appearing in the Washington Post Magazine and mentioned also the overlap of the malpractice problem with the gloom and self-protectiveness in medicine that much of Dr. Patch Adam's message addresses. The Board complimented Mr. Stout on the outline and encouraged him to offer a perspective on the central issues, rather than a series of observations. Ms. Joann Elmore also suggested providing references, addressing the student liability issue, and emphasizing the future of medical practice. Mr. Bob Welch presented an outline for an article on maintaining access to medical education. Included are the following topics: goals of affirmative action, a history of affirmative action in medical education and explanations for its decrease, and a discussion of reason why affirmative action must be maintained. The Board also complimented his work and recommended that he utilize a literature search and the assistance of Dr. Beran and Mr. Dario Prieto.

VIII. Financial Aid Program Update

Mr. David Baime opened with a summary of MedLoans (formerly CoMed) and the status of the negotiations with the Higher Education Assistance Foundation. Funds will be available for the 1986-87 academic year, but the AAMC doesn't expect much borrowing prior to September (applications will be available in mid-May). Mr. Baime stated that the availability of this source of loan funds will be extremely advantageous because it

relieves medical schools from reliance on the Federal government for support.

Next Mr. Baime described activity on three Washington fronts: 1) President Reagan signed the Consolidated Omnibus Budget Reconciliation Act, which contains provisions affecting the Guaranteed Student Loan (GSL) Program: loan consolidation is provided for, and checks will now be delivered to the financial office and made semi-annually. 2) The Senate subcommittee approved legislation reauthorizing the Higher Education Act in a version not quite as attractive as that approved in the House. If enacted, students stand to benefit greatly from this reauthorization because the GSL maximum would be increased to \$7500, loan consolidation provisions are improved, and graduate students are emancipated for purposes of reporting parental financial information. Mr. Baime speculated that the legislation would go to the floor in about six weeks and that, because it is a big spender, there would be difficult compromises over funding levels. 3) Mr. Reagan's 1987 budget was DOA, with the Senate the main focus of activity so far. Because of ceilings introduced by Gramm-Rudman-Hollings, in order to offer amendments to budget resolutions, Congressmen must now simultaneously offer a plan to cut funding levels or to raise taxes. The Board discussed some of these items with him and thanked Mr. Baime for his concise summary.

IX. Northeast OSR Meeting

Mr. Dan Schlager summarized the recent activities of the Northeast OSR meeting in Philadelphia attended by 25 students. He explained the need to ask students for a special registration fee beyond the amount charged by the GSA and expressed the hope that this situation could be remedied in the future. He said that, Mr. David Brooker (Rutgers-Camden) is coordinating the first Northeast newsletter and that Mr. Jon Braverman (Mt. Sinai) is spearheading a project to obtain the cooperation of preclinical students in housing fourth-year students who are interviewing for residencies. Time was also spent discussing Mark Blumenthal's (Rutgers) work with the Association of Teachers of Preventive Medicine vis-a-vis a potential Annual Meeting program and an OSR survey (see XVI below) and alternatives to the Hippocratic Oath being employed by graduating medical students. The highlight of the OSR program was two sessions with Dr. Patch Adams. Also well-received was the take-a-dean-for-a-drink idea, whereby each OSR member drew the name of a student affairs dean out of a hat and invited him or her for a drink. Finally, Mr. Schlager noted that evaluation of the Annual Meeting revealed the need for more social events and Mr. Tom Sherman (Connecticut) had volunteered to coordinate Northeast social events for the Annual Meeting; he suggested the other OSR regions do the same. The OSR Board asked Mr. Schlager to organize a riverboat cruise as the OSR Annual Meeting party.

X. 1986 Annual Meeting

The OSR Board decided that the main theme for its programs would be a combination of "Diversity in Medicine--Who's Responsible" and "Social Responsibility in Health Care". (See last page of minutes for the schedule of events and selection of topics and speakers.)

XI. Report of the Committee on Financing Graduate Medical Education

Ms. Nancy Seline told the Board that the report of this AAMC committee had not been easy to generate, taking two years and many battles. If approved by the Executive Council, copies of the report will be distributed to the membership, including OSR. She mentioned that an area not discussed in as great a depth as staff would have liked is the practice trend toward HMOs and freestanding clinics and its implications for medical education which is still largely provided in hospital-based facilities. Overall, the report is a call for recognition that teaching hospitals are worth supporting, and it summarizes what the AAMC believes are the basic requirements of their support vis-a-vis clinical medical education. Dr. Sanchez observed that, over the course of its development, the report seemed to de-emphasize the tenet that training medical students and residents adds costs to a hospital. Ms. Seline replied that, if the tone of the report appeared softer in this regard, such an alteration was not purposeful. She said that all involved in the report's preparation believe that education costs money, or there would be no need to request financial support for education. The OSR Board unanimously approved the report.

XII. Proposed Medicare Regulations on Payments for Medical Education

Ms. Seline also summarized this Executive Council item on regulatory attempts to dramatically reduce Medicare payments for the medical education costs of hospitals. The Health Care Financing Administration (HCFA) has published draft regulations to disallow program costs attributable to the training of residents, e.g., costs of teaching physicians, classroom space, residency coordinators, etc. Ms. Seline said that, while these regulations have not yet seen the light of day, because of the threat they represent; AAMC has initiated a series of responses as follows and is seeking guidance on additional steps to take. AAMC has: a) sent a copy of the HCFA memorandum to members; b) urged members to immediately contact key Administration and Congressional representatives; c) sent a questionnaire to all COTH members in order to collect up-to-date data on the financial impact of draft regulations; d) contacted legal counsel to discuss the possibility of a legal challenge to any similar final regulations; e) organized a coalition of interested groups and associations, and f) plans to discuss the matter with HHS Secretary Bowen when the Executive Committee meets with him on April 9.

XIII. Interpreting the AAMC Policy on the Treatment of Irregularities in Medical School Admissions

Mr. Joseph Keyes summarized for the Board the two questions before the Executive Council:

1. Should the Association forward irregularity reports to non-member institutions or organizations dealing with non-MCAT related irregularities?

2. Should the Association honor the request of the Federation of State Medical Boards that we forward to it certain categories of irregularity reports? Mr. Keyes said that the main question is: how much can AAMC cooperate with its colleagues in the health professions in their investigations of the background of applicants, given that AAMC-collected information and that AAMC becomes open to law suits brought by applicants for meddling or a related charge. Mr. Keyes stated that Dr. Cooper is convinced the AAMC should not send irregularity reports to non-member organizations. Members of the OSR Board expressed the view that, in the interest of peer review and because of the moral responsibilities of physicians, it would be unfortunate if fear of litigation interfered with opportunities to cooperate with non-member organizations.

XIV. Overview of OSR Budget

Dr. Beran distributed a copy of the proposed fiscal year 1987 OSR budget and explained that this was submitted to Dr. Swanson in February but that the Division would not know the results of the final deliberations until the end of May. He drew the Board's attention to the large percentage of the OSR budget devoted to Board travel expenses and said that it is standard for this request to get trimmed down during the budget review. In response to Mr. Peters' submission last January of a \$7800 request for computer equipment to improve OSR Board communications, Dr. Beran said that staff are not permitted to put equipment requests into the budget but that this request would be considered alongside other equipment needs. He said that budget figures are derived largely from past experience and from projections about projects. Dr. Beran stated that he would help the OSR Board in whatever ways possible to engage in the advance planning necessary to build strong programs and to generate more products. Dr. Beran also explained that OSR's requests are examined in tandem to GSA's. Many admissions, financial aid and student affairs officers perceive that their needs aren't being adequately attended to, and diversity in GSA membership and limited resources have contributed to such conflicts. He said that he and his staff are trying to close these gaps and requested the OSR's help in this regard as well.

XV. Nomination of LCME Student Participant

The OSR Administrative Board approved the recommendations of its subcommittee to nominate the following three students for this committee opening (listed in order of preference):

Ian Cook, Yale
Alan Lorenz, Wisconsin
Katharine Phillips, Dartmouth

XVI. Other OSR Projects

A. Ms. Bickel distributed the introduction that Mr. Stout wrote to the proposal seeking support for Gesundheit Institute presentations at medical schools. She expressed the hope that Board members would give her or Mr. Stout any suggestions based on their experiences with Dr. Patch Adam's regional meeting programs. She said a proposal draft would be presented to the Board in June.

B. Ms. Joanne Fruth summarized the status of the survey on preventive medicine teaching activities. Its purpose is to identify teaching approaches in health promotion and disease prevention that students would recommend to other students and teachers. A final version will be presented to the Board in June, with the intention of mailing to OSR members in late August, so that a presentation of results can be available at the Annual Meeting. Ms. Fruth also reported on her attendance at the Women in Medicine Planning Committee meeting at the AAMC in March and outlined the programs that will be available; OSR members will find many of these of interest.

XVII. The last hour of the meeting, before a 7:15 p.m. adjournment, included discussion of the Western, Central and Southern regional meeting plans and of two articles included in the OSR agenda (Eli Ginzberg's "American Medicine: The Power Shift" and K. Danner Clouser's "A Covenant between Physician and Patient: An Innovation by a Graduating Class.")

Organization of Student Representatives (OSR)

Association of Teachers of Preventive Medicine (ATPM)

SURVEY OF TEACHING ACTIVITIES IN HEALTH PROMOTION/DISEASE PREVENTION

The purpose of this survey is to identify teaching approaches in health promotion and disease prevention (hp/dp) in undergraduate medical education that students recommend to other students and teachers as "good" or "outstanding" and that could be used as models for innovative teaching approaches in other institutions. We are looking not only for obvious courses dedicated to some aspect of health promotion/disease prevention, but also for experiences which might be components of another course or rotation in any department.

Survey results will be used in the following ways:

1. To compile a listing of noteworthy hp/dp teaching activities. This listing will be circulated to OSR representatives and made available to others through the Prevention Education Resource Center of the ATPM.
2. To identify faculty and teaching activities for possible follow up by ATPM. The ATPM Prevention Education Resource Center is establishing a data base of teaching approaches and materials which can be shared with other teachers to help improve the general quality of health promotion/disease prevention teaching.

Your response to the survey form will be compiled as is, without editing, much as abstracts are compiled for conference programs; retyping will be done if necessary. Please respond even if this isn't one of your areas of greatest interest.

Definition of Health Promotion/Disease Prevention

The term "health promotion/disease prevention" is used in this survey to include all knowledge and skills necessary for identification of risk factors and effective intervention to prevent or reduce threats to health. This includes topics traditionally associated with preventive medicine teaching, as well as preventive aspects of clinical practice in all specialties, and elements of the basic sciences relevant to preventing disease and disability.

Listed on the next page is a number of preventive medicine content areas which may help you in identifying courses and teaching components.

Science Content

Epidemiology and Biostatistics
Environmental and Occupational Health Sciences
Health Education and Behavioral Sciences
Administration and Planning of Health Services

Program/Practice Content

Family planning	Accident prevention/injury control
Immunization/infectious disease control	Fluoridation/dental health
Sexually transmitted diseases	Smoking prevention/cessation
Cardiovascular risk reduction	Alcohol and drug abuse prevention/control
Cancer prevention	Nutrition
Maternal and child health	Physical fitness/exercise
Toxic agent control	Control of stress and violent behavior
	Personal health

Please provide the information below, then complete a "profile form" (attached) for each course or clinical experience you recommend. Please duplicate this form as needed. BEAR IN MIND THAT YOU ARE NOT EXPECTED TO DEVELOP PROFILES FOR ALL HP/DP RELATED TEACHING ACTIVITIES WITHIN YOUR SCHOOL'S CURRICULUM--ONLY THOSE THAT YOU FEEL MIGHT BE OF INTEREST TO OTHER INSTITUTIONS.

Name of Medical School _____

Name of Respondee _____

Please check one:

____ I know of no teaching activities to recommend.

____ I know of ____ potential models but don't have time before October 1 to complete profiles.

____ I have attached ____ profiles, and if I had time, would have completed ____ more.

Year in School ____ 1st ____ 2nd ____ 3rd ____ 4th

Address _____

Telephone () _____

Date _____

PROFILE FORM FOR COURSES AND CLINICAL EXPERIENCES

1. IDENTIFYING INFORMATION:

Title of Course or Designation of Clinical Experience:

Department: _____

Elective Required

Year offered: (please check) 1st 2nd 3rd 4th

Hours of duration: _____

Instructor: _____

Number of students: _____

Composition of class: (Please check below)

Medical students only

Interdisciplinary, specify other disciplines

Source of information: (Check all that apply)

personal experience

experience of colleagues

interview with faculty

school catalog or registrar

other, please specify

2. DESCRIPTIVE INFORMATION

Please describe briefly the hp/dp content areas covered in this course or clinical experience:

3. TEACHING MODE:

Below, please describe the teaching approaches used (e.g., lecture, seminar, role playing, field experience). Note those which you consider particularly effective.

4. TEACHING MATERIALS:

Please describe the kinds of instructional materials used (reading, films, risk appraisal tools, case studies, etc.) Note those you consider particularly valuable. Attach any you may have.

5. SELECTION CRITERIA:

Please list the features of this course of clinical experience which you consider most "notable". Add any additional comments on why you would recommend it to other students or teachers.

THE RESULTS OF QUESTIONNAIRES RECEIVED BY OCTOBER 1 WILL BE PRESENTED AT THE NATIONAL MEETING OF THE OSR-AAMC IN NEW ORLEANS, OCTOBER 24-27, 1986.

Return to:

OSR/AAMC, One Dupont Circle, N.W., Suite 200, Washington, DC, 20036

May 31 , 1986

To: OSR Ad-Board

FROM: Kim Dunn

RE: PROBLEM-BASED LEARNING PROJECT

Attached is the latest (and hopefully final) draft of the PBL Proposal. We have four possible sources of funding that look hopeful. By the meeting will also have contacted a few of the proposed schools to test their interest level. Brownie Anderson has met with Dr. Barrows and he has agreed to be involved with the project. Rick will present the proposal to the COD for discussion at their June meeting. Then, we should be able to proceed with actual details of the project. Look forward to seeing you in a couple of weeks.

Cheers,



PROBLEM-BASED LEARNING PROJECT
ORGANIZATION OF STUDENT REPRESENTATIVES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

FORWARD

The proposed project will be organized and conducted by the Organization of Student Representatives (OSR) with staff support from the Association of American Medical Colleges (AAMC). The OSR was initiated in 1972 to express student views on AAMC issues. Each medical school of the AAMC has an official representative to the OSR. Students meet twice a year, once at the Annual Meeting of the AAMC and once at one of four regional meetings. The OSR has an elected interim Administrative Board which meets an additional four times a year at AAMC Headquarters in Washington D.C.

BACKGROUND

INTRODUCTION

Society is rapidly changing. There are dramatic increases in information, new ways of handling information through use of computers, and development of newer and more complicated technologies. The American educational system is responding to these societal changes by evolving from an emphasis on the three R's to the three C's- Reading, writing, and 'rithmetic to compute, calculate, and communicate. Modern medicine is a microcosm of these societal changes. Over the past forty years, medicine has developed an almost incomprehensible body of biomedical information, a large array of pharmacological interventions, and a vast number of diagnostic and therapeutic technologies. Yet, in the main, the medical education system has not changed from the traditional system that has been in place for the past 75 years since the publication of the Flexner Report in 1910. This prompted the development of a highly structured university-based program with a scientific base combined with practical clinical experience. Currently in most American medical schools, the traditional four-year medical curriculum is divided into an initial two-year period of basic sciences followed by a two-year period of clinical rotations. This traditional model

was probably the most appropriate when the basic sciences consisted of the body of biomedical information at the turn of the century and clinical education was based on a mentor relationship with a highly experienced clinician. The climate of medicine has changed significantly since the Flexnerian curriculum was adopted. Today's two years of basic sciences consist of an array of faculty relaying the most up-to-date details on a plethora of biomedical topics. Students are evaluated on ability to recall details and not on ability to learn, synthesize data, or think. Clinical education is primarily taught by those who have little more clinical experience than the medical student and no instruction in teaching, the interns and residents. Recognizing that there was a need to re-evaluate both the content and process of medical education, the Association of American Medical Colleges conducted a national review of perspectives on what should be changed within the system to prepare students to become physicians in the future. This activity culminated in the 1983 publication of a report titled "General Professional Education of the Physician". The essence of the Report is contained on the following page.

SUMMARY OF GPEP RECOMMENDATIONS

A) Purposes of a General Professional Education

1. Faculties should emphasize the development of skills, values, and attitudes by students and limit the amount of information that students are expected to memorize.
2. The level of knowledge and skills that students must attain to enter graduate medical education should be described more clearly.
3. The education of students must be adapted to changing demographics and the modifications occurring in the health care system.
4. Students' education should include an emphasis on the physician's responsibility to work with individual patients and communities to promote health and prevent disease.

B) Baccalaureate Education

1. The baccalaureate education of every student should encompass broad study in the natural and the social sciences and in the humanities.
2. Whenever possible, the courses required for admission should be part of the core courses that all college students take, and medical school admissions committees' practice of recommending additional courses beyond those required for admission should cease.
3. The pursuit of scholarly endeavor and the development of effective writing skills should be integral features of baccalaureate education.
4. Medical school admissions committees should use criteria that appraise students' abilities to learn independently, to acquire analytical skills, to develop the values essential for members of a caring profession, and to contribute to society and should use the Medical College Admission Test only to identify students who qualify for consideration for admission.
5. Communication between medical school and college faculties about selection criteria should be improved.

C) Acquiring Learning Skills

1. Medical faculties should adopt evaluation methods to identify: (a) those students who have the ability to learn independently and provide opportunities for their further development of this skill; and (b) those students who lack the intrinsic self-confidence to thrive in an environment requiring independent learning and challenge them to develop this ability.
2. Attainable educational objectives should be set and students provided with sufficient unscheduled time to pursue those objectives.
3. Medical faculties should examine the number of lecture hours they now schedule and consider major reductions in this passive form of learning.
4. Faculties should offer educational experiences that require students to be active learners and problem-solvers.
5. In programs emphasizing the development of independent learning and problem-solving skills, the

evaluation of students' performance should be based in large measure on faculty members' subjective judgments of students' analytical skills rather than their ability to recall information.

6. Medical schools should designate an academic unit for institutional leadership in the application of information sciences and computer technology to physician education.

D) Clinical Education

1. Faculties should specify the clinical knowledge, skills, values, and attitudes that students should develop.
2. In conjunction with deans, department chairpersons, and teaching hospital executives, faculties should develop strategies to provide settings appropriate for required clerkships.
3. Those responsible for the clinical education of medical students should have adequate preparation and the necessary time to guide and supervise medical students during their clerkships.
4. Faculties should develop explicit criteria for the systematic evaluation of students' clinical performance and share evaluations with students to reinforce the strengths of their performance, identify any deficiencies, and plan strategies with them for needed improvement.
5. Faculties should encourage students to concentrate their elective programs on the advancement of their professional education rather than on the pursuit of a residency position.
6. Where appropriate, basic science and clinical education should be integrated to enhance the learning of key scientific principles and to promote their application to clinical problem-solving.

E) Enhancing Faculty Involvement

1. Medical school deans should designate an interdisciplinary organization of faculty members to formulate a comprehensive educational program for medical students and to select the instructional and evaluation methods to be used.
2. This educational program should have a defined budget that provides the resources needed for its conduct.
3. Faculty members should have the time and opportunity to establish a mentor relationship with individual students.
4. Medical schools should establish programs to assist members of the faculty to expand their teaching capabilities beyond their specialized fields to encompass as much of the full range of the general professional education of students as is possible.
5. Medical faculties should provide support and guidance to enhance the personal development of each medical student.
6. By their own attitudes and actions, deans and department chairpersons should elevate the status of the education of medical students to assure faculty members that their contributions to this endeavor will receive appropriate recognition.

Before the publication of the GPEP report, there were already several schools experimenting with a new method of medical education called Problem-Based Learning (PBL). Many of the GPEP Recommendations were already incorporated into the PBL curricula before publication of the GPEP Report. An overview of Problem-Based Learning is found in Appendix A in the article "Problem-Based Learning, Self-Directed Learning". The article is written by Dr. Howard Barrows who is recognized internationally as one of the leading authorities in the area of problem-based learning and currently the Associate Dean for Educational Affairs at Southern Illinois University. In addition, Appendix B contains 5 Monographs which give an overview of a problem-based learning curriculum currently implemented at Southern Illinois University. Harvard Medical School, Rush Medical School, University of New Mexico and Mercer have implemented problem-based learning as a second track within their curriculum.

NOT REPRINTED
IN AGENDA

One of the primary goals of The Organization of Student Representatives is to implement the Recommendations of the GPEP Report at each of the medical schools. We feel that schools that are currently using a problem-based approach to learning could be instructive in helping more traditional institutions incorporate the recommendations of the GPEP Report.

Students are uniquely suited to be effective change agents within medical institutions because students are not

bound by departmental, financial, or political constraints. In the past, the accomplishment of this goal has been attempted through small group sessions discussing how to implement change, role-playing exercises, case studies of effective curricula changes, student/faculty view exchange workshops, and a formal networking process. These have occurred at both the national and regional meetings. We have also tried to accomplish this goal through the OSR Report (See Appendix C). Although these strategies have met with some success, we feel that we have not been able to effectively deal with a primary stumbling block to effecting significant change in medical education. That block is that students return to their home institutions full of ideas and enthusiasm but are met by faculty and administrators who were not at the meetings and consequently do not share students' enthusiasm. Therefore, to overcome this problem, we would like to invite students, residents, faculty, and administrators with responsibility for the curriculum, from six "traditional" medical education institutions to experience certain aspects of the problem-based approach to medical education and evaluate the merits of this education method for implementing the recommendations of the GPEP Report.

SPECIFIC AIMS

1. Identify strengths and weaknesses of the Problem-based learning method.
2. Compare students' attitudes toward learning in the traditional and problem-based learning curricula.
3. Compare residents' attitudes toward learning and teaching in the traditional and problem-based learning curricula.
4. Compare faculty's attitudes towards teaching in the traditional and problem-based learning curricula.
5. Examine the system of evaluation of students in a problem-based curriculum.
6. Bring students, residents, faculty, and administrators together to consider the pros and cons of problem-based learning.
7. Stimulate "traditional" schools to incorporate more of a problem-based approach in teaching medical students at their institutions.
8. Evaluate the institutional structure of a problem-based curriculum.
9. Prepare and publish a document of the outcome of the symposium and distribute to medical school students, residents, faculty, and administrators.

OUTLINE OF PROPOSED PLAN FOR SYMPOSIUM

OVERVIEW

Twelve institutions will be invited to participate based on commitment to both this project and to effecting change in medical education. Six will be from traditional curricula and six will have problem-based learning curricula. (For sake of discussion we will refer to these as traditional institutions (TI) and problem-based learning institutions (PBL)). Each of the participating schools will identify:

- a) a student (the OSR Representative)
- b) a resident
- c) a clinical faculty member
- d) a basic science faculty member
- e) an administrator with the
responsibility for the curriculum

These five individuals will serve as an ad-hoc committee within each school to evaluate their own curriculum and serve as a catalyst for creating change. See Appendix D for letters of participation agreement from the twelve institutions.

2. At the 1986 AAMC National Meeting in October, a preliminary list of issues to be addressed at the Symposium will be solicited from all Councils of the AAMC.
3. The preliminary list of issues to be raised, appropriate reading materials and a plan for eliciting support will be disseminated to the six TI schools in Nov.-Jan.
4. From Jan-March, each TI will ascertain concerns, issues concerning medical education, and questions from the students, faculty, residents, and administrators at their institutions.
5. In March of 1987, representatives of each participating Institution will meet at Southern Illinois University to take part in experiences representative of those offered at medical schools with a problem-based learning curriculum. To accomplish this, we propose that students and faculty from PBL schools will demonstrate pertinent components of their curriculum (e.g. small-group sessions, tutorials, use of a Problem-Based Learning Module simulated patient sessions, and evaluation sessions. See Appendix B for types of Demonstrations). The TI representatives will

participate in each of these demonstrations in order to experience the teaching and evaluation methods first hand.

6. The representatives will convene and synthesize their thoughts/reactions to what they have experienced.
7. The outcome of these discussions will be compiled and published as proceedings of the symposium. Possible follow-up of this symposium would include collaborative research focusing on problem-based learning for the participating TI's.

SYMPOSIUM SCHEDULE

The following is an outline of the major components of the four day symposium.

- DAY 1
1. Travel day with arrival in the afternoon.
 2. Evening session on:
 - a. Symposium objectives
 - b. Issues of concern to TI institutions
- Day 2
1. Overview of Problem Based Learning
Philosophy
 2. Demonstration of Problem Based Learning
 - a. Simulated Patients
 - b. Problem-Based Learning Module
 3. Evaluation of Students
 - a. Clinical Reasoning Test
 - b. Assessment of Clinical Competence
- Day 3
1. Implementing Problem-Based Learning
 2. Issues of Two-Track Curriculum
 3. Implications for TI
 4. Summary and Evaluation
- Day 4
1. Travel day

BUDGET

Funding is sought for administrative activities of this project, travel, and publishing. An outline of expected expenses is listed.

ADMINISTRATIVE

Mail.....\$ 100.00
Phone..... 150.00
Staff support.....2000.00
Xeroxing, Printing.....1000.00

LODGING.....4950.00

55 people
3 nights
\$30 per night

MEALS.....3600.00

60 people
4 days
\$15 per day

TRAVEL

Airfare.....22,000.00
11 institutions
5 people
\$400 round trip

PUBLICATION.....16,200.00

TOTAL.....\$50,000.00

SUGGESTED READING

- a. The General Professional Education of the Physician Report, AAMC Publication, 1984.
- b. Problem-Based Learning: An Approach to Medical Education, Barrows and Tamblyn, Springer Publications, 1980.
- c. How to Design a Problem-Based Curriculum for the Preclinical Years, Barrows, Springer Publications, 1985.
- d. Implementing Problem-Based Medical Education: Lessons from Successful Innovations, Kaufman, editor, Springer Publications, 1986.
- e. How to Begin Reforming the Medical School Curriculum, Barrows and Peters, editors, Macy Foundation Report, 1984

APPENDIX A

OSR 1986 Annual Meeting

Friday, Oct. 24

- 3:30 - 4:30 pm Regional Meetings
- 4:30 - 5:30 pm Business Meeting
- 5:30 - 6:00 pm New Member Orientation
- 7:30 - 9:00 pm General Session: POSITIVE MESSAGES ABOUT
MEDICINE AND MEDICAL SCHOOL
Carola Eisenberg, M.D.
Dean of Students
Harvard Medical School
- Leon Eisenberg, M.D., Chairman
Department of Social Medicine
and Health Policy
Harvard Medical School
- 9:30 - ? Party

Saturday, Oct. 25

- 8:30 - 11:30 am Plenary Session: PHYSICIANS' RESPONSIBILITIES
FOR KEEPING THE DOORS OPEN IN HEALTH CARE
- H. Jack Geiger, M.D., Arthur C. Logan
Professor of Community Medicine
City U. of New York Medical School
- Vivian Pinn, M.D., Chairman
Department of Pathology
Howard U. College of Medicine
- James B. Spear, Jr., Ph.D.
J.D., Assistant Professor
Department of Biomedical History
U. of Washington School of Medicine
- 1:30 - 4:30 pm OSR Discussion Groups: Four Social
Responsibility Tracks (the first three
include two 1 1/2 hour segments with a
short break in-between)
- A. 1) Alternative Health Care Modes
- 2) ?
(coordinators: Jim Stout and Dan Schlager)
- B. 1) Incorporating Preventive Medicine
into Your Practice

2) Emerging Health Care Delivery Systems
(coordinators: Joanne Fruth, Mark
Blumenthal and Vietta Johnson)

C. 1) Improving the Educational
Environment: Everyday Ethics

2) Giving Human Values Courses
a Clinical Focus
(coordinators: Janet Bickel
and Kim Dunn)

D. Simulated Minority Admissions Exercise

5:00 - 6:00 pm

General Session: Chairperson-Elect

7:30 - 9:00 pm

Campaign Speeches
Andrew Weil, M.D.
(on Healing or Medicine in the Year 2000)

Sunday, Oct. 26

6:30 am

Mississippi River Run

8:30 - 10:00 am

Program: International Health and
Community Service (Joann Elmore)

10:30 - Noon

Program: Problem-Based Learning (Kim Dunn)

1:30 - 4:00 pm

Business Meeting

4:00 - 5:00 pm

Regional Meetings

as of 6/2/86

DISCUSSION WITH COUNCIL OF DEANS CHAIRMAN

When OSR Chairman Rick Peters presented the OSR "Critical Issues" paper to the COD Administrative Board in April, Dr. Clawson expressed an interest in discussing with the OSR Administrative Board some of the issues it raised regarding problems in clinical education. OSR Board members are requested to review this section of the paper prior to the meeting.

A continuing discussion topic which both Kay Clawson and Rick Peters requested be developed into an agenda item for the June meeting is the goal of reducing the influence of the National Boards on medical education, specifically, by reporting scores only on a pass/fail basis. This agenda item appears as an addendum to the CSR agenda mailing.

Albert Schweitzer: A Hero for All Time

By NORRIS FREDERICK

Frederick, executive director of North Carolina SANE, teaches philosophy at UNC-Charlotte.

When I was growing up, we weren't sophisticated enough to know about "positive role models." We were content with plain old heroes. Our icons were the Topps Chewing Gum baseball cards, and we passed hot Carolina afternoons on shaded porches opening and trading cards, looking for treasured photos of our heroes: Ted Williams, Willie Mays, Mickey Mantle and Harmon Killebrew.

In my 11th summer, my mother gave me a subscription to the Landmark Books for Young Readers. One month when I forgot to mail back the card saying I didn't want the current selection, I received a book about a man whose last name I couldn't pronounce. It looked foreign.

So I had this book we would have to pay for. The afternoons were too hot for baseball. There was no cable television. Summer camp was for rich kids. So finally I sat down and read about this foreigner, Albert Schweitzer.

I was intrigued by the life of this man who gave up Europe and its comforts for life in Lambarene in Africa, bringing health care to the natives. I was also vaguely discomfited by the fact that while so many of the older folks in our congregation thought Schweitzer was wonderful to work with the Negroes in Africa, these same adults denied our youth group the opportunity to meet with the youth at the Negro church just two blocks away. The young are quick to spot hypocrisy, not having practiced it as long as adults.

For the past 27 years, I hadn't thought much about Schweitzer, until two weeks ago when I read Norman Cousins' *Albert Schweitzer's Mission: Healing and Peace*. In 1957, Cousins — then editor of *The Saturday Review* — went to Lambarene on a mission of his own.

Schweitzer was 82, and strong enough to outwork people half his age in the tropical heat. He had lived for 40 years at the hospital he had established in Lambarene with the royalties from his book on Bach. Schweitzer was a renowned organist and theologian, as well as being a physician. He worked hard all day, pausing with his staff for meals where his

gentle wit was often the entertainment. After a full day of seeing patients and running a hospital, Schweitzer then worked late into the night on mountains of correspondence from all over the world, and on two manuscripts he had been working on for years: the last two volumes of *The Philosophy of Civilization* and a relatively short manuscript, *The Kingdom of God*. In the latter, the doctor was putting forth his radical thesis that "Christianity has veered away from Christ. Christianity has constructed an elaborate dogma, but it has not really comprehended that the mission of Jesus was to enable every man to discover the Kingdom of God in himself."

And then at the end of his writing, Schweitzer would put down his pen and sit at the tinny organ that had suffered for years in the tropical humidity. The man who had played organs in the finest cathedrals in Europe played in the African night, and almost by sheer will produced beautiful renditions of Bach.

Theologian by African night, doctor by day, Schweitzer was also a

carpenter, hammering boards in place in the open-ended wooden buildings that served as operating rooms and as bedrooms for patients and their families.

Many Westerners who came to visit Lambarene were appalled at what seemed primitive and unsanitary conditions. Schweitzer pointed out that most of his patients were still treated in their villages by witch doctors, and would have been frightened to come to a modern facility even had it been possible to build one there in the jungle.

Schweitzer had detractors on other points as well: Some claimed he was paternalistic toward blacks, others that he was autocratic. Still others said that he wasn't accomplishing much in the overall health situation. Visitors were often disappointed that he would not halt his 16-hour days to spend long hours talking with them.

For some reason, Schweitzer opened up to Norman Cousins and his pleas that if world leaders would listen to anyone about the threat from nuclear weapons, it would be Schweitzer. Schweitzer listened intently, but responded cautiously. He had never engaged in political matters before, and he was reluctant to begin now. Cousins responded that this was a matter of morality and public health, and told Schweitzer of the Japanese who were suffering from the radioactive fallout from tests in the Pacific. Cousins pleaded that the world needed Schweitzer's voice.

The next day, Schweitzer told Cousins he would help, and the two carefully planned the best method for Schweitzer's message. Schweitzer thought that although the world was their goal, they should focus on a single act as an intermediate goal: the halting of nuclear weapons testing. Soon Schweitzer's message was heard over radios in Europe, in a complete transcription of the broadcast in *The New York Times* and in

correspondence between Schweitzer, President Kennedy and Premier Khrushchev. In late 1957, Cousins and a small group formed the Committee for a Sane Nuclear Policy. Schweitzer's voice and the voices of many others succeeded with a 1963 treaty banning atmospheric tests. Until his death in 1965 at the age of 90, Schweitzer worked as tirelessly against nuclear weapons as he had against other forms of disease.

My childhood baseball heroes aren't very heroic anymore. One has served as a front man for a gambling casino, and two others serve as hucksters for various products. Maybe there's nothing wrong in what they do, but there's nothing very heroic there anymore.

My 10-year-old son, Chris, today lives in a society where many sports stars and rock music stars need huge sums of money to keep up their cocaine habits. Where "what's in it for me?" is the primary question for most citizens. Where politicians have endless abilities to lie with sincerity.

He needs heroes. So do we adults. Those same psychologists who talk of "positive role models" may also tell us that "adults don't have fathers or mothers, they just have brothers and sisters." There's an element of truth in that, but there's the larger mythic truth that we all need heroes. Not positive role models, but plain ol' heroes.

Schweitzer obviously wasn't perfect — being human and all that — but his life remains a powerful symbol of how we might live. He understood and lived the importance of duty and calling and their role in a joyful, meaningful life. His choices demonstrate the rare triumph of the human spirit over materialism. And his lifelong hard work and physical strength — coupled with the courage to take on at age 82 the death-dealing forces of nuclear weapons — can speak for us all as a triumph of the spirit over tragic despair.



from Jim Stout

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