

**Organization of Student Representatives
Administrative Board Meeting**

June 27, 1990

8:00 am - 4:00 pm

AGENDA

- I. Call to Order
- II. Consideration of Minutes of February Ad Board Meeting *
- III. Regional Reports
 - A. Central
 - B. Northeast
 - C. Southern
 - D. Western
- IV. Information Items
 - A. Phone Tree Assignments *
 - B. Committee Representatives *
 - C. Consortium report
 - D. Dates for 1991 Meetings *
- V. Discussion Items - Old Business
 - A. 1990 Priorities *
 - 1. Counseling
 - 2. Medical Education *
 - 3. National Boards *
 - 4. Societal Responsibility
 - 5. National Legislation/Federal Update from Sarah Carr
 - B. Annual Meeting Plans *
 - C. OSR progress notes *
 - D. Housing Exchange Network
 - E. AAMC Designated Liaison List *
 - F. Resource Manual/Project Forum
 - G. Committee Reports
 - H. Alternate OSR Reps - Mailing List

* Enclosed Attachment

(Old Business, continued)

- I. DHHS Secretary's Award Presentation
- J. Society for Health and Human Values
- K. Proposal for Selection of Reps to ORR

VI. Discussion Items - New Business

- A. Executive Council Items (separate booklet)
- B. CAS/OSR Breakfast Meeting Agenda *
- C. OSR Member Responsibilities *
- D. OSR Committee Rep Responsibilities *
- E. Orientation Handbook (separate attachment)
- F. Proposed Position Paper on Smoke-Free Medical Schools *
- G. Proposed Educational Video on Issues of Discrimination *
- H. Health Services and Health Policies *; and
AAMC position on HIV-infected medical students
- I. NRMP Student Handbook and Transition Issues *
- J. American College of Physicians (ACP) Representative
- K. Other New Business

VII. Adjournment

* Enclosed Attachment

Organization of Student Representatives
Administrative Board Meeting

June 27-28, 1990

Schedule

Wednesday, June 27

**Association of American Medical Colleges
1776 Massachusetts Avenue**

8:00 am - 4:00 pm	OSR Administrative Board	2nd Floor Conference Room
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Thursday, June 28

Washington Hilton Hotel

7:00 am - 8:00 am	OSR/CAS Breakfast	Hamilton
8:00 am - 12:00 noon	Council of Deans Board Meeting (+)	Conservatory
12:00 noon - 1:00 pm	Joint Boards Lunch	Military
1:00 pm - 3:30 pm	Executive Council Business Meeting (+)	Conservatory

* All Board members will receive formal invitations

(+) Caroline and Lawrence only

Association of American Medical Colleges
ORGANIZATION OF STUDENT REPRESENTATIVES
Administrative Board Meeting

February 21, 1990
1776 Massachusetts Avenue, NW
Washington, DC 20036

MINUTES

Present:

Caroline Reich, Chair
Lawrence Tsen, Chair-Elect
Clay Ballantine, Immediate Past-Chair

AAMC Staff
Donna Quinn
April Morrow
Sarah Carr

Representatives-at-Large

Andrea Hayes
Cynthia Knudson
Anita Jackson
Krishna Komanduri
Lee Rosen

Regional Chairs

Phillip Noel - Southern
Amy Davis - Central
Tom Lee - Northeast
Ashleigh Head - Western

I. Call to Order

Caroline Reich called the meeting to order at 9:00 a.m.

II. Consideration of Minutes

The minutes of the September 27, 1989 Administrative Board Meeting were approved without change.

III. Regional Reports

A. Central

Amy reported on the COSR Regional Meeting, April 26-29 at Nordic Hills in Itasca, IL. The program and activities include a CONFER demonstration and a Project Exchange (which Amy is personally organizing). GEA has not been supportive of Amy's needs; decisions have been made without her input. Clay suggested the Project Exchange at the other region's meetings and possibly the Annual Meeting as well. The Regional Chairs agreed to try it. Data collected could be compiled into the Resources Manual. Consensus was that all regions would ask their registrants to supply one project. The four regional chairs will decide on a basic format/guideline for submissions to ease the abstraction process for the Resources Manual. What's key is that the data be gathered and forwarded to AAMC/Donna who will serve as a clearinghouse.

The question was raised as to whether the other regions were finding it difficult to

work with the GEA or GSA while planning their meeting. The chairs of the three other regions were, for the most part, satisfied with their joint efforts.

B. Northeast

Tom reported on the NEOSR meeting, April 18-21 at the Four Seasons in Toronto, Canada. Two-thirds of the meeting is held jointly with NEGSA. The controversial theme is "not nurturing dysfunctional students", with the premise that "hand-holding" may not necessarily serve them well. They will create case studies of "problems" and encourage discussion of how schools do or might handle that situation.

C. Southern

Phillip reported on the SOSR meeting, April 25-28 at the Seelbach in Louisville, KY. There will be 3 joint plenaries which will incorporate the OSR's priorities, followed by discussions, and separate OSR sessions. Dr. Beran, Sarah Carr and Donna Quinn were invited to join the Round Table on Thursday, April 26th from 5:30 p.m. to 7:00 p.m. Guided tours will be scheduled for the Glow Clinic and the Homeless Shelter. The SOSR Business Meeting is Sat., April 28 from 9 am -10 am.

D. Western

Ashleigh summarized the WOSR Meeting in Asilomar, CA on April 22-25. The theme is "Defining the Product". The popular Fireside Chat will be sponsored again. There are numerous joint sessions, including urban health training, rural health training and legislative strategies. There will be 2 business meetings - Sun., April 22 at 4 pm and Wed., April 25 at 9 am. Of note is the OSR Volleyball Challenge.

IV. Information Items/Housekeeping Items

A. Phone Tree

Caroline asked for feedback from the last Phone Tree. Ad Board members found that some students had met with Deans and others had not, that some had written letters and others had not (many of those who had not written were unsure of how to get started). Ad Board members should follow-up since Sarah's article in OSR progress notes should assist students with this effort. Ad Board members received the names and numbers of the latest phone tree contacts.

B. Miscellaneous

Cindy suggested that Annual Meeting attendees have the opportunity to share rooms/request roommates. The Ad Board agreed that many would appreciate this opportunity to meet others and save money.

Each board member must report any OSR representative changes to Donna, prior to the regional meetings. Identify all schools without a representative and provide Donna with the names of those schools.

V. Discussion Items

A. Health Promotion and Disease Prevention

Lois Bergeisen, unable to be present, asked for input on the following:

1. **DHHS Secretary's Award Presentation at Annual Meeting - Ad Board supports the idea of enabling award winners to present their paper and would like to cosponsor the event. They suggested that DHHS should offer assistance to the student for attending the presentation and that a letter - signed by AAMC president/OSR chair/DHHS Secretary - be sent to schools' Deans to increase their awareness and encourage further support.**
2. **National Cancer Institute Training Program - there was interest, but the Ad Board needs more information before making a decision about building it into the Annual Meeting program.**
3. **Improved communication - the consensus was that it can be made better if Lois keeps in close contact with Donna, Caroline and Lawrence.**

B. Federal Update by Sarah Carr

1. Student Loan Interest Deductibility
Congressman Schultz and others, including the Student Loan Interest Deductibility Restoration Coalition (SLIDRC), of which AAMC is a part, testified on February 22nd.
2. President's Budget for Title VII Programs
(includes HPSL, HEAL, EFN, FADHPS, HCUP, AHEC). Reagan had sought to eliminate funding in these areas. Bush has chosen to eliminate specific programs and proposes a new Minority Health initiative. On the other hand, the National Health Services Corps (NHSC) and help to minorities and disadvantaged students will increase.
3. Reauthorization of the NHSC
Efforts by Cooper, Slattery, Richardson and Waxman aim to: enhance loan repayment, scholarships and the selection of disadvantaged/minority students; add a residency fellowship program; emphasize those who want to serve the underserved; and open it up to "secondary providers".
4. HEAL
Sarah talked about the proposed phase-out of Heal funds to new borrowers and clarified the status/projections of the Student Loan Insurance Fund.
5. Minority Health Bill
This proposed bill affects the financial aid aspect of Title II. One item of disagreement is the language of "underrepresented vs. disadvantaged". AAMC supports the word "underrepresented". The bill addresses loan repayment, scholarships and faculty development. There are conflicting opinions as to which schools most deserve the assistance. AAMC is trying to influence the bill's development. Anita suggested that eligibility for funds might be based on the graduation (as opposed to enrollment) figures or on the school's success across all four years.
6. Reauthorization of the HEA

States/Legislators to focus on: Montana/Williams; Missouri/Coleman; Massachusetts/Kennedy; Rhode Island/Pell. Lee Rosen asked what the next steps should be. Sarah's recommendation: prioritize your issues. She believes the Deferment issue should be top priority. The time is just right for the Reauthorization of the NHSC as well. She sees loan interest deductibility as another important issue. She made it clear that the OSR needs to decide how it wants to rank these. When asked if she could help identify local people in these arenas, Sarah admitted she did not have the time to do that.

7. Other
Terry Hartle has recommended that a Study on Indebtedness, originally proposed to be done by the Department of Education, should be handled in the General Accounting Office.

The Student Status Deferment restriction did go into effect January 1, 1990. Sarah clarified when the deferment period begins and that whatever grace period was established when a loan was originated would still hold.

C. Priorities

1. National Legislation

#1 Issue: Deferment. First step - create a "How-to" ACTION PACK for letter-writing and petition-signing. Petitions should go to Sarah. Next step - follow-up with specific schools to confirm they are doing it. Third - invite a state legislator to a medical school in that state, a student-sponsored event coordinated with the help of school administrators. Possible targets for the pilot are: Brown University (Senator Pell) and University of Washington (several state's Representatives).

OSR focus in OSR progress notes: article by Krishna

federal update in OSR progress notes: Reauth. of NHSC, Minority Health Bill, by Sarah

Annual Meeting: Legislative Update session, planned by Amy and Sarah

2. Counseling

The handout "Career Decision-Making Opportunities" was discussed. Each month one or more of the ideas will be an OSR Newsletter enclosure to be posted. Ashleigh will submit them to Donna on a regular basis. There was extensive discussion of the counseling issue, with distinctions between peer and career counseling, particularly in regard to Annual Meeting activities. Ad Board does not want GLAXO there.

OSR focus in OSR progress notes: article by Ashleigh

project forum in OSR progress notes: Peer Counseling, by Lawrence

Annual Meeting: Workshop on peer counseling/support, by Krishna; Lunch on career counseling, by Anita

3. Medical Education

Krishna presented a survey seeking information on innovative curricula and students interested in sharing them at Annual Meeting. This could generate

model curricula or the basis for a student-initiated curricula review (the latter suggestion was preferred by the board). Other topics in this area: 1) peer responsibility/peer evaluations/honor codes; 2) Outstanding Teaching Award, sponsored by the OSR. Several proposals were shared in regard to the selection process, the number of awards, the criteria, needing AAMC support, what to do with the list of award winners, etc. The board members were all supportive of the concept and interested in fine-tuning it; and 3) Faculty evaluation forms. For student input on teaching to be valued, methods of evaluating faculty must be sound. Samples of good forms need to be collected and a guideline prepared (GEA and CAS are also interested in this project).

OSR focus in OSR progress notes: article by Tom and Cindy

OSR Newsletter: Survey distributed, by Tom, Cindy and Krishna

Annual Meeting: Presentation of the survey results on student input into review of curricula, by Tom and Phillip

project forum in OSR progress notes: Aesculapian society, by Phillip

4. National Boards

Caroline reported: a) GEA Steering Committee supports Pass/Fail. GEA will discuss the issue at regional meetings. b) GSA Steering Committee supports GEA's statement with one reservation. They too will discuss it regionally. c) COD was eager to meet with OSR (next day) to discuss it; the Chair indicated there was support. d) OSR plans to meet with CAS in June. e) It was suggested that the focus be on a Clinical Skills Assessment Examination. f) The NBME Liaison Committee Meeting was postponed by Dr. Volle.

The Ad board discussed and voted on the GEA's proposal on NBME. It was unanimously approved, with one modification. Strategies for determining COD's stand were discussed, with general agreement that OSR needed to present a clear, unified stand to COD. Consensus was that student support is there. Discussion of strategies needed to approach CAS were tabled.

OSR focus in OSR progress notes: article about supporting GEA's proposal without final clause, by Anita

OSR Newsletter: same as above

Regional Meetings: Discuss the issue with students to confirm support

Annual Meeting: Sunday - joint plenary with COD (numerous topics suggested, including the priorities and student abuse issue)

5. Societal Responsibility

The issues in this area include Indigent Care, Preventive Medicine and Ethics courses in curricula. Most of the discussion revolved around the Annual Meeting. Ideas include: Indigent Care Workshop; Plenary with panel of community advocates/activists sharing their expectations of health care professionals, followed by a group discussion; and a session on ethical responsibility/medicine and the law. Plans are under way for a joint session with the Group on Public Affairs to address promoting and publicizing Indigent Care projects and programs.

Annual Meeting: several ideas (described above)

D. Annual Meeting
Tentative Schedule attached

E. OSR progress notes

The students had generally favorable comments on the new look and contents of the newsletter. There were a few minor corrections. Contents for the Spring 1990 issue were selected: chair's message, supplied by Caroline; OSR focus, small write-ups for all priorities but societal responsibility; FYI, Ad Board with all graduation years; federal update, Reauthorization of NHSC and the Minority Health Bill; AAMC focus, GEA/Brownie; bulletin board, theme of Annual Meeting; calendar of events, Ad Board meetings and Annual Meeting; project forum, Peer Counseling and Aesculapien Society; action items, Housing Network.

F. Designated School Liaisons List

The board members liked the list and suggested: a) delete the address to provide space for other data; and b) add the OSR rep to the list so that it may be utilized by other groups and so that the OSR reps can distribute it around their own campuses. Donna will send it, as is, as soon as possible to the OSR reps, explaining its purpose, encouraging its use and asking reps to pass it on to the other liaisons. The list will be generated again, with revisions, and copies sent to the other groups. The descriptive information may need some embellishment and OSR needs to be added to that page as well. This list should be updated in early Fall.

G. Resource Manual

There was brief discussion on the format, data-collection and contents of the revised manual. LCME and CONFER should be included. Project Exchange information, gathered at regional meetings, should be in it as well.

VI. Executive Council Items

- A. Transfer Guidelines - discussion, vote, approval
- B. Establishing ORR - discussion, vote, approval
- C. Group of Hospital Educators - discussion, vote, approval

VII. New Business

Areas to cover on next Phone Tree: Peer Review; Career Counseling; Ethical Development; Indigent Care; Meeting with Dean; Project Exchange at regional meetings.

VIII. Adjournment

The meeting was adjourned at 5:45 p.m.

ANNUAL MEETING
Tentative Schedule

Friday	9:00-12:00	NCI Training	
	12:00-1:00	OSR Ad Board Meeting	
	3:00-3:30	New Member Orientation	Reps at Large
	3:30-5:15	Regional Meetings	Regional Chairs
	5:30-7:30	Opening Session: Global Health Issues	Caroline
	7:30 -	Reception	
Saturday	8:00-10:45	Plenary: Community Expectations of Physicians	Cindy/Amy/Lee and Clay
	11:00-12:00	Committee Reps' Sessions	
	12:00-1:00	LCME Lunch	Clay
	12:00-1:00	Mentor Lunch	Anita
	1:30-2:45	Workshops	
	3:00-4:30	Workshops	
	5:00-6:00	Chair-elect Speeches	
	7:30-9:00	Evening Program	Caroline
Sunday	7:00-8:00	GEA Steering Committee Breakfast?	
	8:00-10:00	Regional Meetings	Regional Chairs
	10:15-12:30	Speeches for Reps at Large	
		Elections	
		Business Meeting	
	12:30-1:30	Lunch	
	1:00-3:00	COD/OSR/GSA plenary	Caroline
Workshops:			
	Legislative Update		Amy
	Peer Counseling		Krishna
	Student Input into Curricula Review		Tom/Phillip
	Indigent Care: How to plan community Meeting		Lee/Andrea
	Medicine and the Law		Phillip
	Minority Recruitment		Andrea/Tom
	Cultural Awareness/Intn'l Health		Ashleigh/Cindy
	Financial Aid		Lawrence

OSR ADMINISTRATIVE BOARD

PHONE TREE WORKSHEET

Topics/Issues

Reps to Contact

1.

A.

2.

B.

3.

C.

4.

D.

5.

6.

E.

7.

F.

8.

9.

G.

10.

H.

I.

J.

STUDENT REPRESENTATIVES TO AAMC COMMITTEES/ORGANIZATIONS

COMMITTEE	REPRESENTATIVES NAME AND ADDRESS	TERM EXPIRES
Association of Teachers of Preventive Medicine	Cindy Niggley University of Kansas 3712 Bell Street Kansas City, MO 64111 (816)561-4325	Upon Graduation (May, 1991)
Flexner Award Committee	Ingrid Kohlstadt Johns Hopkins University 10506 Vincent Farm Lane White Marsh, MD 21162 (301)335-8750	November, 1991
GSA-Committee on Admissions	Antonio Hernandez Boston University 80 East Concord Street, Box 224 Boston, MA 02118 (617)442-8832	Upon Graduation (May, 1991)
GSA-Committee on Student Affairs	David Carlson University of North Dakota 1207 North 16th Street Bismarck, ND 58501 (701)255-3550	Upon Graduation (May, 1991)
GSA-Committee on Student Financial Assistance	Jeffrey Brink University of Florida P.O. Box 15506 Gainesville, FL 32604 (904)377-8904	Upon Graduation (May, 1992)

GSA-Minority Affairs Section Coordinating Committee

Kyndall Beavers
Meharry Medical College
Box 220
Nashville, TN 27208
(615)327-6764

Upon Graduation
(May, 1991)

Liaison Committee on Medical Education

Sonja Erickson
Yale University
812 Orange Street
New Haven, CT 06511
(203)773-0734

May, 1991

National Board of Medical Examiners

Krishna Komanduri
University of Minnesota-Minneapolis
433 S. 7th Street, #1704
Minneapolis, MN 55415
(612)375-9327

Upon Graduation
(May, 1991)

Michael Cantor
University of Illinois-Urbana
2304 Belmore Drive
Champaign, IL 61821
(217)352-0217

Upon Graduation
(May, 1992)

National Resident Matching Program

Jeffrey Honeycutt
Eastern Virginia University
1002 Langley Road
Apartment 4
Norfolk, VA 23407
(804)624-9358

May, 1992

Women in Medicine Coordinating Committee

Lisa Staber
University of South Dakota
205 N. Harvard
Apartment B
Vermillion, SD 57069
(605)342-5407

March, 1991

DATES FOR 1991 MEETINGS

1991 GSA SPRING REGIONAL MEETINGS

<u>Region</u>	<u>Dates</u>	<u>Location</u>	<u>OSR contact</u>
Central	April 11-14	Indianapolis, IN	Kevin Baskin 402-422-1430
Northeast	April 17-19	Pittsburgh, PA	Linda Lorenzani 716-834-6412
Western	April 21-24	Pacific Grove, CA	Sondra Bradman 714-852-1018
Southern	April 24-27	Galveston, TX	Robert Bright 919-962-8333

1991 AD BOARD/COUNCIL MEETINGS

All are held in Washington, DC

February 20-21

June 19-20

September 25-26

1991 AAMC ANNUAL MEETING

November 8-14 in Washington, DC

AAMC OFFICER'S RETREAT

December 12-14 (only the Chair and Chair-Elect attend)

OSR PLANNING RETREAT

December 10-11 (Tentative - need Ad Board to confirm these dates)

Worksheet

1989-1990 Priorities

1. Counseling

a. Follow up/Comments

- 1) Monthly Newsletter Ideas
- 2) Newsletter Enclosures

b. Annual Meeting Plans

- 1) Peer Counseling Workshop - Krishna
- 2) Mentor Lunch - Anita
- 3) Report at Business Mtg:
- 4) Additional Ideas?

c. Progress Notes

- 1) OSR Focus Assignment:
- 2) Additional Article?

d. Newsletter Ideas

2. Medical Education

a. Follow up/Comments

- 1) Newsletter/Progress Notes articles
- 2) Survey on Innovative Curricula
- 3) Outstanding Teacher Award
- 4) Faculty Evaluation Forms

b. Annual Meeting Plans

- 1) Wkshp-Student Input into Curricula Review (Tom/Phillip)
- 2) Report at Business Mtg:
- 3) Additional Ideas?

c. Progress Notes

- 1) OSR Focus assignment:
- 2) Additional Article?

d. Newsletter Ideas

3. National Boards

a. Follow up/Comments

- 1) P/F NBME draft
- 2) NBME Liaison Committee

b. Annual Meeting

- 1) Report at Business Meeting
- 2) Additional Ideas?

- c. Progress Notes
 - 1) OSR Focus assignment:
 - 2) Additional Article?
- d. Newsletter enclosures
- 4. Societal Responsibility
 - a. Follow up/Comments
 - 1) Newsletter enclosures
 - 2) Lack of information in Progress Notes
 - b. Annual Meeting Plans
 - 1) plenary - Community Expectations of Physicians - Cindy, Amy, Lee and Clay
 - 2) Indigent care workshop - Andrea and Lee
 - 3) Cultural Awareness/Int'l Health - Ashleigh and Cindy
 - 4) Minority Recruitment - Andrea and Tom
 - 5) Report at Business Meeting:
 - c. Progress Notes
 - 1) OSR focus
 - 2) additional article?
 - d. Newsletter enclosures
- 5. National Legislation
 - a. Follow up/Comments
 - 1) Newsletter enclosures - Action Pack
 - 2) Progress Notes articles
 - 3) Select schools for follow up
 - 4) Select states for targeting legislators
 - b. Report from Sarah Carr
 - c. Annual Meeting
 - 1) Legislative update - Amy
 - 2) Medicine and the Law - Phillip and Clay
 - 3) Report at Business Meeting:
 - 4) Additional ideas?
 - d. Progress Notes
 - 1) OSR Focus assignment:
 - 2) Federal update topics:
 - e. newsletter enclosures

OSR

Sample Curriculum Survey Questions:

Innovative Curriculum:

- 1) **Problem Based Learning (PBL):**
 - A) What courses involve PBL
 - B) For each course mentioned, what percentage is devoted to PBL
 - C) Is the material presented during PBL represented on the exam
- 2) Are the first two years structured in the classical format or is it system oriented
- 3) Do your classes use novel teaching aids (ie. computers, videotaped lectures, etc)
- 4) Are tutors available for students who are having trouble in courses
 - A) Faculty tutors (professors and graduate students)
 - B) Upperclass students in the school
- 5) Are you satisfied with the your basic science training
 - A) With the content
 - B) With the way it was taught

Student Evaluation:

- 1) **Grading System:**
 - A) Fail / Pass
 - B) Fail / Pass / Honors
 - C) Fail / Pass / High Pass / Honors
 - D) Fail / Low Pass / Pass / High Pass / Honors
 - E) Percentage Grade
- 2) **How does each basic science course determine passing**
 - A) Standard deviation
 - B) Straight cutoff (no adjustment)
- 3) **Does the grading system effect:**
 - A) The way in which you study the material
 - B) The atmosphere between students (competition, etc.)
- 4) What grading system do you prefer

Course Evaluation:

- 1) **Course surveys:**
 - A) Which classes give this out
 - B) Who in the administration evaluates the surveys and who acts on them
 - C) Have the surveys had any effect on the course in the past
- 2) **Professor Evaluation:**
 - A) Are the professors evaluated during the course

- B) Are there any special awards for exceptional teaching ability
- C) Is the professor's ability to teach a factor in the tenure decision process

- 3) Are there other avenues for students to give feedback to faculty either formally or informally:
- A) Student / Faculty lunches
 - B) Deans

GEA Statement In Support of Pass/Fail Reporting of NBME Scores

May 16, 1990

In the past few years a number of major changes have occurred or are planned that will influence medical licensure examination procedures. Among these are:

- 1) adoption of a single path to licensure, the United States Medical Licensing Examination;
- 2) NBME development of new examination blueprints (Comp I and Comp II) which may increase the number of integration and application items on each examination and may decrease the number of items sampling traditional disciplinary domains;
- 3) further separation of NBME Subject (Discipline) Test and Licensure Test development, along with scoring and feedback procedures to better accommodate the distinct functions these tests were designed to serve;
- 4) eliminating the practice of reporting discipline scores to students who take the NBME licensure test since the number of items covering each discipline has been decreased to the point where discipline scores will not provide reproducible estimates of discipline competence.

The AAMC Group on Educational Affairs (GEA) believes the above changes are constructive steps toward improved licensure examination development and score reporting practices. Additionally, the GEA urges adoption of one additional change in NBME score reporting practices. Based upon the recommendation of its Task Force on Appropriate Use of Results of NBME Examinations and a national vote of the GEA membership, the GEA recommends adoption of a policy to report NBME licensing examination results on a pass/fail basis. If this policy were implemented the examinee would no longer receive a numerical score. The failing examinee would, however, receive non-numeric information sufficient in detail and specificity to allow the candidate to prepare for re-examination.

The following points are offered in support of this recommendation.

1. Licensure decisions are binary. The individual is either judged sufficiently competent to warrant licensure or is judged not to merit licensure until competence is attained. Reporting results as pass or fail is consistent with the inherent nature of the decision to be made.
2. Residency program directors currently use NBME Part I and/or Part II scores for residency selection purposes. Items designed for a licensure examination and those designed for selection (admissions) do and should have different characteristics. The licensure examination should establish basic competence to practice without regard for the performance of other examinees. The selection examination is designed to produce a large range of scores so that the most proficient examinees can be identified. This type of examination includes items from a broad spectrum of difficulty levels. Reporting NBME examination performance as strictly

pass/fail will decrease alternate uses such as for selecting residents and will allow development of a pure licensure examination.

3. The use of NBME Parts I and II for residency selection purposes (especially Part I) has resulted in student review practices that are often detrimental to the goals of the medical school curriculum. Students neglect those portions of the curriculum which occur immediately preceding Part I examinations except for content they believe will be covered on NBME Part I. Pass/fail reporting would decrease the emphasis on examination preparation somewhat and decrease its disruptive effect on the medical school curriculum.
4. The content of NBME Part I is limited to coverage of the sciences basic to medicine. These scores do not provide a comprehensive indication of clinical competence and are thus an inadequate basis for residency selection or screening. Pass/fail reporting will likely decrease the emphasis placed on this examination for residency selection purposes and may result in selection procedures that use a more balanced set of measures which are better suited to the decisions being made.
5. Pass/fail reporting would mean that medical schools and the LCME would only have access to information regarding the percentage of students passing NBME licensure examinations. Mean class scores would not be available. This change would eliminate the problem of over-interpreting differences in average class performance (changes from year to year or difference from school to school) that are not truly reflective of real differences in competence or achievement.

Worksheet Annual Meeting

1. Activity for Thursday Evening
 - a) Plans:
 - b) Coordinator:
2. NCI Training Update
3. New Member Orientation (all At-Large Reps to be Involved)
 - a) Plans:
 - b) Coordinator:
4. Opening Session
 - a) 5:30-6:00 Reports on Priorities
 - b) 6:15-7:00 Speaker (Caroline)
 - c) 7:00-7:30 Questions
5. Evening Reception
 - a) Plans:
 - b) Coordinator:
6. Committee Rep Sessions
 - a) Committees to be included:
 - b) Coordinator: Caroline
7. LCME lunch (Clay)
8. Financial Aid Workshop (Lawrence)
9. Chair-Elect Speeches - moderator:
10. Sat. Evening Program
 - a) Schedule - 7:30-9:00 or 6:15-7:30 leaving the entire evening free
 - b) Speaker (Caroline)
11. GEA Steering Committee Breakfast - Agenda Items
12. Rep - at - Large Speeches - Moderator:
13. Business Meeting - Agenda Items
14. 12:30-1:30 • Ad Board Lunch
15. COD/OSR Plenary
16. Info to Share Network - Ideas to make it more functional
17. How to make it easier for reps to find roommates
18. OSR display for IME exhibit



National Institutes of Health
National Cancer Institute
Bethesda, Maryland 20892

TRAINING PHYSICIANS IN SMOKING CESSATION TECHNIQUES

The National Cancer Institute (NCI) has developed a training program for physicians which teaches them techniques to help their patients stop smoking. This program is based on a series of randomized, controlled clinical trials funded by NCI for the purpose of developing and validating useful smoking cessation techniques. The results of these trials have clearly shown that physicians can have a significant impact on smoking rates among their patients, through the use of these brief interventions.

The techniques developed in the trials are described in document entitled, How To Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians. This manual is designed for use by practicing physicians and their office staff. Using the information contained in the manual, one-hour and three-hour courses for physicians have been designed, and supporting materials produced. A one-day workshop has been designed to teach physician trainers how to conduct these courses for their colleagues.

In order to teach physicians throughout the Nation, NCI is seeking collaborative relationships with organizations who share a commitment to cancer prevention and who can reach practicing physicians. NCI will conduct programs to train physician trainers from these organizations. These trainers will then work with their organization to train other practitioners.

Collaborating organizations to date have included the American Cancer Society, the American Medical Association, the Association of American Medical Colleges, the American Medical Women's Association, the Association of Teachers of Preventive Medicine, the American College of Preventive Medicine, several state medical societies, and several large health maintenance organizations. Organizations who would like to collaborate in this effort are encouraged to contact NCI by calling Dr. Marc Manley at 301-496-8520.

The goal of this project is to train 100,000 practicing physicians by the end of 1992. This project is part of NCI's effort to reduce cancer mortality in the Nation by 50% by the Year 2000.

"POSITION DESCRIPTION" FOR PHYSICIAN TRAINER

This training is designed to teach physicians how to conduct 3-hour and 1-hour courses in smoking cessation techniques. The qualified trainer should:

- 1) Practice medicine (preferably in a primary care specialty), so that he or she can discuss personal experiences with the smoking cessation techniques and thus give advice and training based on experience;
- 2) Be experienced in organizing and promoting medical education programs;
- 3) Be accepted by the local medical community as a credible source of medical information;
- 4) Be willing to conduct courses in this topic.

February 25, 1990

Lois Bergeisen
Staff Associate
Division of Minority Health,
Disease Prevention/Health Promotion

Dear Ms. Bergeisen:

I'm sorry we missed an opportunity to meet with you at the February OSR Ad Board meeting. I understand that you had a family emergency; I hope that all is well.

Thank you for preparing your topic sheet. It is my understanding that Donna Quinn will talk to you on our concerns. Let me briefly reiterate them:

- 1) The DHHS Secretary's Award: We're interested in co-sponsoring the honor; our thinking is that we can write a joint Dr. Sullivan, Dr Petersdorf, and Caroline Reich letter addressed to the individual schools to increase the awareness of this award. We would also like to encourage the DHHS to increase their support to help defray some of the costs associated with attending the presentation; we will happily write a letter if you think this would be the most appropriate direction.
- 2) The National Cancer Institute (NCI) Workshop: The students were very interested in this offering, but we need more information ie. how long the program is, if teaching materials are given in bulk so that students can bring the program to their own institutions, and when it is scheduled on the Saturday. Saturday is typically the most busy day in our OSR agenda, and our activities on that day would most likely rule out any participation in other events.
- 3) Improved Communication: The best way is to keep Donna, Caroline and I informed of events and programs where you would like student participation. We welcome your interest.

Thanks for making an effort to participate with OSR.

Sincerely,
Lawrence Tsen
OSR Chair-Elect
4449 Francis Street
Kansas City, Kansas 66103

cc: Donna Quinn, Caroline Reich

Donna,

These cases are pretty rough. Please edit them as you wish. I hope that they serve as a starting point for planning this session. Case 1 illustrates a few of the blatant as well as the subtle problems encountered during the Basic Science years. They are hard to describe. Students feel particularly stressed about the mixed signals that are sent concerning evaluations. I hope that this case portrays that dynamic.

Cases 2 and 3 describe incidents of sexual discrimination. Other issues in this realm may or may not need to be addressed at this forum. Overt sexual advances are discussed often. In addition, there is the problem of female students being ignored by some professors when interacting with small groups of students.

Case 4 is probably more what you had in mind. This scenario encompasses several incidents. I will be interested in the suggestions for handling these situations. It is easy to see how the cumulative effect of these incidents is detrimental to a student's ability to learn and function effectively. Most students would fail to report any of these individual problems because they would feel like kindergardeners tattling on a playmate.

Keep me posted as this session develops.

Caroline

Case 1

After receiving his grade on his first biochemistry exam, John realized that he needed to change his focus of study. Although he had made a B, he was now aware that he must study to recognize details rather than focus on major concepts to really do well on the types of multiple-choice questions being asked.

"After all," he reasoned, "National Boards are going to be this detailed. At least this is what the professors keep telling us. Not only must I pass them to go onto 3rd year, I need to do well since I want to go into ophthalmology."

The word had filtered down to John that the more competitive residencies looked closely at these scores to screen applicants.

After going through his own notes, the transcripts and referring to the suggested text, he noticed that there were some areas of discrepancy which he was unable to reconcile. The next day he stopped by the course director's office to ask a few questions. As John approached the professor in his lab, he was met with a [REDACTED]. The professor informed John that he was in the middle of an important experiment. Although he was unable to talk at the moment, he would be able to see John that afternoon. Apologetically, John left and returned later that day. As John began to ask his questions, the professor, [REDACTED], [REDACTED]

"You medical students are all alike," [REDACTED] "Always focusing on minutia - Only concerned about what is going to be on the test or worse - on the boards. Why don't you ever come to me with really interesting, conceptual questions. You only care about your grades." The professor continued, "In my opinion that is what [REDACTED] - the people we let into this profession are not intellectual. They only care about their evaluations." Then Dr. Jones paused, regained his composure and asked, "Now, what was your question?"

18 months later...

When John received his board scores, he was particularly pleased that he had done so well in biochemistry. A few weeks later he ran into Dr. Jones who stopped him in the hall.

"John, I reviewed your class's biochemistry board scores the other day," he said. "The class average was 10 points above last year's class. I noticed that you were among the top in your class. Congratulations! What we need at this medical school are more bright minds like yours!"

Case 4

Mike was just beginning his long-awaited 3rd year of medical school. The dream of finally making it to the wards had kept him going through many long nights of study during the first two years. Now he was ready to start. His first clinical rotation was OB-GYN, and he was scheduled to begin at 6:00 a.m. on the GYN floor. When Mike arrived, Kevin, the chief resident, told him to pick up two of the new patients, review their charts and be ready to present them on rounds at 6:30. There wasn't much time to know all the details, but Mike felt that he could get a grasp of the overall situation. When the attending arrived, the team, consisting of 2 residents, 1 intern and 4 medical students, went to see a patient that had been in the hospital several days and was seriously ill. The attending reviewed the chart and asked the resident why a particular medication had been ordered during the previous evening. The resident stated that he had consulted with another attending who had been on call that night. Before he could explain the rationale behind the decision,

"How many times do I have to tell you," [redacted]. "Drug X is no good! I always use Drug Y. [redacted] You are so anxious to get out in the "real world" and make money. [redacted] Well, if you don't start paying attention to me, you'll see. [redacted] and get slapped with a law suit. All because you were [redacted]." He continued, "Tomorrow, [redacted] the indications, dosage, pharmacokinetics and potential side effects of Drug X vs Drug Y."

The team then went to see one of Mike's new patients which he was able to present reasonably well. The attending asked about the x-ray results, but Mike had not obtained that information. The attending turned to Kevin looking for an answer; but before Kevin could respond, the attending had to leave to answer a page. Kevin [redacted] and said:

"What do you mean you don't know what the x-ray results are. This is your patient, and you are expected to know everything about her. [redacted] look for [redacted]"

When Mike stammered to explain that he hadn't had time to go to radiology before rounds, Kevin [redacted].

"I don't want to [redacted]" [redacted] "If you can't get your work done, then just get here earlier in the morning. [redacted] and look at [redacted] I don't like being embarrassed by a medical student in front of [redacted]. Do you understand?"

As Mike nodded, Kevin continued, "By the way, why don't you spend some time tonight reading about drugs X and Y. You can tell us all about it in the morning."

Still feeling dismal after the morning's humiliating incident, Mike went to the OR to watch a TAH (total abdominal hysterectomy). This was his first time to go to the OR. Remembering what he had been shown, he carefully scrubbed and was helped into his gown and gloves. Mike watched as the resident slapped betadine on the patient's abdomen to pre her. The OR was rather warm, and beads of sweat began to form on Mike's brow and roll down his face. He felt his glasses beginning to slide. He instinctively reached up with his gloved hand to push them back on his nose. Instantly, he heard [redacted]

"What do you think you are doing?" [redacted] "You just broke scrub. Not only have you contaminated your gloves, you touched your gown, too. Come here so we can change it!" [redacted] "We waste more gowns and gloves on [redacted] and pay attention!"

With his clean gown and gloves and his glasses taped to his forehead, Mike returned to the OR table just as the attending entered the room. Spying the unfamiliar face, the attending smiled.

[redacted] "Today, we will find out how well they're teaching anatomy these days." Mike's heart skipped a beat as the attending continued, "Son,

we're going to make an incision through this woman's abdomen, can you tell me what structures we will penetrate with the scalpel?"

Mike hesitated but correctly identified the muscles and fascia to be incised. Additional questions [redacted]. Mike assumed he was answering them correctly since no one had told him he was wrong.

Pearing over his glasses, the attending gazed at Mike and said, "Describe for me the boundaries of Hesselbach's triangle." Mike had no idea and explained that his anatomy class had refrained from using all eponyms.

"[redacted] basic scientists?" [redacted] "If you are going to be a surgeon, you must know eponyms because we use eponyms." Then as an afterthought he added, "[redacted] matter." Turning to Mike he asked, "[redacted] be a head, do you?"

"Well," Mike stammered, "I haven't done my rotation in Medicine yet, but I have been interested in cardiology."

"[redacted]" the surgeon responded. [redacted] conversation was directed toward the [redacted]

In a few minutes, the resident's beeper chimed and the page indicated that the patient in room 1327 needed an IV started. Evidently the nurses reported that they had tried several time but had been unsuccessful. The resident turned to Mike and asked him if he would mind starting the IV. Mike agreed but explained that he had only learned how to start IV's the previous day. He was unsure that he would be able to succeed any better than the more skilled nurses. The resident just said, "You'll only learn by practice."

When Mike reached the patient's room, he was puzzled. He thought that the nurses had attempted to start the IV, but none of the necessary fluids or tubing could be found in the room. Mike wondered if he had the right patient so he went to check the chart. Suddenly he understood, the [redacted] was not [redacted]. Everyone [redacted] the unsuspecting [redacted]

Mike was on call that night and picked up his first patient about 7:30 p.m. About 10:30 he completed his work up and write up, making careful notes of all pertinent labs, x-rays, etc. Then he headed to the library to prepare for the next day's pharmacology presentation. Mike was determined to "look sharp" during morning rounds. He felt that he needed to redeem himself in the eyes of his resident. About 1:00 a.m., Mike decided to go to his call room to catch a few hours of sleep. At 2:00 a.m. he was awakened by his beeper. A 16 year old girl was in the ER with a suspected ruptured ectopic. Mike needed to help with the pre-op blood work and then follow the patient to the OR. The surgery was over by 4:30 a.m. and Mike decided that it was useless to try to sleep. He would need to be on the wards by 5:30 to pre-round on his patients. Anyway, after his 2:00 p.m. class, he would be free to go home.

Shortly before the attending appeared for morning rounds, Kevin realized that he had forgotten to order a CBC on one of the new patients that was admitted during the night. There really wasn't any reason to believe that the values would be abnormal. Kevin was anxious to avoid a repeat of the yesterday's humiliation on rounds, so he ordered the test but made up lab values to present to the attending. Kevin informed the team that he would present the CBC as normal. He made it clear that no one should challenge him about these values in front of the attending.

In contrast to the previous day's rounds, today's experience was fairly benign. As anticipated, the attending questioned Kevin about the new patient's CBC. Kevin reported that it was normal, and the rest of the team kept their mouth shut. Mike was anxious to show off how much he knew about Drugs X and Y, but both the resident and attending seemed to have forgotten about the assignment.

"So much for being able to make a good impression." Mike thought.

All day long Mike felt as if he were moving in slow motion. With the help of his favorite drug, caffeine; he was able to get all of his work done and would be able to go home as soon as his

Resident covering up students

Document from the collections of the AAMC. Not to be reproduced without permission.

class was over.

Today's lecture was on endometrial cancer. Mike had a patient with this diagnosis and was extremely interested in the material. But when the lights went off and the slides came on, Mike could no longer keep his eyes open. He leaned his head against the wall and fell asleep. Somewhere in a fog, Mike heard a patient calling his name, "Dr. Williams, Dr. Williams". Suddenly he awoke to discover that it was not a patient but his [redacted] who was giving a film calling his name.

"Dr. Williams, if you feel that you know this information so well that you can sleep through my class, then maybe you would like to give this lecture yourself. If you do not feel capable of that, I would ask you to kindly stay awake. If that is too much to ask of you, then maybe you would prefer to excuse yourself and go home."

Patronizing Sarcasm

Although going home was exactly what Mike wanted to do, he managed to stay awake the rest of the lecture. But he knew he was doomed.

"Is this what the next two years is going to be like?" Mike thought. "Why have I been so anxious to trade the lecture hall for this?" "I've just had a bad day," he rationalized. "Sometimes you're just unlucky - a victim of the system."

But self doubt crept back into his thoughts. "Maybe it's not the system, maybe it's just me. What if I'm not really tough enough or smart enough? Maybe I won't be able to [redacted]. Am I even capable of becoming a competent physician."

As Mike's thoughts wandered he began to imagine his parents' reaction when he informed them that he was going to business school instead.

OSR *progress notes*

News from the Organization of Student Representatives

Vol. 14, No. 2

Winter 1990

chair's message

**Caroline Reich
Emory**

"Medical Student Abuse" has become quite a hot topic during the last few months. In most cases the discussion degenerates into a debate over perceptions of and definitions of the term "abuse." No matter what label is used, a consensus usually emerges that medical students do face imposed attitudes and conditions which foster several undesirable outcomes. Many students emerge from the first two years much less enthusiastic about basic sciences, having had their intellectual curiosity squelched beneath the weight of the massive amount of factual information they were expected to master. Upon graduation, few students are comfortable facing the limitations of their knowledge. When being "pumped" by a resident or attending physician, students often face verbal harassment or intimidation when unable to recall a particular fact correctly. Only a few such incidents are needed for a student to adopt the attitude that survival depends on "playing the game," assuming a confident demeanor and keeping your mouth shut. We all recognize that physicians must be life-long learners, but are graduates of our medical schools truly prepared for this process?

Without a doubt, our medical schools are producing competent physicians, but is this due to the innate resilience of the graduates who are successful in spite of the system rather than because of it? Although we can deservedly take pride in the medical education process which has emerged during the past 100 years, we must recognize that the demands upon physicians are constantly changing. Therefore, our medical education process must also adapt. The complexities of the health care delivery system and research enterprises within the academic medical center are directing focus and energy away from the educational process. Students must accept the responsibility to serve as the constant

reminder to administrators and legislators that the health of our society tomorrow depends on the education of future physicians today.

The OSR Ad Board has adopted "Taking the Initiative in Our Evolving Medical Environment" as the theme for our annual meeting in October as well as our philosophy for the year. There are numerous examples of student-sponsored initiatives which have created a positive impact on the educational process. Through regional and annual

meetings, the OSR fosters exchange of such information between different schools providing opportunities for cross-fertilization of ideas and insights. This organization is structured to provide assistance to students who are interested in improving the medical education process. If you need additional information to tackle a problem at your school, feel free to contact your local OSR representative, any OSR Administrative Board member or Donna Quinn at the AAMC. ■

OSR *focus*

OSR's 1990 PRIORITIES

Career Counseling

**Ashleigh Head, U. of Washington
Anita Jackson, U. of Illinois**

OSR Ad Board action on career counseling over the next year will be to outline a variety of career development projects in the monthly newsletter which goes to each medical school's OSR rep. These project outlines are based on ideas that have already proven useful and popular at different schools. If career guidance at your school could be enhanced, we hope you will examine the ideas with your OSR rep and initiate one (or more!) that will make a difference.

Medical Education

**Cynthia Knudson, U. of Colorado
Tom Lee, Cornell U.**

In recent years, medical schools have realized that the classical teaching environment can not always address the changing needs of medical students. Various schools have devised their own answers to such issues as curriculum reviews, problem-based learning, grading policies, and teaching evaluation. During this time of change, sharing of success and failures can be critical. To help, the OSR will send out a survey to collect the different approaches schools have on these issues. Once compiled, these ideas will be distributed to students to present at their own school.

National Legislation

**Krishna Komanduri, U. of
Minnesota-Minneapolis**

Recent Congressional measures such as the elimination of the "student status" deferment on government educational loans and the elimination of tax deductibility of interest paid on educational loans have worsened what is already a grave financial situation for many future physicians. (See the article by Sarah Carr, AAMC Legislative Analyst, in the Winter *OSR progress notes* for more information.) Due to these measures, and because Congressional debate will soon begin regarding the reauthorization of the Higher Education Act (which provides funds for loans for higher education), medical students *must* act now to place pressure on members of Congress to increase their support for the education of future physicians.

The OSR is acting to facilitate medical student action in this crucial area by en-

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Donna M. Quinn, Editor

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couraging schools to begin letter-writing campaigns and to circulate petitions on important issues which members of Congress should consider. If you are interested in helping with these efforts, please contact your OSR representative or a member of the administrative board.

National Board Exams

Anita Jackson, U. of Illinois

As presented at the last Annual Meeting by Dr. Robert Volle, President of the National Board of Medical Examiners (NBME), the current licensing exam is to be remodeled. The new exam is expected to be more comprehensive in its content and different in format, with more matching and no K-type questions. The OSR Administrative Board is in full support of an improved knowledge-based exam and increasingly more interested in its proper use.

As indicated by the NBME, it is not a diagnostic/scholastic exam and should not be used for such purposes. OSR has been concerned with use of NBME exams to drive medical school curricula and residency selection. We have recently joined with other AAMC groups to re-discuss the issue of making the Boards Pass/Fail. At the last Ad Board Meeting, the Ad Board voted to support a statement written by the Group on Educational Affairs (GEA) Steering Committee and approved for discussion at regional meetings by the Group on Student Affairs (GSA) Steering Committee which proposed "...that the results on Comprehensive Part I and Comprehensive Part II examinations be reported only as Pass/Fail. . . ." No action has been taken; these issues are still under considerable scrutiny.

Send your comments in regard to this issue; we will incorporate your suggestions and keep you up-to-date on its status. Write to: **Donna Quinn, Section for Student and Educational Programs, AAMC, 1 Dupont Circle NW, Suite 200, Washington, DC 20036.** ■

federal update

1990 NHSC REAUTHORIZATION

The National Health Service Corps (NHSC) is up for reauthorization this year and bills are expected to be introduced in the House and Senate in the very near future. The OSR Administrative Board is encouraging students to contact legislators to express support for reauthorization. This article provides background information on the Corps' purpose, discusses AAMC's recommendations for legislative changes, and describes who to contact to express support for the Corps.

Purpose: The AAMC supports the NHSC reauthorization because geographic and specialty maldistribution of physicians remains a serious problem and the nation continues to need the NHSC to provide primary care services in underserved areas. While the NHSC may not solve the more systemic causes of physician maldistribution, with improvements it may be able to go beyond its mission and actually exert some influence over health manpower development. The improvements AAMC would like to see Congress consider during NHSC reauthorization are discussed below (proposed revisions are printed in bold type).

Recruitment Mechanisms: The NHSC currently has authority to use both loan repayment and scholarships as recruitment devices. These incentives are necessary because most medical students (81 percent in 1989) must assume large debt in order to finance their education. For 1989 indebted graduates, average debt amounted to \$42,374; 83 percent had debts in excess of \$50,000. With these levels of debt, it is difficult, if not impossible, for physicians to set up practices in areas that are not economically viable. Incentives like loan repayment and educational scholarships are needed to allow physicians to join the NHSC.

Loan Repayment. The AAMC prefers loan repayment as a recruitment mechanism because it allows physicians to make a service commitment later in their training when they are in a better position to take on such an obligation. **Congress should revise the loan repayment program to ensure that undergraduate debts, which currently average about \$7,000, are also allowed to be forgivable loans.** (Current NHSC policy allows only medical school educational debt to be forgiven.) **The program would also be enhanced if the monetary value of the loan repayments were tax exempt and if the amount of loan repayment per year, particularly for those making only a two-year commitment, were increased.** (Current law allows "up to \$20,000" to be repaid per year of service and "up to \$25,000" per year of service to Native Americans. Physicians agreeing to serve for two years are provided with \$13,333 and \$16,667 in loan repayment per year.) **Congress should consider limiting the amount of discretion the executive branch has in setting these levels.**

Scholarships. Although loan repayment may be preferable from the obligor's standpoint, in the government's view scholarships have two advantages. First, they can be used to attract disadvantaged students who might not otherwise attend medical school. Also, apparently they are also more successful in ensuring placements in the hardest-to-fill sites. Clearly, keeping the profession of medicine open to all qualified candidates, regardless of economic background, is an important societal goal to which the AAMC is wholeheartedly committed. Philosophically, however, the Association believes that ensuring access is more appropriately accomplished through non-service connected student assistance. If the principal source of financial aid to disadvantaged students were in the form of service-connected scholarships, the principle of equal access to education would be undermined. **Congress should ensure that scholarships are used to a lesser extent than loan repayment and limited to students in their third and fourth years (so they are more capable of making**

HOUSING NETWORK

Please contact your OSR rep if you are willing and able to provide accommodations to a 4th-year student who will be interviewing for a residency. We will begin the process of updating the Housing Network which will be distributed to OSR representatives in early Fall.

RESOURCES MANUAL

We are looking for examples of innovative courses/curricula, programs, projects and resources for inclusion in an updated, revised Resources Manual to be distributed to each medical school's Office of Student Affairs in the Fall. If you have an item to submit, contact the

action items

such a commitment). Using a combination of loan repayment and scholarships, with the Corps having the discretion to mix and match as warranted, is possibly the best approach. In any case, scholarship recipients should be carefully screened and efforts made to select candidates whose backgrounds and educational experiences are compatible with the Corps' mission. **Congress should also ensure that the Corps' programs are publicized widely and that the Corps works closely with medical school student affairs and financial aid administrators so that students are fully informed of NHSC opportunities. Further, to enhance the Corps' recruitment and retention efforts, Congress should ensure program stability and provide secure funding from year to year.**

Contacting Legislators: The OSR Administrative Board encourages students to contact members of Congress to express support for the NHSC reauthorization and for the legislative changes described above. In addition to writing to your own Congressman and Senators, students should send letters of support to the following key legislators.

The Honorable Edward M. Kennedy
Chairman, Senate Committee on
Labor and Human Resources
527 Hart Building
Washington, D.C. 20510

The Honorable Henry A. Waxman
Chairman, Subcommittee on
Health and the Environment
2415 Rayburn Building
Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Minority Member,
Senate Committee on Labor
and Human Resources
835 Hart Building
Washington, D.C. 20510

The Honorable Edward R. Madigan
Ranking Minority Member,
Subcommittee on Health and
the Environment

OSR Ad Board member for your region:
a) Central—Amy Davis, U. of Missouri,
Columbia; b) Northeast—Tom Lee,
Cornell U.; c) Southern—Phillip Noel,
LSU, New Orleans; and d) Western—
Ashleigh Head, U. of Washington (or
Donna Quinn, AAMC).

564 House Annex II
Washington, D.C. 20515 ■

MINORITY HEALTH INITIATIVE

Legislation was introduced in both the House and Senate last fall to address the disparity in minority health status. The bills, S. 1606 and H.R. 3240, would authorize additional funding in three major areas: health promotion and disease prevention programs; financial assistance for minority health professions students and minority faculty development; and, enhancement of federal public health programs in the Pacific Basin. S. 1606, sponsored by Senator Edward M. Kennedy (D-MA), was approved in November, 1989. Companion legislation sponsored by Rep. Louis Stokes (D-OH) is currently pending in the House Subcommittee on Health and the Environment. The Subcommittee is expected to hold a hearing on H.R. 3240 at the end of April.

The AAMC's particular interest in the legislation revolves around the student financial assistance programs authorized to address the underrepresentation of minorities in the health professions. The bills would provide additional financial aid resources for underrepresented minorities and a loan repayment program for minority faculty serving in institutions with a historic commitment to training minority health professionals.

The OSR Ad Board encourages students to write to the Honorable Edward R. Madigan (see above) and the Honorable Henry A. Waxman (see above, but direct to 512 House Annex I rather than 2415 Rayburn Building) to encourage passage of the minority health legislation. ■

For additional information on these issues, call Sarah Carr in AAMC's Office of Governmental Relations at 202-828-0525.

OSR progress notes

The deadline for the Fall 1990 issue of *OSR progress notes* is **August 24th**; if you have an item to submit, forward it to Caroline Reich (Emory) or Donna Quinn (AAMC).



M. BROWNELL ANDERSON
Director of Educational Programs
Executive Secretary, Group on
Educational Affairs

Brownie, as she is known to her friends, joined the AAMC in October, 1983. She came to the Association after 6 years at Southern Illinois University School of Medicine where she was the coordinator for the second year curriculum and staff to the Internal Medicine clerkship.

Since joining the staff of the AAMC, Brownie's responsibilities have evolved to include: 1) the Group on Educational Affairs—GEA—(formerly called the Group on Medical Education); 2) activities concerning medical school curriculum and student evaluation, including the *AAMC Curriculum Directory*; and 3) academic management workshops sponsored under the aegis of the AAMC Management Education Programs.

As Executive Secretary for the GEA, Brownie's duties include planning the GEA's Annual Meeting program, coordinating the Research in Medical Education (RIME) Conference and the Innovations in Medical Education (IME) exhibits. She staffs the GEA Steering Committee and works closely with the national chairman to advance the programs of the GEA, edits the newsletter "The GEA Correspondent," and attends four regional meetings annually. The GEA Steering Committee has worked to foster the relationship between the OSR and the GEA.

She has developed a database of medical school curriculum information and is working to improve the information provided in the *Curriculum Directory*. When asked to describe her job, she replied, "I find myself being a broker of information to medical school academic deans and faculty (and the occasional reporter)."

The "academic" management workshops are designed for a team of four or five individuals from an institution. One workshop addresses the medical school's evaluation system. The second explores the concept of problem-based learning, the resources and skills needed to institute such an approach to teaching and provides participants an opportunity to experience a problem-based learning approach. ■

project forum

The Aesculapian Society: promoting the consistent betterment of the educational, medical and scientific standards of the medical school

The staff of Aesculapius, the mythical god of healing, remains the ancient symbol of the art of healing; it is formed by a crude stick with a snake wound around it. Snakes were considered sacred because they had the power to renew their youth by shedding their old skin and growing a new one. So too must medical education continually shed its skin and yield to change if it is to retain the youthful vigor and vitality which has generated the highest degree of health care.

In 1963, the students at Louisiana State University (LSU) School of Medicine in New Orleans founded a service and honorary organization, the Aesculapian Society, whose primary purpose was the betterment of medical education and whose membership is students elected by their peers for their leadership abilities, sound judgement and constructive concern for the improvement of medical education at LSU. All members in good standing serve in the society until graduation.

The society scrupulously reviews each course in the freshman and sophomore

curriculum and one clinical rotation from the junior and senior curriculum each year. Standard multiple-choice evaluation forms are distributed to students for each course and the results are compiled and statistically analyzed. In addition, subjective course-specific questionnaires elicit commentary from students and more in-depth analysis. For each course, student reviewers create a report which provides the results and suggestions for improvement. Copies of these "Aesculapian Reports" are available to course directors as well as the curriculum committee.

Course directors receive a timely, responsible and well-constructed evaluation of their course by those most qualified to comment on its strengths and weaknesses, enabling them to make better decisions about the texts, laboratory exercises, handouts, instructors, etc. Many year-to-year changes in courses are made as a result of student opinions and constructive comments in the evaluations. Students have a voice in the formation of their medical education and some recourse when they recognize potential roadblocks to learning.

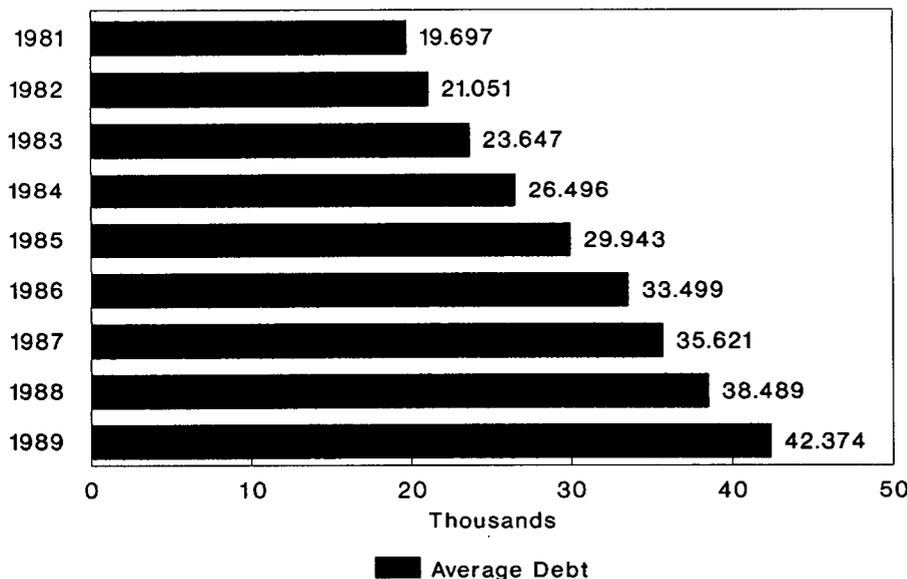
Departments in which the Aesculapian Reports are utilized correctly have created an atmosphere in which instructors/teaching residents are accountable to the students they are teaching, aware that the department head views the stu-

dent evaluations seriously. The curriculum committee, of which the society's president is a voting member, also reviews the reports. Courses have undergone major changes or have been eliminated in part on the basis of the society's reports. This empowers students to shape their own education; as beneficiaries of the system, they are often its best caretakers.

The Aesculapian Society also sponsors an Annual Banquet at which outstanding professors and house officers, selected by students, are honored for their teaching ability, an opportunity to recognize individuals devoted to excellence in *teaching* in a system which rewards research and clinical activity. It is hoped the award recipients will receive tangible career benefit (e.g., tenure) for their recognized achievements.

Through these and many other activities, the Aesculapian Society serves as an instrument of change to continually shed the "old skin" and keep medical education vibrant and new as medicine moves with dizzying speed into the next millenium. For information on starting a student-run organization for curriculum review, write or call: **The Aesculapian Society, Harry Gould-President, c/o Associate Dean of Student Affairs, LSU School of Medicine, 1542 Tulane Avenue, New Orleans, LA 70112-2822, 504-568-4874.** ■

Average Debt of Indebted Graduates



Source: AAMC Graduation Questionnaire

calendar of events

OSR ANNUAL MEETING

The 1990 Annual Meeting of the OSR will be held Friday, October 19 through Monday, October 22 in the San Francisco Hilton, San Francisco, CA. This year's theme is "Taking the Initiative in our Evolving Medical Environment". The program includes: new member orientation; a training seminar by the National Cancer Institute; regional meetings; several plenaries, including a joint session with the Council of Deans; workshops; sessions with committee representatives; elections and the Business Meeting. Mark your calendar now!

OSR Administrative Board Meetings

June 27-28	DC
September 26-27	DC

ADMINISTRATIVE BOARD MEETING
June 27-28 1990
FALL ISSUE OF OSR PROGRESS NOTES

Contents:	<u>Suggested</u>	<u>Need Ideas</u>
chair's message	Caroline supplies	
OSR focus	5 priorities	
FYI (box)	What is OSR?, Ad Board, committee student reps	
federal update	Medicare (Ivy's article- attached)	other issues?
AAMC focus		what area/person?
bulletin board		what's new?
calendar of events	Annual Meeting? OSR Ad Board Retreat	what events?
letters to the editor		do not have any yet
project forum	Lawrence's - counseling	have any others in mind?
action items		?

Reminder: all items will be considered in light of the space available. The Ad Board, and in the end Caroline, must **prioritize** the submissions in order to decide the final contents.

The deadline for submissions for the Fall 1990 issue is August 24th.

Please think about the contents and enclosures of the August, September and October OSR Newsletter's. Deadlines will be **the first day of the month**, with the newsletter being mailed out mid-month. There will not be a JULY newsletter.

May 30, 1990

MEMORANDUM

TO: Donna Quinn
FROM: Ivy Baer 
Division of Clinical Services
SUBJECT: Article for "Progress Notes"

I would like to write an article for your next edition of "Progress Notes" that will explain how Medicare's new method of financing hospital's costs of interns and residents (direct graduate medical education - GME - costs) may affect residents who want to switch residency programs. In brief, the problem is that Medicare used to pay for its share of graduate medical education costs without regard to the number of years a physician was in an approved residency program. Under the recently implemented regulation, Medicare will pay its full share for a maximum of 5 years for each intern; beyond the 5 years Medicare will pay for only a portion of its share.

An example of one effect of the change in GME financing comes from a phone call I recently received from a physician who is board certified in emergency medicine and now wishes to do an anesthesiology residency. He was accepted into an anesthesiology program but was told that because of Medicare's new payment method for GME there is no money for him.

For the "Progress Notes" article I propose to outline Medicare's previous policy regarding payments for GME and then discuss the legislation and accompanying regulations that have recently altered the payment method. I will use the example of the phone call as a way to give medical students a practical understanding of how their careers may be affected by Medicare's GME financing policies. I believe that this will be of interest to medical students who are, or will shortly be, in the process of selecting a residency program.

If you have any questions, or need additional information, please do not hesitate to call.

X4499

cc: Jim Bentley

Worksheet

Progress Notes

1. Format Suggestions

- a) always include Phone Numbers with addresses of contacts
- b) include list of schools without OSR reps to stimulate interest
- c) Additional comments, ideas?

2. Articles

- a) Chair's Message Topic:
- b) OSR Focus:
 - 1) Counseling:
 - 2) Medical Education:
 - 3) National Legislation:
 - 4) NBME:
 - 5) Societal Responsibility:
- c) Emphasis for Federal Update:
- d) Action Items:

- e) AAMC Focus:
- f) Visuals/Graphics:
- g) Project Forum:
- h) Calendar of Events:

(peer counseling)

PROJECT
FORUM
CANDIDATE

Counseling

This past month an elderly Yugoslavian man who spoke only in his native tongue appeared in the emergency room with diffuse abdominal pain. The work-up involved a parade of specialists and many unnecessary procedures to finally reach a treatable diagnosis; there are several studies which suggest that the most important source of information in reaching a diagnosis is a good patient history, which in this case was not available. This case highlights the importance of communication as a vital facet in our daily professional and personal lives.

Five years ago, students at the University of Kansas School of Medicine realized the importance of good communication skills and initiated efforts to obtain them. With the direction of Bruce Liese, Ph.D., a psychologist in the Family Practice Department, the course "Interviewing and Counseling Methods" was established to teach these skills, as well as psychological diagnostic screening techniques and crisis intervention skills. The 6-week, 2-credit course consists of 80 hours divided evenly between lecture and practice through which students learn to actively listen by questioning, reflecting, confronting, interpreting, and communicating nonverbally. The elective course has been very successful, now enrolling 150 students each session.

Two outgrowths, for which the class serves as a prerequisite, are an advanced class and the Hawklane. The advanced class has students lead small discussion groups, teach basic listening skills, observe students role-playing these skills, review students' counseling audio tapes, and prepare final examination questions. In addition to enhancing their interviewing and counseling techniques, students gain valuable administrative and teaching skills. Hawklane is a peer counseling service operated by medical students for students and employees of the medical center. The counselors handle a variety of problems and concerns as well as provide referrals where appropriate. Hawklane services are accessible 24 hours daily, free of charge, confidential, and, if the caller wishes, anonymous.

The value of good communication skills can not be overstated. For more information, please contact Lawrence Tsen, U. of Kansas, at 913-384-2172. ■

DESIGNATED SCHOOL LIAISONS TO AAMC GROUPS

**Bowman Gray School of Medicine
of Wake Forest University**

**GRADUATION QUESTIONNAIRE
COORDINATOR**

Dr. Patricia L. Adams
Assoc Dean, Stu Affs
300 S Hawthorne Rd
Winston-Salem, NC 27103
919/748-4271

GSA - STUDENT AFFAIRS REPRESENTATIVE

Patricia L. Adams, M.D.
Associate Dean for Student Affairs
300 South Hawthorne Road
Winston-Salem, NC 27103
919/748-4271
919/748-4204 Fax

**GROUP ON EDUCATIONAL AFFAIRS (GEA)
CORRESPONDENT**

John D. Tolmie, M.D.
Assoc Dean for Academic Affs
The Bowman Gray
School of Medicine
of Wake Forest University
300 S. Hawthorne Road
Winston-Salem, NC 27103
919/748-4271
919/748-4204 Fax

GSA - FINANCIAL AID REPRESENTATIVE

Larry Stombaugh
Financial Aid Director
300 South Hawthorne Road
Winston-Salem, NC 27103
919/748-2889
919/748-4204 Fax

WOMEN LIAISON OFFICERS

Christine A. Johnson, M.D.
300 South Hawthorne Road
Winston-Salem, NC 27103
919/748-4324
919/748-4204 Fax

MINORITY AFFAIRS SECTION (MAS)

Velma G. Watts, Ph.D.
Director of Minority Affairs
300 South Hawthorne Road
Winston-Salem, NC 27103
919/748-4201
919/748-4204 Fax

Elizabeth F. Sherertz, M.D.
300 S. Hawthorne Road
Winston-Salem, NC 27103
919/748-3926
919/748-4204 Fax

**ORGANIZATION OF STUDENT
REPRESENTATIVES**

Chip Tilman
300 S. Hawthorne Road
Winston-Salem, NC 27103
919/768-6539

DESCRIPTIONS OF THE LIAISON POSITIONS

Each of the liaisons listed is part of a national network of people concerned with similar medical education issues, having access to a vast array of ideas and programs. They attend national meetings to discuss the key issues and resolve major problems; many of the groups have newsletters and updates which are distributed to the representatives. Each of the individuals on this list can be a resource and ally. Keep in mind that the terms for these appointments varies; when contacting someone on the list, you may find a new person in that role. The listing will be distributed, as a rule, once a year; it will be as up-to-date as possible at the time it is generated.

GRADUATION QUESTIONNAIRE COORDINATOR

Each Winter, the AAMC distributes and collects a survey of all final year students. It covers a broad range of topics, including general demographics, residency/career plans, debt levels, assessment of curriculum, and experiences in the Resident Matching Program. The Graduation Questionnaire (GQ) Coordinator is appointed by the Dean to be responsible for all matters concerning the GQ. This includes distribution of questionnaires, collection of the completed forms, and reporting, to the Dean, the school level results of the GQ Summary Report.

GROUP ON EDUCATIONAL AFFAIRS (formerly the Group on Medical Education - GME)

The GEA has as its mission the advancement of medical education - particularly curriculum, educational research and evaluation - at the undergraduate, graduate and continuing education levels. It provides information/ideas, identifies issues and priorities, and provides technical assistance as needed. The GEA Correspondent, appointed by the Dean, is a communication link between the medical school, the National Steering Committee and the AAMC; he/she channels information, requests, announcements and inquiries to the appropriate persons. The Correspondent casts the institutional vote for National Chair and key issues.

WOMEN'S LIAISON OFFICER

The Dean names one individual (or two, if appropriate) to serve as the AAMC's principal contact on issues related to the participation of women in medical education. In addition to attending the AAMC Annual Meeting and making available to interested parties information channelled from the AAMC, typical activities of Women's Liaison Officers (WLO) are: providing continuity to women student groups and suggesting/initiating programs; serving as the resource at the medical school on matters concerning women faculty and students; and encouraging/sharing results of research and other activities related to women in medicine.

GROUP ON STUDENT AFFAIRS

Committee on Student Financial Assistance (COSFA): The AAMC monitors the rapidly changing legislation affecting the provision of financial aid and develops programs and publications to assist financial aid officers in their work. The liaison to COSFA, usually the director of financial aid, is appointed by the Dean. He/she attends meetings and disseminates information.

Committee on Student Affairs (COSA): With the help of this committee, AAMC determines policies and regulations governing student services - student advising, counseling, health services, the transition from medical school to residency, etc. The liaison, appointed by the Dean, provides information from the medical school to the AAMC and vice-versa.

MINORITY AFFAIRS SECTION

The Minority Affairs Section (MAS) was established as part of the GSA in 1976. The designee, appointed by the Dean, holds membership in GSA as well as MAS. The MAS serves as a resource to the AAMC on issues of minority concern, provides a voice and channel for minority medical educators, and assists/facilitates the development and implementation of methodologies which enhance the recruitment, retention and graduation of underrepresented minority students.

ORGANIZATION OF STUDENT REPRESENTATIVES

The representative to the OSR is generally appointed by the Dean, often with the input of the student body or Student Government. He/she brings student concerns to the AAMC's attention and, in turn, distributes information from the AAMC to the school/students. OSR reps have local responsibilities, attend regional and national meetings, and take an active role in ongoing OSR projects.

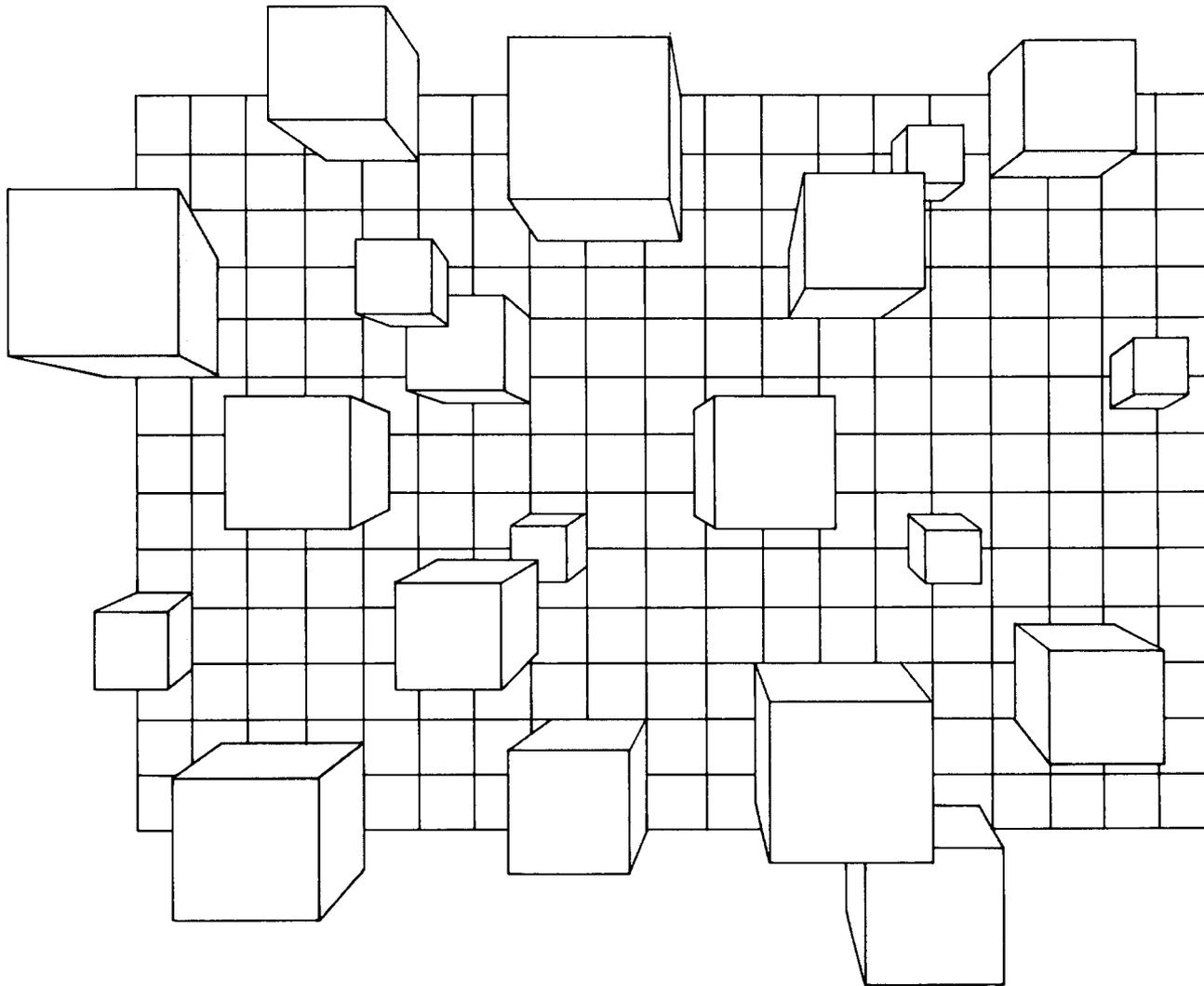
CAS/OSR Breakfast Agenda

I. Rewarding Teaching in Medical School - How can students provide valid input?

II. Evaluation Mechanisms used for Selection of Residents by Program Directors

- A. Dean's Letters**
- B. National Board Scores**
- C. Development of a Clinical Skills Examination**

A GUIDE TO THE PREPARATION OF THE MEDICAL SCHOOL DEAN'S LETTER



FOREWORD

THE DEAN'S LETTER OF EVALUATION

In the 1985-86 academic year, the Association of American Medical Colleges (AAMC) appointed a Committee on the Transition from Medical School to Residency. The committee's final report, "Improving the Selection of Residents," states in part:

The committee recommends that AAMC appoint an *ad hoc* committee composed of deans, deans for student affairs and program directors from several specialties to develop guidelines on the evaluative information desired by program directors. The committee should explore the feasibility of providing a model format for deans' letters.

After careful deliberation and in consultation with both program directors and those responsible for organizing and preparing letters of evaluation for medical students, the committee decided to prepare a guide to the preparation of medical school deans' letters. The AAMC does not intend to impose a rigid form. This guide will enable those who assume this responsibility at AAMC-member medical schools to evolve a similar format and consistent content for these important documents.

August G. Swanson, M.D.
AAMC Vice President for Academic Affairs
March 1989

Graduation from medical school is not the completion of a student's education. It is the students' transition from a general phase to a specialized phase. Eligibility to pass through this transition is granted when the student receives the M.D. degree from an accredited medical school. By conferring a degree, the medical faculty publicly acknowledges that the recipient has met its requirements and is eligible to enter the specialized phase of his or her education as a resident in a graduate medical education program. The degree should signify that the faculty recommends the graduate without reservation.

However, this unreserved recommendation is not sufficient for those who are responsible for selecting residents for the specialized phase of their education. Residency program directors and their selection committees require information about the levels of accomplishment candidates for their programs have achieved during medical school. The transmission of this information is through an instrument termed THE DEAN'S LETTER OF EVALUATION. This instrument is not a letter of recommendation; it is a letter of evaluation.

FORMAT AND LENGTH

Residency program directors and their selection committees are heavily burdened by a large number of applications. The use of a standard outline or format and adherence to a reasonable overall length with a short summary will improve both the quality of the information transmitted and the quality of the interpretations made by the

TO EVALUATE OR TO ADVOCATE

recipients. The following outline is recommended. The use of the standard headings is encouraged.

Introduction

The introduction is a succinct chronology of a student's entry and progress through medical school. Pre-matriculation academic, social or employment background characteristics may be included. Irregular progress and any required remediation should be indicated and explained.

Preclinical Record

Avoid a course-by-course description. Highlight and explain unusually good or poor achievements.

Clinical Clerkship Record

The letter should describe the student's performance in each of the required clinical clerkships, focusing on the student's knowledge, data gathering, analytic reasoning and interpersonal skills. Arrange the description in the chronological order in which the clerkships were taken. At the end, cite unusual accomplishments in elective clerkships.

Special Activities

Report those activities that provide information about the student's talents (e.g., research experience, voluntary services and leadership roles).

Personal Qualities

This section should provide the reader with a sense of the student as a person. When necessary, it should include comments about personal limitations.

Summary

Recipients most likely will read this section first. It should provide a clear and balanced synopsis of the preceding sections.

COMPARATIVE PERFORMANCE DATA

A common, recurrent complaint of those who must interpret deans' letters of evaluation is that too often it is impossible to estimate how a candidate performed in comparison to his or her peers. The Dean's Letter can provide information about comparative performance. The comparative report should be compiled and formatted so that a recipient can perceive a candidate's performance profile consistent with the medical school's grading system.

Approximately 90 percent of medical schools now use grading systems with three or more intervals (e.g., Honors, Pass, Fail=3 intervals; High Pass, Pass, Low Pass, Fail=4 intervals; A, B, C, D, F=5 intervals). These gradations are sufficient to place a candidate's performance in relationship to his or her classmates. These descriptions of performance can be included in the body of the letter, but a more easily interpreted display is recommended. An example is the ratings sheet shown on p. 6. This display permits convenient assessment of where a candidate's achievement fell within four grading intervals in each required clerkship and in written examinations for each discipline.

As medical students graduate, they also begin to differentiate. Medical school has provided a general professional education, and a dean's letter should convey an honest evaluation of a student's achievements across all aspects of this general education. Rarely do those who prepare deans' letters of evaluation have sufficient information to be students' advocates for selection for training in a particular specialty. Students should be counseled to identify faculty members who will advocate their suitability for a career in a specialty and to ask that they write a separate *letter of recommendation* for their training in that specialty.

SUGGESTED FORMAT FOR DEANS' LETTERS

HEADING

November 1, 19____

Dear _____:

This letter is an evaluation of the achievements of

Name

INTRODUCTION

- ◆ This section should provide a concise chronology of the student's progress through medical school.
- ◆ Indicate and explain irregular progress and any required remediation.

PRECLINICAL RECORD

- ◆ Avoid course by course descriptions.
- ◆ Highlight unusually good or poor achievements.

CLINICAL CLERKSHIP RECORD

- ◆ In chronological order, describe the student's performance in each required clerkship.
- ◆ Focus on knowledge, data gathering, analytic reasoning and interpersonal skills.
- ◆ Cite unusual accomplishments in elective clerkships at the end of this section.

(First Clerkship: _____)

**CLINICAL
CLERKSHIP RECORD**

continued

(Second Clerkship: _____)

(Third Clerkship: _____)

(Fourth Clerkship: _____)

(Fifth Clerkship: _____)

(Sixth Clerkship, etc.)

(Elective Clerkships—only list unusual accomplishments)

SPECIAL ACTIVITIES

- ◆ Report activities reflecting the student's talents (e.g., research experience, volunteer work, leadership roles).

PERSONAL QUALITIES

- ◆ This section should provide the reader with a sense of the student as a person.
- ◆ When necessary, include comments about personal limitations.

SUMMARY

- ◆ The program director most likely will read this section first.
- ◆ Provide a clear, concise and balanced synopsis of the above sections.

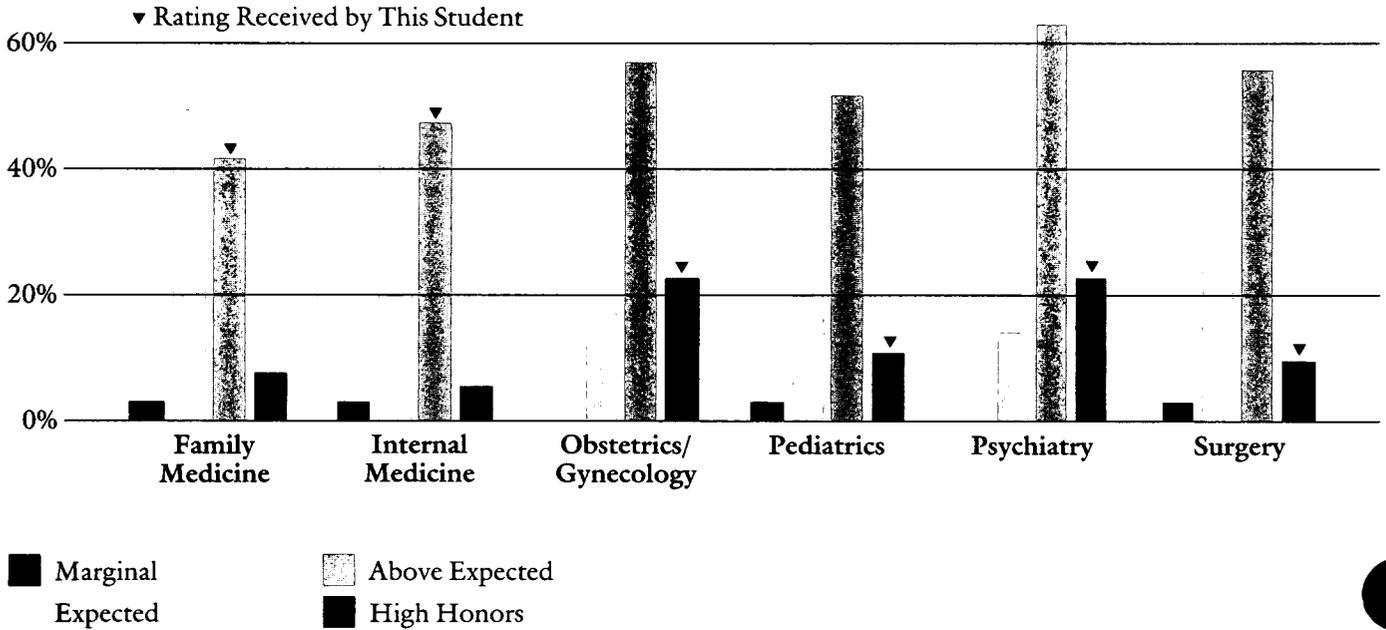
Signature

SAMPLE RATINGS SHEET

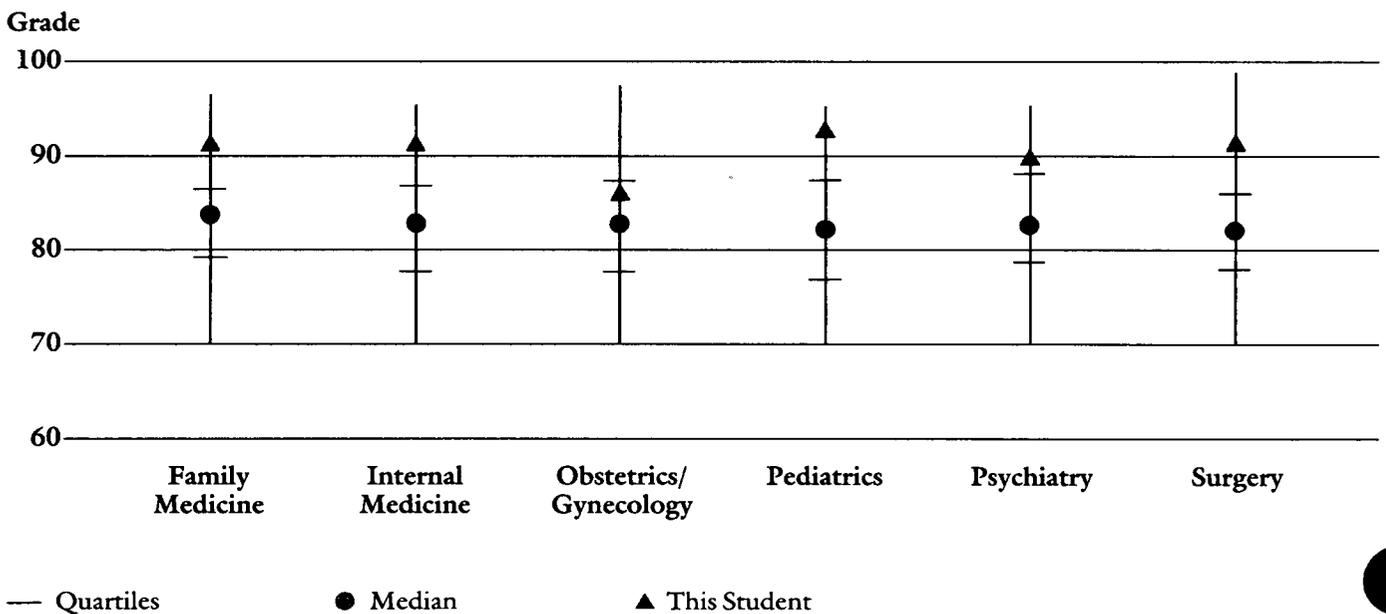
CLASS OF 19 _____

Name _____

RATINGS OF CLINICAL COMPETENCE IN CORE CLERKSHIPS



WRITTEN EXAMINATION GRADES IN CORE CLERKSHIPS



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AAMC COMMITTEE ON DEANS' LETTERS

David F. Altman, M.D.
*Associate Dean for Student and
Curricular Affairs*
University of California, San Francisco
School of Medicine

Wilton H. Bunch, M.D., Ph.D.
Dean
University of South Florida College
of Medicine

Joseph S. Gonnella, M.D., Chair
Vice President and Dean
Jefferson Medical College of
Thomas Jefferson University

James J. Leonard, M.D.
Professor and Chairman
Department of Medicine
Uniformed Services University of the
Health Sciences
F. Edward Hebert School of Medicine

Carol F. MacLaren, Ph.D.
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School of Medicine

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Assistant Dean for Student Affairs
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School of Medicine

J.W. Roddick, Jr., M.D.
Dean of Students
Southern Illinois University
School of Medicine

Jane G. Schaller, M.D.
Department of Pediatrics
New England Medical Center

Henry M. Seidel, M.D.
Associate Dean for Student Affairs
The Johns Hopkins University
School of Medicine

Norman Snow, M.D.
President
Association for Surgical Education

Stefan Stein, M.D.
Director of Education
The New York Hospital
Cornell Medical Center—
Westchester Div.

OSR MEMBER RESPONSIBILITIES*

Each OSR representative is the link between his or her school and the OSR and AAMC, and, as such, is responsible for disseminating to other students the information received. While the Administrative Board of the OSR does much of the work, each Representative must also assume an active role in improving OSR's quality, both locally and nationally. In addition to administrative responsibilities, Representatives have the opportunity to build their leadership capabilities and to expand their participation in their own institution, in national issues and in the AAMC.

Each Representative's role will be individually and institutionally shaped, but certain duties come with the position, as outlined below:

A. General Administrative

1. Distributing Progress Notes to all students (help from the student affairs office may be sought).
2. Sharing information and publications which the official representative receives (e.g., President's Weekly Report), with junior OSR members, other student leaders, and faculty and deans, as appropriate. Common avenues for sharing information with the whole student body include a central bulletin board or an OSR file in the library.
3. Working to achieve continuity of representation and revisions in the OSR member selection process, as needed. Following are examples from three schools.

B. Meetings

1. The Representative will maintain the necessary contact with the student council or dean's office so that both spring regional and fall national meetings can be attended. Representatives are encouraged to also seek funding for junior members and successors.
2. Following meetings, representatives should submit a report to the student affairs dean and student council president summarizing highlights of special relevance to the school.

C. Legislative Affairs

1. The Representative should contact Congressmen as requested via memos from the AAMC President and should respond in a timely manner when asked by the AAMC to conduct a student letter-writing campaign.

*Developed and approved by OSR Administrative Board

Responsibilities of OSR Committee Representatives

(DRAFT)

The students chosen by the OSR to serve on AAMC committees serve as the primary link between the OSR administrative board and these committees. In order to facilitate communication concerning topics of student interest, each committee representative is required to:

1. Contact the OSR chair as soon as the agenda is received for an upcoming committee meeting to receive administrative board input on relevant issues
2. Submit a written report to the OSR staffperson at the AAMC within one month of attending any committee meeting. This report will be included in the agenda of the OSR Administrative Board as well as included in the OSR monthly newsletter
3. Present an oral report at the OSR annual meeting during the closing business meeting
4. Coordinate a discussion session during the OSR annual meeting to gather student input on issues of concern to his/her committee

Michael C. Caldwell '90
Mount Sinai Sch. of Med.
50 East 98th St. # 1E
New York, NY 10029
(212) 996-1136

25 April 1990

Clayton Ballantine
234 Franck Avenue
Louisville, KY 40206

Dear Clay:

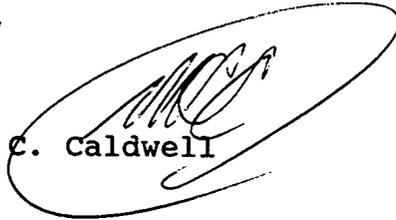
I have enclosed a copy of the "OSR position paper on smokefree medical schools." Please read it, answer the survey on the back of this letter and mail this form in the enclosed, addressed and stamped envelope. A prompt response is appreciated.

Please join me in calling for smokefree medical schools. If enough of the Ad Board approves this position paper, I will send it out to all the OSR representatives to get a response. I hope to have enough support by the June Ad Board meeting so that you can forward this proposal to Dr. Petersdorf and the entire AAMC in time for the national meeting in San Francisco.

If you have any comments or questions, please feel free to call me.

Regards,

Michael C. Caldwell



DRAFT

OSR POSITION PAPER ON SMOKEFREE MEDICAL SCHOOLS

We, the members of the Organization of Student Representatives of the Association of American Medical Colleges, hold that all medical schools in the Association develop and enact a smokefree policy by September 1991. This policy should be formed by a committee of administrators, faculty and students at each school and should include:

1) The prohibition of smoking on all school premises and all entrances leading to designated school areas.

2) Prohibition of smoking by students and faculty during any teaching session or official meeting regardless of location.

3) Formation of a permanent committee to investigate and correct any violations of the above, to be carried out in a confidential manner.

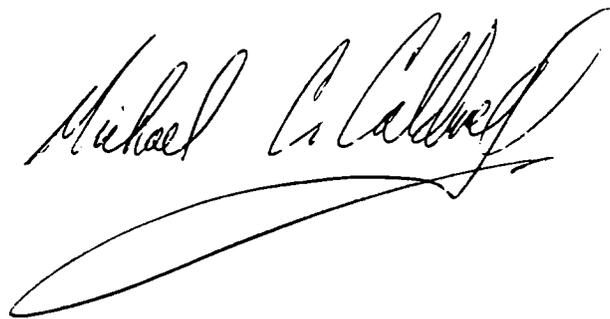
4) Easy access for students and staff to smoking cessation treatment therapy.

5) Increasing students' awareness of their important role in influencing their future patients to stop smoking.

6) An active effort, on the part of the individual medical school administrations, to enact a smokefree environment at their major teaching hospital and other affiliate hospitals.

The smokefree policy should be clear and well publicized. It should uniformly prohibit smoking without exception. In addition, this policy should be required for recertification of medical schools by the LCME.

As future physicians and leaders in the medical profession, we feel that the most logical place to begin working towards Former Surgeon General C. Everett Koop's goal of a smokefree society is in our schools of medicine. We must present a clear and uniform position to all our patients and fellow citizens ... smoking debilitates and kills and we will no longer tolerate it in any form. As the world is becoming more aware of tobacco's destructive forces, the time is right for all medical schools to join in a uniform voice to clear the air and promote smokefree environments.

A handwritten signature in cursive script, reading "Michael C. Caldwell". The signature is written in dark ink and is positioned to the right of the main text block. It features a large, sweeping underline that extends across the width of the signature.

3233 Hennepin Ave. 1
Minneapolis, MN. 55408
May 4, 1990

Carolyn Reicht OSR Chair
1291 Mayfair Dr.
Atlanta, GA 30324

Dear Carolyn:

I am a second year medical student at the University of Minnesota in Minneapolis and one of the OSR-AAMC representatives of my school. I was responsible for writing and compiling the minority student surveys for our LCME accreditation procedure this winter. In April, I attended the central regional meeting of the AAMC and participated in the GSA-AAMC workshop on cultural diversity. It seems that there are very pertinent topics in the medical education of minority students that have ~~not yet been addressed by our current system.~~ I ~~share the concerns of~~ many regarding the need to discuss the issue of cultural diversity within the specific context of medical education. I feel that by forthrightly confronting the racial biases which minority students face in medical school, that we may educate students and faculty alike with the goal of celebrating the cultural diversity that brings different facets to the face of our medical education in the United States.

To this end, my proposal to the AAMC is to make an educational video addressing these concerns, to be used in the training of medical students and faculty. The video will include four vignettes depicting common examples of discrimination which minority students experience during their medical school tenure. The focus of the vignettes will include topics such as the use of exclusionary language, reduced expectations of minority students by faculty, presentation of racially biased data, and other topics. The appropriate topics will be chosen by a committee of students as well as by review of any LCME minority student surveys contributed by interested medical schools. After each vignette, the tape will be stopped by a moderator and questions will be available for discussion. The discussion will focus on two specific areas. First, to heighten awareness of this problem, the discriminatory behaviors dramatized in each vignette will be identified by the group. Identification of the problems will then be followed by a discussion of positive methods of changing each scenario so as not to alienate the minority students or prejudice the non-minority students portrayed in the video.

I have spoken to Anita Jackson, member-at-large of the OSR-AAMC administrative board, who feels that the video could serve as a positive and much needed educational tool. There is a sound base of interest in the idea among my minority and non-minority colleagues at the University of Minnesota Medical School.

I am asking the AAMC to consider funding this project. I have contacted both private video taping companies and the facility available at the University of Minnesota. The estimate was less at the University facility. An estimate of \$15,000 for taping, editing, and directing the video was given to me by Mr. David Sleeper at the University of Minnesota Media Resources and Television, 540 Rarig Center, University of Minnesota, Minneapolis, 55455. Enclosed please find the credentials of the facility.

I am certain that the goal of educating a richly diverse population of students is of paramount concern at the AAMC; therefore, I am asking for your support, feedback, and suggestions regarding this proposal. Thank you for your attention to this matter. I can be reached at the above address and at (612) 822-4368.

Sincerely,

Joia Stapleton Mukherjee

Joia Stapleton Mukherjee
Second year medical student
OSR-AAMC representative
University of Minnesota

*P.S. Looking forward to meeting you
in San Francisco!*

UNIVERSITY OF MINNESOTA
UNIVERSITY MEDIA RESOURCES TELEVISION
History and Activities

University Media Resources (UMR) was created in 1972 as a comprehensive audio visual service department of the University of Minnesota administered by Continuing Education and Extension. While it is not the only such service within the University, it is by far the largest, and the only one which is University-wide in scope. Over 100 full-time professional producers, artists, technicians and support staff devote their energies to the creation and distribution of educational materials in print, photos, graphics, audio, radio, motion picture and television.

UMR TELEVISION has been producing programs since 1955. The television staff consists of 20 full-time professionals including producer/directors, studio/graphics designer, electronic technicians and the necessary clerical and administrative staff. The on-campus Rarig Center television facilities include two color studios with three cameras in each. Recorders include two Ampex quads, three Ampex VPR II's (1"), one RCA quad and seven Sony U-Matic machines. Both manual and CMX computer editing are possible. In addition, there is a remote production truck with two Sony BVP-30 broadcast-quality cameras, full audio and video mixing/switching facilities and recorders. It has expansion capabilities for additional cameras and recorders as required. Two single-camera remote ENG units include Ikegami HL-79 cameras with Sony U-Matic and Betacam recorders. The department also has a complete Sony DUV (3/4") editing system and a complete Betacam recording and editing system.

Replacement value of the University's present television installations is approximately \$3 million, excluding the building space.

The television section of UMR completes over 200 program units a year covering a full range of program types, including documentaries, short promotional spots, public affairs broadcasts, laboratory demonstrations, classroom credit courses and independent study courses designed for learning at a distance. Approximately half of the programs produced each year are broadcast to the general public. The others are used for in-classroom instruction, for research, for off-campus continuing professional education and for other informational purposes.

UMR TELEVISION duplicates over 6,000 tapes a year in all standard formats -- VHS, Betamax, Betacam, VPR and quadriplex. Programs are also designed and produced for videodiscs used in interactive instruction.

The University of Minnesota does not have its own television transmitter but utilizes a number of public and commercial stations and cable systems throughout the State of Minnesota. Some individual programs and series get national distribution over PBS stations and through other distribution services.

University Media Resources Television
540 Rarig Center
330 21st Avenue South
Minneapolis, Minnesota 55455
(612) 625-4006 or (612) 625-4315

11/89

SURVEY OF HEALTH POLICIES AND HEALTH CARE SERVICES
FOR MEDICAL STUDENTS
SUMMARY OF RESPONSES

GSA Committee on Student Affairs

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SURVEY RESPONDENTS

University of Texas, San Antonio
Mount Sinai
University of Alabama-Birmingham
Georgetown
George Washington University
University of Iowa
Western Ontario
University of Hawaii
New Mexico
Northwestern
Emory
Caribe
Ottawa
Johns Hopkins
University of Virginia
Southern California
University of Pittsburgh
New York University
University of Puerto Rico
Oral Roberts
Washington-Seattle
Stanford
California-Davis
Albert Einstein
SUNY-Syracuse
South Florida
University of Wisconsin
Rochester
UT-Houston
Alberta
Baylor
UT-Galveston
Nevada
Medical College of Wisconsin
Brown
Eastern Virginia
Creighton
Temple
University of Miami
University of Michigan
Minnesota-Minneapolis
Morehouse
UMDNJ-New Jersey
Loyola
Medical College of Virginia
Case Western Reserve
Northeastern Ohio
University of Illinois
Oklahoma
Mercer
New York Medical College
Medical College of Ohio
University of Missouri
Bowman Gray
Washington University
University of Indiana
Texas A&M
Mayo Medical School
South Carolina-Columbia
SUNY-Brooklyn
Arkansas
University of Tennessee
Maryland
Minnesota-Duluth
University of Kentucky
Dartmouth
Chicago Medical School
Vanderbilt
Columbia
Jefferson
LSU-Shreveport
Hahnemann
Tufts
Chicago-Pritzker
North Carolina
Oregon
Saskatchewan
Meharry
Medical College of Georgia
Uniformed Services
Kansas
Southern Illinois
Vermont
Ponce
Howard University
Cincinnati
University of Pennsylvania
Wayne State

GSA STUDENT AFFAIRS COMMITTEE

SURVEY OF HEALTH POLICIES AND SERVICES FOR MEDICAL STUDENTS

In the summer of 1988, the GSA Student Affairs Committee distributed a Survey of Health Policies and Services for Medical Students to the 143 LCME accredited medical schools in the US and Canada.

Responses were received from 88 medical schools, for a response rate of 61.5%. Of the responding schools, 52% were public and 41% private institutions; 11% identified branch campuses and 35.6% were part of the university campus. A list of respondent schools is included in the handout.

GENERAL POLICIES/ HEALTH CARE SERVICES

While most respondents indicated that they had written health policies, 6 stated that they had no written policy and 10 did not answer the question. Sixty-nine schools indicated that they had written policies and 26 specifically stated that health policies were addressed during student orientation.

Health care coverage for visiting students is variable, with only 40% making provisions for visiting US and Canadian students and 42% providing for visiting foreign students. One school indicated that foreign students prepaid health care and US and Canadian students were on fee-for-service basis. Several schools required visiting students to show proof of coverage or purchase insurance or pay a student health fee.

Responsibility for defining health care policies for medical students most commonly falls to the Director of Student Health and/or the Dean of Students. In a small number of schools, central university administration sets the policies. Of the 62% that give students input in discussion and/or setting of health care policies, many had a health advisory committee with student members or provided for input via student government. A number indicated that student input was informal. About 58% have some mechanism for periodic review, either annual or at specified intervals.

As expected, the structure and scope of health care services for medical students are diverse, including the following: required Blue Cross & Blue Shield with care by HMO; combined approach with 50% care from student health service and 50% from Family Practice group; combined HMO for employees and students; university-wide student and employee health service; Family Practice center; contract with faculty group practice; Internal Medicine faculty and "patchwork". Many respondents specified that services provided were predominantly comprehensive out-patient care associated with required student fee. Nearly half (48.9%) said medical school faculty provide some student health care in an unstructured setting; 17.8% noted that faculty also provide services for other health professions students. Nearly 47% utilize a student health service at the

medical school and 52.2% a university student health service. Only 7.8% indicated they used an HMO or PPO through contractual agreement. Fifty-nine percent said students could consult their personal physician; presumably many of these are schools that require student health insurance.

Hospitalization is clearly a more difficult issue, with required (47%) or optional (18,5%) health insurance being the usual mechanism of payment and only 16.7% noting that professional courtesy is a mechanism at university or affiliated hospital (11% if hospital not affiliated). Since only 68% of respondents require students to carry health insurance, presumably some students are uninsured or underinsured and, therefore, exposed to the financial risk of of being personally responsible for hospital bills.

GENERAL POLICIES/HEALTH CARE SERVICES

2. Do you make health care provisions for visiting U.S./Canadian students?

Yes 40.0% No 57.8%

Visiting foreign students?

Yes 42.2% No 56.7%

4. Do students have a voice in the discussion and/or setting of these policies?

Yes 62.2% No 32.2%

5. Do you have a mechanism for periodic review of these policies?

Yes 57.8% No 37.8%

6. If you have geographically separate campuses, are health care policies identical at all sites?

Yes 32.2% No 14.4%

Is comparable health care available at all sites?

Yes 28.9% No 12.2%

8. Health care services for medical students are provided by (check all that apply):

48.9%	Medical school faculty in unstructured setting
46.7%	Student health service at medical school
52.2%	Student health service at college/university
7.8%	HMO or PPO through contractual agreement
58.9%	Student's personal physician (not contractual agreement)
23.3%	Other

11. If a student requires hospitalization while in school, indicate the site of hospitalization by checking sites routinely utilized:

67.8%	University-owned hospital
72.2%	Affiliated hospital of student's choice
63.3%	Non-affiliated hospital of student's choice

Payment mechanisms (composite):

25.6%	Student responsibility
47.0%	Required health insurance
18.5%	Optional health insurance
2.9%	Institutional self-insurance
14.8%	Professional courtesy
7.8%	Other

MENTAL HEALTH SERVICES

The identification of a student in need of mental health services is most often done by the student himself, followed in order of frequency by student affairs staff, clinical faculty and peers. Curricular affairs office staff, family and significant others were least likely to identify a student in need of counseling.

The most common sources of care available to students are attendings on the faculty (80%), university clinics (63%), non-faculty practitioners (60%) and residents (50%).

Mental health services available to students at most institutions include short-term therapy, marriage and relationship counseling, crisis intervention and long-term therapy. Behavior modification groups, ethnic support groups and hospitalization for diagnosis or therapy are available at more than half the responding schools. Long-term therapy and group therapy are also commonly available. Gender-oriented support groups are available in about 60 percent of institutions, while gender-preference oriented support groups, and human dimension support groups are available only at about one institution in five. The responders mentioned a number of other mental health services that were of particular interest. Included were groups specifically designed for medical students, support groups for older and returning to school students, and groups on test-taking skills, stress management, learning disabilities, career counseling, sexuality, and drug and alcohol dependency. Assessment services provided by institutions were extremely comprehensive.

Students who do not have personal insurance or resources to cover the cost are most commonly taken care of by the student health service. A university counseling service or other medical faculty were commonly named as sources of help. Community facilities such as mental health centers and private clinics or practitioners received the lowest ranking.

Most institutions (54.7%) do not have a system to confirm that a referral appointment was made and kept by the student. From comments it appeared that most institutions requested confirmation of an appointment only if the mental health service was demanded by or requested by the administration. If a student was mandated to have an evaluation, a letter to the associate dean was often required as a report. In other instances, mandatory referral required only a brief statement stating that the appointment was kept.

Cost is covered by student fees, insurance, or provided at no cost about equally.

In general, administrative offices are not allowed access to the treatment records of the student without written consent. The health professional doing therapy is usually provided access. In about half of the institutions, the student is allowed access to treatment records. In two instances, it was noted that the student affairs office did have access to treatment records. In no instances did the academic affairs office have access. Almost all institutions stated they did not keep psychotherapy records in an institutional computer system nor was there access to

records of diagnostic evaluation. A larger percent kept billing records for psychiatric disorders in their computer system but restricted access. A few institutions (11.6 percent) stated that they did keep records of psychotherapy in the student's permanent file but restricted access, and two institutions stated that records of psychotherapy were kept in the student's permanent file and apparently did not limit access.

The item asking about the role of the "counselor" or mental health professional at the institution in dismissal proceedings produced the most variability and the most comments. In general, it appears that the student's health problems or issues that the counselor has dealt with are held in confidentiality, and only at the student's request is information released. It was often pointed out that if there are administrative psychiatric evaluations required that information would become available to the administration while counseling received by the student at his own request would remain confidential. Some counselors conducted exit interviews for students who were dismissed or were withdrawing. Others provided consultative input regarding the student's problems when the student permitted. In other circumstances, the counselor would serve as an advocate at the request of the student. Counselors at some schools refused or were not permitted to participate in dismissal proceedings.

MENTAL HEALTH SERVICES

2. What sources of care are usually available at your institution to a student in need of mental health services? Check all that apply.

53.3%	Residents
80.0%	Attendings on faculty
60.0%	Nonfaculty practitioners
38.9%	Specified employee hired for this responsibility
32.2%	Community clinic(s)
63.3%	University clinic(s)
17.8%	Other

3. Which of the following mental health services are available to your students at your institution? Check all that apply.

95.6%	Crisis intervention
97.8%	Short-term therapy
80.0%	Long-term therapy
68.9%	Group therapy
78.9%	Hospitalization for diagnostic workup
76.7%	Hospitalization for therapy
86.7%	Marriage/relationship counseling
61.1%	Ethnic support groups
58.9%	Religiously-oriented support groups
61.1%	Gender-oriented support groups
32.2%	Gender-preference oriented support groups
21.1%	Human dimensions support groups
58.9%	Behavior modification groups for specific purposes
12.2%	Other

4. When a student is identified by Student Affairs Office or faculty member as being in need of mental health services, what referral sources are available to the student who does not have personal insurance or resources to cover the cost? Check all that apply.

21.1%	Professional therapist in College of Medicine (not faculty)
42.2%	Medical faculty
27.8%	Housestaff
46.7%	Student health service
47.8%	University counseling service
28.9%	Community mental health center
30.0%	Private clinic or practitioner that provides gratis care
6.7%	None of the above

5. Does your institution have a system to confirm that a referral appointment was made and kept by the student?

Yes	44.4%	No	51.1%
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6. What is the fee to the student for ambulatory mental health care services provided within your institution? Check only one response.

33.3%	No cost
7.8%	Sliding scale fee
14.4%	Covered by student fees
25.6%	Covered by mandatory (or optional) student insurance
6.7%	Other
12.3%	No response

10. Are billing records for psychiatric disorders kept in an institutional computer system?

5.6%	Yes
17.8%	Yes, but restricted access
68.9%	No
7.8%	No response

11. Are records of psychotherapy kept in a student's permanent file?

2.2%	Yes
10.0%	Yes, but restricted access
83.3%	No
4.4%	No response

12. Which of the following comprehensive assessment/services does your institution provide? Check all that apply.

71.1%	Diagnosis of learning disabilities
71.1%	Neuropsychological testing
75.6%	Study skills
65.6%	Reading skills
13.3%	Other

INSURANCE

About two-thirds (67.8%) of respondents indicated that medical students are required to have health insurance and another 22% noted that health insurance was recommended to students. A number of sources of available health insurance were identified with student chosen carrier (72.2%), AMSA insurance (50%) and school provided (50%) or school recommended carrier (38.9%) being most common. When more than one source of insurance is available, only 31.1% of schools require comparability of benefits. In general, about 80% of schools indicate availability of health insurance that would include student spouse and dependents. However, the survey does not permit determination of spouse and dependent coverage on school provided policies. About 38% of respondents noted that students could continue their health insurance after graduation.

The yearly cost of student health insurance varies widely, with 40% of respondents indicating that cost per student exceeded \$400/year. Nearly 10% identified costs in excess of \$700/student/year and at least some of these schools are self-insured. One school providing comprehensive self-insurance for students and their families identified annual costs of \$1200/student. The most frequent yearly costs to the student are between \$200 and \$600. The survey did not permit identification of the number of students uninsured or underinsured and it is suggested that a future study be done to focus on this issue. A recent study by the Employee Benefit Research Institute concluded that 3 million college students (24%) have no health insurance at all and estimated the another 18-24% have inadequate insurance.

Required/recommended health insurance for medical students commonly covers inpatient (62.2%) and outpatient (51.1%) mental health services and maternity care (58.9%) but it is clear that there are significant gaps in coverage. Only about a third provide complete coverage for physician and hospital charges or coverage for prescription drugs; coverage for dental care (11.1%) and preventive care (18.9%) is uncommon but it is possible that these services are provided through student health service. Only 16.7% indicate coverage for organ transplants. Somewhat surprisingly, 41.1% of the required/recommended policies include catastrophic care coverage. Problems identified included non-uniform coverage among students, gaps in coverage during vacations and high cost of self-insurance.

Disability insurance is generally not available to students at most institutions although one school does require coverage. Since disability insurance is commonly based on income, it is not readily available to students. Most schools (75.6%) do not have life insurance available to students and none require it.

Astonishingly, 8% of respondents indicated that they did not provide malpractice coverage for students. It is hoped that there is statutory protection for students in those institutions although this was not indicated in the survey. The most common coverage limits of coverage provided were \$1 million and \$5 million with the lowest coverage reported as \$25,000. The limits of coverage are usually extended to other major clinical affiliates and to students when out of state for electives.

Malpractice coverage is extended to visiting US and Canadian students by 38.4% and to visiting foreign students by 40.7% of respondents; about 48% provide no malpractice coverage for visiting students.

Many problems with malpractice insurance were identified. Many schools were unsure of malpractice coverage for students taking electives away from the home institution or out of state. Rapidly escalating costs from insurers have created severe problems. One school in Georgia noted that the students had lobbied effectively to get the state legislature to pass a law granting students immunity from malpractice prosecution. In some states, the student is not liable unless acting outside the scope of their duties or outside supervision; however, such students likely still need coverage for the cost of defense, should they be named in a malpractice suit. Some schools are currently considering the advisability of carrying liability insurance on students away from the home institution(s).

INSURANCE

1. Medical insurance for medical students at your institution is (check only one response):

67.8%	Required
22.2%	Recommended
4.4%	Optional
5.5%	No response

2. Is there a requirement for comparability of benefits if there is more than one source of insurance available to students?

31.1%	Yes
54.4%	No
14.4%	No response

3. What are the sources of student medical insurance at your institution? Check all that apply.

50.0%	School provided
38.9%	School recommends carrier
72.2%	Private carrier chosen by the student
17.8%	Obtained through local or state medical society
50.0%	Obtained through the American Medical Student Association
40.0%	Obtained through military
18.9%	Other

4. Who is eligible for medical insurance coverage? Check all that apply.

74.4%	Student only
78.9%	Spouse included
78.9%	Children included
36.7%	Other dependents/family included

6. What is the approximate yearly cost to insure one student?

3.5%	Less than \$100
7.0%	\$100 - \$200
17.4%	\$200 - \$300
16.3%	\$300 - \$400
10.5%	\$400 - \$500
12.8%	\$500 - \$600
7.0%	\$600 - \$700
2.3%	\$700 - \$800
2.3%	\$800 - \$900
3.5%	\$900 - \$1000
15.1%	No response

7. What is the extent of coverage of the required/recommended medical insurance at your institution? Check all that apply.

33.3%	Total physician charges
45.6%	Partial physician charges
37.8%	Total hospital charges
40.0%	Partial hospital charges
41.1%	Catastrophic coverage
33.3%	Prescription drugs
2.2%	Prescription glasses/lens
62.2%	Inpatient mental health services
51.1%	Outpatient mental health services
18.9%	Preventive care (routine physicals, well baby care)
11.1%	Dental care
25.6%	Oral surgery
58.9%	Maternity care
16.7%	Organ transplants

8. Disability insurance for medical students at your institution is:

1.1%	Required
1.1%	Recommended
12.2%	Optional
77.8%	Not available

11. Life insurance for medical students at your institution is:

0.0%	Required
1.1%	Recommended
15.6%	Optional
75.6%	Not available

15. What is the limit of your malpractice coverage for medical students?

8.1%	0
3.5%	\$ 25,000
1.2%	\$ 30,000
1.2%	\$ 75,000
4.7%	\$100,000
1.2%	\$250,000
2.3%	\$300,000
3.5%	\$500,000
1.2%	\$600,000
22.1%	\$1 Million
3.5%	\$2 Million
8.1%	\$3 Million
11.6%	\$5 Million
2.3%	\$6 Million
2.3%	\$10 Million
2.3%	No limit
20.9%	No response

16. What is the limit of coverage at other major clinical affiliates?

9.3%	0
3.5%	\$ 25,000
2.3%	\$100,000
1.2%	\$250,000
2.3%	\$300,000
3.5%	\$500,000
1.2%	\$600,000
22.1%	\$1 Million
3.5%	\$2 Million
8.1%	\$3 Million
10.5%	\$5 Million
2.3%	\$6 Million
2.3%	\$10 Million
2.3%	No limit
25.6%	No response

17. What is the limit of coverage out-of-state?

10.5%	0
2.3%	\$ 25,000
1.2%	\$ 30,000
3.5%	\$100,000
1.2%	\$250,000
1.2%	\$300,000
3.5%	\$500,000
1.2%	\$600,000
19.8%	\$1 Million
2.3%	\$2 Million
5.8%	\$3 Million
10.5%	\$5 Million
2.3%	\$5 Million
2.3%	\$10 Million
2.3%	No limit
30.1%	No response

18. Are visiting U.S./Canadian students covered?

38.4%	Yes
48.8%	No

19. Are foreign students covered?

40.7%	Yes
47.7%	No

HEALTH SCREENING AND INFECTIOUS DISEASES

Most respondents indicated that they require some documentation of the health status of matriculants to medical school. Few require any additional health status information during progress through medical school. However, many schools indicated that evaluation of immune status to some infectious agents occurred at varying times during the course of the medical curriculum, including tuberculin testing, immunizations for polio, rubella, rubeola, mumps, diphtheria and tetanus. Although the majority of respondents indicated no requirement for hepatitis B serology, most recommended that it be done and appeared to encourage students who were non immune to receive the vaccine. The recently available varicella-zoster serologic study was rarely used to determine immune status.

Most institutions who responded indicated no policy regarding the immune status of visiting students. This may be an important issue since some medical schools do not require proof of immunity for any contagious diseases. In addition, many schools that have such requirements have no mechanism in place to assure compliance. Despite the fact that health records of students are maintained in an employee and/or student health service, compliance and/or monitoring is fractionated among the Health Service, Student Affairs Office, Registrar, clinical facilities or departments. Similar fractionation is evident regarding instruction of students about precautionary measures in caring for patients infected with Hepatitis B and HIV and even more evident in methods of assuring that students have obtained the information.

HEALTH SCREENING AND INFECTIOUS DISEASES

1. Is a complete history/physical examination required of the student before matriculation and/or before beginning clinical work?

Required before or at matriculation	Yes	72.2%	No	22.2%
Required before clinical work	Yes	12.2%	No	54.4%

5. Do you require an immunization profile and serologic status of visiting students?

18.9% Yes 72.2% No

7. Who is responsible for keeping records of required health screening?

21.1%	Student affairs office
77.8%	Student health service
8.9%	Clinical department
7.8%	Other medical school office
24.4%	Student

If you have geographically separate campuses, are health screening records maintained at more than one site?

8.9%	Yes
41.1%	No
50.0%	No response

8. Do you have an attendance policy for infected, contagious students?

44.4% Yes 50.0% No

9. Are students instructed specifically regarding protective and/or precautionary measures when dealing with high-risk patients (e.g., HbV or HIV)?

90.0% Yes 5.6% No

10. Do you have a procedure for accidental exposure of medical students to infectious agents?

85.6% Yes 12.2% No

If yes, check all that apply.

75.6%	Incident report in hospital in which exposure occurred
25.6%	Incident report in Dean's Office
2.2%	Report in student's academic record
32.2%	Other

11. Has your institution developed a policy regarding students who test seropositive for AIDS?

53.3% Yes 43.3% No

GSA Survey of Health Policies
and Health Care Services

Chemical Dependency Section

This section of the GSA Survey of Health Policies pertains to the issues surrounding chemical dependency among medical students. Eighty eight institutions responded. There is great variance among institutions in terms of knowledge of the issues and formal or official institutional involvement attempting to address these issues. Forty six percent of the institutions responding to the survey appear to have thoughtfully stated policies or sets of practices regarding institutional response to known or suspected chemical dependency. Almost as many institutions have no definition for "chemical dependency", nor do they have a set of practices to deal with such dependency. And among those who do have policies and practices proscribing institutional response, it seems that twenty six percent include a requirement for formal monitoring of the "recovering" student as an aspect of these policies.

1. Does your institution have a policy or a set of practices regarding institutional response to known or suspected chemical dependency by one of your students? If so, please attach a copy.

43.3 (1) Yes 53.3 (2) No 3.3 missing

Fifty three percent of the institutions responding either have no stated policy or set of practices, or are now in the process of developing policies and practices. Representative of the institutions with no formal policy, yet with what appear to be practices are the following: "Is handled as the situation requires" and "each case treated ad hoc by Assistant Dean Student Affairs and if necessary leaves of absence committee. Programs for rehab are reasonably easy to access as is follow up." "Failure to comply or failure of therapy in a setting of documented impairment would be viewed as ethical misconduct. Ethical conduct is viewed as an academic matter, thus promotions committee would then be involved." Of those with formal policies and practices, "impaired physician type programs," and Phoenix and AIMS programs are representative.

2. How does your institution define "chemical dependency"?

Forty six percent of the respondents (40) were from institutions which had no formal definition. Four respondents were from institutions developing policies and practices.

Representative of those institutions with official definitions are the following: "The personal use of any chemical substance in such quantity in such frequency or under such circumstances as to produce significant impairment or the likelihood of the development of impairment." "Is a cluster of cognitive, behavioral and physiologic symptoms that indicate that the person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences." Eight institutions said they used the DSM-11-R criteria; at least two use the AMA definition of impairment.

Six institutions stated definitions that seemed to imply use as central to the definition, rather than abuse. Examples are as follows: "alcohol and drug use"; "student uses alcohol or drugs"; "use of alcohol or illegal drugs"; "use of illicit substance."

3. How is the decision made that an impairment problem exists? Check all that apply.

22.2 (1) Evaluation by an impaired or "recovering" physician

Evaluation by a council of:

6.7 (2) Peers

17.8 (3) Faculty

20.0 (4) Both

41.1 (5) Evaluation by an organization whose purpose is to evaluate and treat chemical dependency (hospital outreach, mental health facility, etc.)

34.4 (6) Other

Forty one percent on the respondents said that the evaluation was conducted by an organization whose purpose is to evaluate and treat chemical dependency. Faculty and recovering physicians were next in number most often checked. One school noted that the evaluation was done by a council comprised solely of peers. One institution noted "when brought to attention of Academic Deans, an ad hoc committee is formed." The "other" responses most frequently seen were the "final decision resides with the students affairs dean after consultation with staff, faculty, peers and therapists," or handled on "case by case basis," and/or "student health," and/or handled by the "psychiatry department."

4. What factor (or factors) determines the appropriateness of outpatient versus inpatient treatment? Rank in order of importance with the most important factor being "1" and the least being a "5".

___ (1) Degree of impairment	75.6 (1); 2.2 (2)
___ (2) Cost of treatment	3.3 (1); 20.0 (2); 14.4 (3); 8.9 (4); 3.3 (5)
___ (3) Academic standing	4.4 (2); 7.8 (3); 14.4 (4); 8.9 (5)
___ (4) Location of facility	13.3 (2); 14.4 (3); 8.9 (4); 3.3 (5)
___ (5) Other	8.9 (1); 7.8 (2); 1.1 (3); 3.3 (5)

Degree of impairment was noted as most important by seventy six percent of the respondents. Cost of treatment was not seen as the most important, yet was clearly viewed as of importance, listed as second and third in importance more often than any other possibility. Academic standing was of significance but less so than cost and location. The importance of degree of impairment in this decision underscores the need for an knowledgeable evaluator.

5. Where do your students receive treatment? Check all that apply.

75.6 (1) Locally
63.3 (2) Within the state
50.0 (3) Hospital affiliated with institution
53.3 (4) Private hospital
38.9 (5) Out of state

"Locally" was checked most frequently by seventy five percent and half said with a hospital affiliated with their institution. Thirty eight percent of the respondents listed one response as out of state.

6. What determines treatment location chosen?

"Student's choice," or "primarily student's choice," or "student and therapists' choice" or "student and student's family," was noted by fifty percent of the respondents. Severity of the problem, accessibility and cost were also noted as factors bearing upon the decision. "Student Choice--but must meet the standards of the Committee on students and its consultants" is representative of what seems to be the intent of a majority of responses. One responded "arrangements with other area medical schools to accept each other's students."

7. How is the treatment funded? Check all that apply.

5.6 (1) Medical school pays
72.2 (2) Individual receiving treatment pays
27.8 (3) Treatment provided as courtesy
24.4 (4) Other

That the individual receiving the treatment pays was checked by seventy two percent of the respondents. Twenty eight percent said that the treatment was provided as a courtesy, with one institution specifying courtesy as out patient only. Thirty three of the respondents also commented under "other." Of this group, twenty two noted student health insurance, or health insurance coverage. One institution noted that insurance through the university would pay up to \$4500. Another stated the "university pays" and another that a "medical school scholarship was available, if needed."

8. If treatment requires a leave of absence, is the Dean's Office informed as to the specific reason for the leave?

65.6 (1) Yes 21.1 (2) No 13.3 missing

Comments:

Sixty six percent said yes. Representative of the twenty one percent who answered "no" are the following: "Deans office formally approves all leaves but only knows the reason if a student volunteers the information or if treatment is mandated", and "student is placed on leave of absence for reasons of health! Specific reasons not divulged to the Dean's office", and "Student Health Committee asks for time off, no reason stated."

9. Is there a formal policy/program for post treatment follow-up?

30.0 (1) Yes 52.2 (2) No 17.7 missing

If yes, please describe briefly.

Over thirty percent answered this question with a "yes". This seems particularly significant in light of one response which said "Follow-up is the most critical point of the treatment program." Among those who state they have a formal program for follow-up, the form varies greatly. Some stated "Student Affairs monitors treatment and progress," and "follow up is recommended when condition which required treatment is liable to recur." Others outlined follow-up practices similar to the "Impaired Physician Program."

10. Does your policy mandate institutional report of known chemical dependency?

11.1 (1) Yes 67.8 (2) No 21.1 missing

If yes, to whom, or what organization?

Eleven percent said "yes" and among their responses are the following: "Residency Program Director"; "Provincial medical licensing authority"; (student must self report); "Impaired Physician's Program"; "Dean's office."

11. Under what circumstances is treatment for substance abuse recorded in the student's permanent academic record? Check all that apply.

11.1 (1) Whenever it is known to have occurred
28.9 (2) When there is public record of abuse (e.g., arrest)
6.7 (3) When more than one course of treatment is needed.
37.8 (4) When it entails leave of absence
30.0 (5) When abuse interferes with clinical work
36.7 (6) When treatment is mandated by the school
23.3 (7) Other

The highest percentage checked, 37.8, said "when it entails leave of absence." The close second at 36.7 percent was "when treatment is mandated by the school." Eleven percent said "whenever it is known to have occurred." A not infrequent response in the narrative section was "when treatment is refused or fails." Others stated that this information was kept as a part of the medical record only. Several said "if handled by the Impaired Student Committee or equivalent there is no permanent record." One institution commented that the "university is notified if there is a felony. We will not interfere with legal agencies."

12. Is testing for substance use ever required at your institution?

30.0 (1) Yes 60.0 (2) No 10.0 missing

If yes, under what circumstances?

Thirty percent said yes. Many referenced this as part of their after care treatment plans. Other common responses included "for administrative referral," "mandate by Committee on Impairment" and "if Promotion Committee establishes as condition for reinstatement." One institution said "individual basis/random testing."

13. Would your admissions committee admit an applicant known to be a recovering alcoholic or drug addict?

46.7 (1) Yes 16.7 (2) No 36.7 missing

If so, what follow-up is required?

Forty seven percent of the respondent said "yes." Thirty seven percent did not answer. Seventeen percent said "no". Of the institutions which responded to "if yes, what follow-up is required" many commented that such situations would be individualized. Many others said "local evaluation and appropriate follow-up would or might be mandated." Fourteen said they were unsure as to what their follow-up policies or practices would be. One institution said "yes" to admission, and that "no follow-up would be required." Another said "yes" to admitting a "recovering alcoholic, some reservations about drug addiction." One responded "No. We did once and it was a disaster."

14. If it is learned that a recovering alcoholic or drug addict was admitted unknowingly, what occurs?

These narrative responses were similar to the last question. One respondent stated "discussed with student. If no problem exists, there is no further action," and "we don't worry about non problems." The majority said "nothing occurs," with very few requiring even post admission counseling. Several noted a "wait and see" approach. Of those who offer support, the following are representative: "Referral to Aid for Impaired Students Committee," and "we would required continued treatment and monitoring."

15. How does your institution define "recovering"?

Forty six percent of the respondents do not define recovering. Of those who do, only 24 include monitoring or follow-up as part of the definition. Many defined recovering as "abstinence." or abstinence for a certain period of time, e.g., "three months", "one year", "two years", and one said "currently off the addiction." Perhaps more to the point are these two responses: "Forever." "Anyone who has been an addict."

LEAVES OF ABSENCE

The overwhelming majority of respondent medical schools have a rather flexible approach to the Leave of Absence. With only a few exceptions, Leaves of Absence are granted in a manner which appears to be simple, straightforward and compassionate. Most schools do, in fact, have a formal, written policy governing LOA's. In the great majority of situations, information about their policy is disseminated to students through catalogues, bulletins or student handbooks. Only in one situation was there the suggestion that the primary method of informing students about the policy was by "word of mouth".

Dean's of Student Affairs or of Academic Affairs are most likely persons who will make decisions about granting a Leave of Absence. In a few schools the decision is made by a student performance or student promotions committee. In the institution with the most stringent policy, only the "Dean of Medicine" may decide about a leave of absence. The range of potential durations of LOA's is three (3) months to four (4) years. The majority of schools seem to allow an initial Leave of Absence of one year with the potential for approval of an additional year. The number of schools which have policies that differ from the general guidelines is quite small.

LOA's are approved for a wide range of issues, and there is general concurrence among the schools in this area. One-third of the medical schools report an increase both in requests for LOA's and in LOA's granted during the past three years. Some of the reasons cited include financial problems and the need to reaffirm career goals. Both maternity and academic problems were cited.

LEAVES OF ABSENCE

1. Are leaves of absence (LOA's) granted for any of the following reasons? Check all that apply.

93.3%	Physical health
93.3%	Mental health
68.9%	Unspecified personal reasons
93.3%	Maternity
70.0%	Child care
90.0%	Family crisis
77.8%	Financial
75.6%	Substance abuse
64.4%	Academic problems
16.7%	Other

2. Does your institution have a policy governing leaves of absence (LOA's)?

84.4%	Yes
10.0%	No
5.6%	No response

5. Is there an appeal mechanism for students who are denied a LOA at the first decision level?

57.8%	Yes
28.9%	No
13.3%	No response

8. Must a student be in "good academic standing" before a LOA is granted?

36.7%	Yes
54.4%	No
8.9%	No response

Is there a separate mechanism for granting LOA to a student not in good academic standing?

23.3%	Yes
68.9%	No
7.8%	No response

9. Do you have written descriptions of the reasons for which LOAs are granted?

30.0%	Yes
60.0%	No
10.0%	No response

10. For each question, circle "yes" or "no" for each LOA reason.

	LOA REASONS					
	Physical Health Yes	Physical Health No	Mental Health Yes	Mental Health No	Substance Abuse Yes	Substance Abuse No
Is medical documentation required prior to a LOA?	64.4%	27.8%	56.7%	33.3%	50.0%	31.1%
Is medical documentation required prior to return from LOA?	66.7%	23.3%	78.9%	11.1%	72.2%	8.9%
Will a student who has received a LOA be required to have follow-up care after return from the LOA in order to maintain student status?	17.8%	56.7%	32.2%	38.9%	46.7%	17.8%
Can a person other than the individual student request a LOA?	18.9%	70.0%	24.4%	64.4%	24.4%	54.4%
Can a LOA be required by the school over a student's objection?	52.2%	26.7%	65.6%	17.8%	57.8%	16.7%

11. Is LOA documented in student record/dean's letter for any of the following?

	<u>Yes</u>	<u>No</u>
Physical health		
Student record	76.7%	7.8%
Dean's letter	50.0%	18.9%
Mental health		
Student record	71.1%	12.2%
Dean's letter	36.7%	26.7%
Unspecified personal reasons		
Student record	62.2%	8.9%
Dean's letter	37.8%	18.9%
Maternity		
Student record	75.6%	8.9%
Dean's letter	43.3%	22.2%

11. Is LOA documented in student record/dean's letter for any of the following?
(continued)

	<u>Yes</u>	<u>No</u>
Child care		
Student record	65.6%	14.4%
Dean's letter	33.3%	25.6%
Family crisis		
Student record	73.3%	12.2%
Dean's letter	42.2%	21.1%
Financial		
Student record	64.4%	12.2%
Dean's letter	34.4%	21.1%
Substance abuse		
Student record	60.0%	15.6%
Dean's letter	34.4%	22.2%
Academic problems		
Student record	64.4%	5.6%
Dean's letter	40.0%	15.6%

12. Does the student have access to such records?

88.9% Yes
3.3% No

13. Do faculty members with a need to know have access to such records of enrolled students?

74.4% Yes
13.3% No

14. Does the student have the right to challenge the accuracy of such institutional LOA records?

87.8% Yes
1.1% No

15. Are confidential files of health-related LOAs maintained?

61.1% Yes
27.8% No

16. Have requests for LOAs increased over the past three years?

34.4%	Yes
56.7%	No

If yes, is the increase in a specific category mentioned in question 11 above (i.e., physical health)?

Financial, career decisions, family problems, mental health

Have more LOAs been granted over the past three years?

34.4%	Yes
53.3%	No

17. In your opinion, are LOAs at your institution successful?

91.1%	Yes
0.0%	No
8.9%	No response

HEALTH-IMPAIRED STUDENTS

1. Do you have any written policies regarding standards for medical school applicants with respect to eyesight, hearing, motor abilities, psychological profile, or other (specify)?

Eyesight	33.3% Yes	55.6% No
Hearing	32.2% Yes	56.7% No
Motor abilities	32.2% Yes	56.7% No
Psychological profile	27.8% Yes	60.0% No
Other	20.0% Yes	38.9% No

4. Have you enrolled/graduated one or more students with any of the following characteristics? Check all that apply.

	<u>Enrolled</u>	<u>Graduated</u>
Blind	8.9%	7.8%
Deaf	15.6%	15.6%
Wheelchair-bound	33.3%	25.6%
Paraplegic	23.2%	20.0%
Quadraplegic	4.4%	3.3%
Learning disabled	51.1%	34.4%
AIDS/HIV positive	11.1%	3.3%
Diabetic with complications	46.7%	42.2%
Juvenile rheumatoid arthritis	12.2%	8.9%
On dialysis	10.0%	4.4%
Recovering alcoholic	27.8%	23.3%
Recovering drug addict	18.9%	15.6%
Known history of major psychiatric disorder	25.6%	22.2%
Cancer	48.9%	37.8%
Serious criminal record	6.7%	4.4%
Other	12.2%	5.6%

Recommendations of the GSA Committee on Student Affairs Regarding Health Services for Medical Students

1. All schools should have written policies regarding provisions for outpatient care, mental health services, and hospitalization and these policies should be reviewed with students on a regular basis. Effort should be taken to ensure that students are aware that the cost of hospitalization is their personal responsibility. If insurance is required, provisions for hospitalization should be clearly delineated and gaps identified.
2. Medical schools are encouraged to emphasize to students that it is the student's responsibility to have health insurance and to understand the limits of coverage of that insurance. If insurance is not required, students should be alerted to the risk of being uninsured.
3. Medical schools should be encouraged to work with the American College Health Association to lobby for adequate mandatory health insurance for students at the lowest possible cost. Because of the effect that risk pool has on the size of the premium, it would probably not be advantageous to attempt to broker insurance for medical students as a group separate from other students.
4. Medical schools should have clear policies regarding the confidentiality of mental health service records for medical students, making any necessary distinction between confidentiality when evaluation and/or treatment is administratively mandated. It is also recommended that schools have guidelines regarding the utilization of mental health professionals and/or records of assessment and treatment by mental health professionals in proceedings regarding student advancement and dismissal.
5. All medical schools should publish and regularly update for their students a list of available mental health assessment and counseling services, means of access, and cost to the student.
6. All medical schools should establish written policies regarding institutional response to known or suspected chemical dependency in students, including definition of what constitutes impairment. Schools are also encouraged to develop programs that will identify and assist impaired students.
7. Medical schools should be encouraged to have written policies about availability and guidelines for medical leave of absence for medical students.
8. All students should be required to have a complete history and physical examination after admission is assured and before matriculation to medical school and this should be reported to the school. Medical schools are encouraged to develop a program to identify students at high risk for treatable conditions (e.g., hypertension, diabetes, hypercholesterolemia), and refer them to appropriate services.
9. Pre-matriculation and annual testing for tuberculosis should be required at all medical schools.
10. All medical schools should require that all students present proof of immunity to rubeola, mumps, rubella and polio, consistent with current recommendations of the Center for Disease Control. Students should also have diphtheria-tetanus boosters in accordance with CDC guidelines.

STUDENT HEALTH SURVEY
MEDICAL COLLEGE OF GEORGIA

This is a brief questionnaire designed to get feedback from you about student health services at your medical school. We are aware that some of this information is not readily at-hand, so please answer the questions to the best of your ability. If you have any questions or are interested in the results of this survey, feel free to contact me. Thank you again for your time.

Michael Greenberg
OSR Representative
MCG Box 572
Augusta, GA 30912

Medical School: _____
Contact person for more info: _____

- A1. Does your institution currently have written policies to handle student injuries (i.e. needle sticks) that occur while performing clinical duties?
 yes no
- A2. If yes, who is responsible for paying for tests and any necessary medical treatment? institution student both other _____
- A3. Does your institution have written policies for handling students who may have become infected with HIV? yes no
- B1. Are routine immunizations (e.g. MMR) required for matriculation?
 yes no
- B2. If yes, immunizations are required as a result of...
 state legislature law state university system policy local university policy
 other _____
- B3. Is PPD testing for tuberculosis required routinely? yes no
- B4. Is the Hepatitis B vaccine required for students before clinical rotations?
 yes no If yes, who pays and how much?
 institution _____ student _____ both _____ other _____
- C1. Student Health insurance is: voluntary mandatory
- C2. Does your school offer special insurance policies for students? yes no
- C3. Are foreign students required to obtain health insurance? yes no
- D1. Does your school offer rehabilitation opportunities for students with substance abuse problems? yes no
- D2. Are mental health services part of student health facilities? yes no
- D3. If yes, are counselors available who are not part of the faculty with whom students might have future clinical contact? yes no
- E1. Does the State subsidize any part of student health fees? yes no
- E2. If yes, what percent is subsidized by the state? _____%
- E3. Are there intra- or extramural funds allocated for student health?
 yes no If yes, what are the sources? _____
- E4. How much do students pay for health fees? \$ _____ per quarter
\$ _____ per semester

Please use the back of this sheet to include any information you feel might be relevant that has not been addressed above. Once again, thank you for your time.

Date: 5-15-1990
To: August Swanson, MD
From: Clayton Ballantine, MD, OSR Past-Chair
Re: Issues for the Forum on the Transition Agenda

1. It would be very helpful to students if they were promptly notified when a program decides NOT to offer them an interview. This is important for trip scheduling and to keep travel costs down. If the program would also indicate, in broad terms, WHY the applicant has not been offered an interview, it would avoid the situation where the reason was due to a paperwork error or oversight in getting the application materials to the program.
2. The OSR would like to again express its strong support for the development and implementation of both the Uniform Application Form, and the Centralized Application Service for the dissemination of residency applications. The AMA-MSS will probably have a resolution on their agenda this winter supporting these programs as well.
3. There is an increasing trend to require starting interns to report for work before the July 1 starting date for "orientation" programs. Many students have voiced concerns about the additional hardships the shortening of the period between graduation and the start of residency places on them for getting relocated, etc. There are also questions about whether or not the interns are being paid for their time in these advance orientation programs.
4. Although it is not a widely prevalent yet, the trend appears to be toward an increase in the number of programs which are requiring applicants to pay fees to have their applications processed. The OSR is strongly opposed to this development of programs charging graduating students to apply for a job.

March 15, 1990

MEMORANDUM

To: Clay Ballantine

From: Lawrence Tsen

RE: Revision of the NRMP Student Handbook

In speaking to students and administrators involved in the match process, I was able to elicit the following comments concerning the NRMP Student Handbook:

- 1) Many felt that the paragraphs on "If You Don't Match" (pg. 13 and Pg. 16) were much too terse. How does the process actually work? Are schools that have not matched enough residents put on a list? How many people don't match? How many people who were unmatched were able to find a residency position? How many slots are typically still available per each speciality? Many people desired more statistics here.
 - 2) The section on "How the Match Works" (pg 23) was unintelligible to most people. Can we simplify this example?
 - 3) Many people wanted information on which specialties get to participate in early match and how those are selected. Many surgical subspecialty candidates desired to know why their programs weren't considered in the early match process. Where do people get information on the early match?
 - 4) Most people were frustrated with the Universal Match Form found in the back of the handout because it was not used at any of the residencies for which they applied. How can we encourage its use?
 - 5) Most people wanted statistics such as: the general number of applicants per specialty, the number of people who interview, and the number of unmatched people per specialty. How many people go through couples match? How many people go through shared residency match? What do their success rates look like?
-

In addition, several people wanted more information on the process of fellowship matches; what influence does going to a university-based vs. a community-based hospital have on the individual's future practice of medicine; and the FRITA computer system.

Association of American Medical Colleges
ORGANIZATION OF STUDENT REPRESENTATIVES
Administrative Board Meeting

June 27, 1990
1776 Massachusetts Avenue, NW
Washington, DC 20036

MINUTES

Present:

Caroline Reich, Chair
Lawrence Tsen, Chair-Elect
Clay Ballantine, Immediate Past-Chair

Regional Chairs

Phillip Noel - Southern
Tom Lee - Northeast
Amy Davis - Central

Representatives-at-Large

Andrea Hayes
Cynthia Knudson
Krishna Komanduri

AAMC Staff

Donna Quinn
Sarah Carr

Absent: Lee Rosen, Anita Jackson, Ashleigh Head

I. Call to Order

Caroline Reich called the meeting to order at 8:00 a.m.

II. Consideration of Minutes

The minutes of the February 21, 1990 Administrative Board Meeting were approved without change.

III. Regional Reports

A. Southern

Phillip summarized the regional meeting sessions and highlights; the OSR portion of the meeting went very well, particularly the project exchange. Next year's meeting will be in Galveston, TX.

B. Northeast

Tom described the "Fred Friendly" (cases) format of the meeting in Toronto, giving examples of the OSR topics. Next year's meeting, on evaluating students, will take place in Pittsburgh, PA.

C. Central

Amy explained how the OSR meeting overlapped, at both ends, with the GSA and

GEA. The OSR workshops were well received. Kevin Baskin provided a CONFER demonstration, encouraging the central region to utilize it. Amy raised a concern that CONFER is not as user-friendly as it could be. It was also suggested that all members of the Administrative Board use CONFER as an additional means of communicating with one another. Amy indicated that the new GEA Chair is very interested in working with the OSR on one major issue (possibly TEACHING) over the course of the next year. Next year's regional meeting will be in Indianapolis.

- D. Western
There was no report for the western region.

IV. Information Items

- A. Phone Tree
Caroline distributed the phone tree assignments and referred the Board to the phone tree worksheet (noting that each item was to be recorded as it came up during the meeting).
- B. Committee Representatives
It was noted that phone numbers were added to the list of committee representatives and decided that the name, school and phone number of each committee's representative would be printed in the Fall OSR progress notes.
- C. Consortium Report
Lawrence, who chaired the most recent Consortium Meeting in Chicago, summarized the agenda. It included discussion of the mission statement and membership policy, the concerns of the Native American students regarding self-identification on the AMCAS application, recruitment into medicine (particularly of minorities), a Minority Education Panel at a major meeting, the NRMP, Deans' letters and uniformity of evaluating students, student abuse and what organizations are doing about it, maternity leave policies, legislative concerns and organizations efforts to address the issues, and, finally, consideration of two organizations interested in becoming consortium members.
- D. Dates for 1991 Meetings
It was agreed that the dates for the 1990 retreat would be determined after the election of new Ad Board members at the Annual Meeting. It will likely be before the Officer's Retreat.
- E. Other
Caroline described the goals and format of the Annual Meeting joint plenary on student mistreatment before departing for a planning meeting, at which point Lawrence served as chair until her return.

V. Discussion Items

- A. 1990 Priorities

1. Counseling

Everyone present agreed that the monthly career guidance ideas were worth continuing and that the concept should be expanded into other areas.

For the Annual Meeting, Krishna is planning a workshop with examples of effective programs at his school (and offering schools with outstanding programs the opportunity to provide materials as well), emphasizing the "ingredients" of a successful comprehensive counseling program. The session would entail an overview of counseling followed by a description of the various components, and would end with a discussion of the role of the student affairs administrator.

Anita is coordinating a luncheon; she was not present at the meeting. The board discussed issues surrounding the purpose, format and funding. Amy volunteered to assist with the logistics, securing funding, inviting faculty, etc. Specific details are still to be decided, as quickly as possible, in regard to the event's objective(s), size, cost and set-up. Those present agreed that it was a worthwhile event as long as it provided a "take-home" model for repeating the event at each medical school. Amy will provide a descriptive write-up for the preliminary program and a synopsis of the OSR's activities in regard to the counseling priority at the Business Meeting.

For the OSR progress notes, Amy will write an article for "OSR focus" promoting the counseling-related sessions at the Annual Meeting. The monthly newsletter will have another career guidance idea. Lawrence's article on a Peer Counseling Program at the University of Kansas will be the "project forum".

2. Medical Education

Krishna and Tom are revising the Curriculum Survey they designed. The new survey will focus on two issues -- students in the curriculum evaluation process and innovative curricula. The revised survey will be sent, **to official representatives only**, in the August newsletter, with an RSVP of September 1st. If needed, a reminder will go out in September to non-responders. Results of the survey will be printed in the October newsletter.

There has been no progress in developing an Outstanding Teacher Award. It may be an excellent project to focus on next year, particularly with the new GEA chair very interested in this area.

For the Annual Meeting, Tom and Phillip are creating a workshop to assess innovative curricula. The goal is to get OSR reps to encourage schools to explore problem-based learning. Knowing there are already excellent presentations on video tape and that there are additional people likely to be willing to be taped, Tom and Phillip will attempt to arrange for a video to be produced (for rent or sale) as a result of this session. OSR could also promote GEA's professional development workshop for problem-based learning to deans.

Tom will present a report on this priority at the business meeting and will prepare a write-up for the "OSR focus" in the OSR progress notes.

Information about schools with upcoming LCME site visits will be placed in the August newsletter and in the Fall OSR progress notes.

3. National Boards

Since it is clear that the liaison committee to the NBME is not functioning appropriately, the OSR will apply for a student representative on the NBME's Board.

The position paper on the NBME examinations was revised and approved by the Board members present. Caroline reported on her discussion with Dr. Volle in regard to the results of the recent NBME survey about the pass/fail issue and additional arguments against eliminating numerical scores. In anticipation of the OSR/CAS breakfast meeting, the Board re-examined its key arguments in support of pass/fail. (Minutes of that meeting, when supplied by Jennifer Sutton on behalf of the CAS, will be attached to these minutes.)

For the Annual Meeting, Krishna will give a report at the Business Meeting. He will also write an article for OSR progress notes "OSR focus". Space permitting, there will also be an article about changes in the examinations and the United States Medical Licensing Examination (USMLE). The August newsletter will contain the approved statement and background information to support it.

4. Societal Responsibility

Andrea offered to prepare the article for OSR progress notes and to provide several monthly contributions to the newsletter.

Cynthia, Andrea, Lee and Clay are designing a plenary dealing with community expectations of physicians. Format and speaker(s) need to be finalized. Lee's indigent care workshop will be similar to last year's. Ashleigh has the cultural awareness workshop well in hand. Andrea and Tom are preparing a workshop on minority recruitment. Phillip and Clay are working on a workshop dealing with ethics in medicine. One of the speakers under consideration is from the Society for Health and Human Values.

Cindy will give the Business Meeting report on these issues and activities.

5. National Legislation

Sarah updated the Board on legislative issues, including the Minority Health Bill, the NHSC, the Penny bill extending deferment throughout residency, and the Reauthorization of the HEA. Sarah also reviewed the AAMC's policies regarding these and other issues, offering insight into the status quo and seeking student input in relation to these policies.

Krishna was commended for the Action Pack. (Follow-up note: soon after

the AD Board meeting, I received copies of four different petitions sent by students to their legislators.) Targeting specific schools for a bigger push will be discussed at the September meeting.

Amy will arrange a legislative update session at the Annual Meeting. Lawrence will present a National Legislation report at the Business Meeting and will write an article for the "OSR focus". The OSR progress notes will also include Ivy Baer's piece on Medicare reimbursement changes and their effect on residents, and a synopsis of the Penny bill. (Follow-up note: there is now another bill, introduced by Rep. Cohen of Maine, seeking deferment extension throughout residency.)

B. Annual Meeting

In addition to the various assignments previously mentioned regarding the priorities and their corresponding meeting sessions, the following was decided:

- Krishna and Lawrence will organize a social event for Thursday evening, Oct. 18.
- The NCI Training Seminar, limited to 30 persons, will be promoted on the OSR program, with students asked to confirm that they will attend.
- Anita, working with Donna, will finalize revision of the Orientation Manual. Lee and the at-large reps will coordinate the New Member Orientation.
- Caroline is securing the speaker for the opening session.
- Clay and Ashleigh will be responsible for the Friday evening reception. Many decisions need to be made ASAP, with details to be worked out later.
- Caroline, coordinating the committee rep sessions, will set them up as follows:
 1. MAS
 2. all GSA
 3. WIM, NRMP, NBME
- Lee will be the moderator for the all election speeches.
- The group agreed to change the Saturday evening program's starting time from 7:30 p.m. to 6:15 p.m.
- The GEA breakfast agenda will be determined at the September meeting.
- Business Meeting agenda items will be decided in September also.
- Caroline is pleased with how the COD/OSR joint plenary is shaping up.
- The Ad Board will try to meet for lunch Sunday before the joint plenary.
- The "Information to Share" exchange will be handled utilizing the new Resource Manual and a system, to be devised, for adding new projects to it.
- Once again, an extra effort will be made to help students find roommates. Lawrence will try to locate housing for the DHHS Secretary's Award recipients who will be at the meeting to present their papers.
- The OSR will have a display at the IME area.

C. OSR progress notes

The Fall issue will consist of the following:

- FYI (screened box) -- committee representatives, with phone #'s
- chair's message -- to include information on the AAMC and OSR
- OSR focus -- article on each of the five priorities in terms of annual meeting activities
- federal update -- Medicare article; Penny (Cohen) bill(s)
- AAMC focus -- new legislative analyst
- project forum -- peer counseling (Lawrence's, revised)

calendar of events -- annual meeting
action items -- ?
graphic -- ?
bulletin board -- NBME/USMLE; LCME site visits 1/91 - 4/91; schools
without OSR representative

- D. Housing Exchange Network
The response, in terms of returned forms, has been light. The Ad Board will remind reps of the August 1st deadline via the phone tree.
- E. AAMC Designated Liaison List
The next mailing of this listing, to OSR representatives and each of the other designates, will be generated in early fall by the computer services area.
- F. Resource Manual/Project Forum
Two of the four regions have submitted a collection of project forum abstracts. Other materials, being organized by several OSR representatives in the field, need to be forwarded to Donna. The format and a timeframe and plan for construction of the manual need to be determined as soon as possible.
- G. Committee Report
None were given at the meeting. A written report of the GSA Committee on Student Affairs was mailed by Melissa Conte. A written report of the GEA Steering Committee was submitted at the meeting by Clay (both are attached).
- H. Alternate OSR Reps - Mailing List
A database for alternate/junior representatives has been created on the computer. In order to enter all the appropriate persons, the following is needed for most of the records: address, phone number, and graduation date. The Certification Form has been updated to provide room for this data. Regional chairs have been asked to assist in identifying these representatives.
- I. Executive Council Items
Several items were discussed, including the proposed changes in Medical School Accreditation Standards and the Student Financial Aid Issues.
- J. CAS/OSR Breakfast Meeting Agenda
The first item for discussion, rewarding teaching in medical school, was intended as starting point to possible joint efforts between the two boards in this area. The second, and more controversial, topic of residency selection necessitated that the OSR be clear on its position. The position paper on the National Boards being pass/fail was revised and approved, with copies prepared for distribution at the breakfast. The board agreed that certain arguments would be more effective than others and that listening to counter arguments was as important as presenting those that support their position.
- K. Orientation Handbook
Each board member received the revised draft of the handbook and is encouraged to offer feedback. The goal is to complete the revision and reprint of the handbook

for distribution in September (so that reps may get the most use of it), with additional copies for the new member orientation and display table at the Annual Meeting.

L. Proposed Position Paper on Smoke-Free Medical Schools

Michael Caldwell from Mount Sinai School of Medicine asked the Administrative Board to consider his proposal. Several Ad Board members had concerns about the authoritative nature of the statement, the language and/or the link to the accreditation process. Everyone supported the aims of the proposal and Michael's effort. The OSR would like to support him by helping to provide information to schools on model programs and implementation strategies. Lawrence will ask Michael to continue to work on this valuable project and the Ad Board will reconsider it at the next meeting.

M. The following discussion items were deferred to the September meeting:

- DHHS Secretary's Award Presentation
- Proposal for Selection of Reps to ORR
- OSR Member Responsibilities
- OSR Committee Representative Responsibilities
- Proposed Educational Video on Issues of Discrimination
- Health Service and Health Policies/HIV-infected medical students
- NRMP Student Handbook and Transition Issues
- American College of Physicians (ACP) Representative

VI. Adjournment

The meeting was adjourned at 5:00 p.m.

4871 Coldstream Drive
Doraville, GA 30360
March 1, 1990

Ms. Donna Quinn
Association of American Medical Colleges
One Dupont Circle, NW
Washington, D.C. 20036

Dear Donna:

On February 27, 1990 I attended a meeting of the Group on Student Affairs/Committee on Student Affairs in Washington, D.C. I am writing to inform the Organization of Student Representatives of what we accomplished at this meeting.

We discussed the Recommendations of the Committee on Student Affairs Regarding Health Services for Medical Students (attached) which had been reviewed by the GSA Steering Committee earlier in February. These recommendations were developed from the results of a health services survey conducted within the last few years. The results of this survey will be forwarded to all medical schools. In addition, several past/present members of the COSA plan to write an article based on this survey for Academic Medicine. Finally, the AAMC staff will develop a framework document based on these recommendations which will be distributed to all medical schools through the Executive Council.

Next, we discussed material concerning Guidelines for the Development of Chemical Impairment Policies for Medical Schools which was also reviewed by the GSA Steering Committee. The Position Statement and General Goals for Chemical Impairment Programs in Medical Schools are attached. The AAMC staff will develop a framework document based on the position statement and goals, but will not include the document describing a model chemical impairment program. The document describing the model program could be made available to interested schools. During the meeting, it was emphasized several times that the position statement and goals are "guidelines" not "mandates."

The committee discussed medical student abuse next. The AAMC is working to develop a questionnaire on medical student abuse. The questionnaire would be reviewed by the COSA before distribution. This questionnaire would not be incorporated into the graduation questionnaire, but may be distributed through the OSR representative at each medical school.

At the last Council of Dean's meeting, plans were made for a combined session involving the COD, OSR, and GSA at the annual meeting. The topic will be medical student abuse. The COSA felt that this session should be constructive and not a response to the articles on abuse which appeared in JAMA. It was suggested that this session might focus on professional development and professionalism in the medical school. There was much discussion on the topic of student abuse.

We discussed topics for the COSA primary session at the annual meeting which is scheduled for 1½ hours. The group decided on the title, "Professionalism: What is it? How do you develop it? How do you evaluate it?" This topic was prompted by the earlier discussion on student abuse and professionalism. This topic will deal with professionalism in students. Dr. Seidel will contact committee members to work on the topic.

We also discussed topics for a secondary session (1½ hours) at the annual meeting. Dr. Seidel had been approached by the Admissions Committee to work on a joint session. The committee agreed that they would like to develop a session on counselling premedical students who are holding several medical school acceptances. Topics such as comparing financial aid packages, changing applicant demographics, and promoting honesty (student and medical school) might be discussed. Dr. Seidel will get back in touch with the Admissions Committee to work on the details.

In the future, the COSA plans to develop a program concerning professional development of the student affairs officer. This program could be presented on a national basis. A tentative agenda will be discussed at the next COSA meeting in October.

This letter covers the major topics which were discussed by the committee; more detail will most certainly be provided in the official minutes. Please contact me at 404-454-7713, if you need additional information.

Sincerely,



Melissa A. Conte
Student Representative to the
Group on Student Affairs/
Committee on Student Affairs

Attachments

Recommendations of the Committee on Student Affairs
Regarding Health Services for Medical Students

1. All schools should have written policies regarding provisions for outpatient care, mental health services, and hospitalization and these policies should be reviewed with students on a regular basis. Effort should be taken to ensure that students are aware that the cost of hospitalization is their personal responsibility. If insurance is required, provisions for hospitalization should be clearly delineated and gaps identified.
2. Medical schools are encouraged to emphasize to students that it is the student's responsibility to have health insurance and to understand the limits of coverage of that insurance. If insurance is not required, students should be alerted to the risk of being uninsured.
3. Medical schools should be encouraged to work with the American College Health Association to lobby for adequate mandatory health insurance for students at the lowest possible cost. Because of the effect that risk pool has on the size of the premium, it would probably not be advantageous to attempt to broker insurance for medical students as a group separate from other students.
4. Medical schools should have clear policies regarding the confidentiality of mental health service records for medical students, making any necessary distinction between confidentiality when evaluation and/or treatment is administratively mandated. It is also recommended that school have guidelines regarding the utilization of mental health professionals and/or records of assessment and treatment by mental health professionals in proceedings regarding student advancement and dismissal.
5. All medical schools should publish and regularly update for their students a list of available mental health assessment and counseling services, means of access, and cost to the student.
6. All medical schools should establish written policies regarding institutional response to known or suspected chemical dependency in students, including definition of what constitutes impairment. Schools are also encouraged to develop programs that will identify and assist impaired students.
7. Medical school should have written policies about availability and guidelines for medical leave of absence for medical students.
8. All students should be required to have a complete history and physical examination after admission is assured and before matriculation to medical school and this should be reported to the school. Admission to medical school should not be dependent on the results of this history and physical examination. Medical schools are encouraged to develop a program to identify students at high risk for treatable conditions (e.g., hypertension, diabetes, hypercholesterolemia), and refer them to appropriate services.
9. Pre-matriculation and annual testing for tuberculosis should be required at all medical schools.
10. All medical schools should require that all students present proof of immunity to rubeola, mumps, rubella and polio, consistent with current recommendations of the Centers for Disease Control. Students should also have diphtheria-tetanus boosters in accordance with CDC guidelines.

11. In accordance with CDC guidelines, all medical students should be immunized against hepatitis B virus as part of their preparation for the practice of medicine. Students should also provide serologic proof of immunity after they have been immunized against hepatitis B virus. Medical schools should not be required to pay the cost of immunization, but are encouraged to do whatever they can to make the vaccine available to students at the lowest possible cost.

12. Medical schools should require documentation that visiting students meet the same health examination and immunization requirements as regularly enrolled medical students.

13. Each medical school should develop a centralized system for monitoring health and immunization status of medical students which assures maintenance of confidentiality of the system.

14. All medical schools should have a written policy regarding infection with HIV.

15. Medical schools should implement effective instruction in precautionary and infection control measures prior to students' first contact with patients.

Guidelines for the Development of Chemical Impairment Policies for Medical Schools

POSITION STATEMENT

The Association of American Medical Colleges and its Group on Student Affairs encourage medical schools to:

recognize that chemical dependency (including alcoholism) is a disease that affects all of society.

accept a responsibility to identify and to facilitate the potential for recovery for chemically impaired students, housestaff, faculty, and other employees and their immediate families toward recovery.

accept a responsibility to create a supportive environment for students, housestaff, faculty, and other employees in their recovery from co-dependent relationships with chemically impaired individuals.

advocate referral of chemically impaired students, housestaff, faculty, and non-physician employees to appropriate evaluation and treatment programs.

cooperate with state licensing boards wherever public safety may be endangered by impaired students, housestaff, or faculty.

accept responsibility to provide professional education concerning chemical dependency.

participate in public education and prevention programs concerning chemical dependency diseases.

discourage alcohol promotion and use on campus.

develop and disseminate policies which address illicit drug use by students, housestaff, faculty, and staff.

develop and promote wellness programs for students, housestaff, employees, faculty, and staff.

GENERAL GOALS FOR CHEMICAL IMPAIRMENT PROGRAMS IN MEDICAL SCHOOLS

1. Protect patients and others from harm that impaired students, housestaff, faculty, and other employees may cause.
2. Provide a compassionate environment for chemically impaired or co-dependent students, housestaff, faculty, and other employees and their immediate families.
3. Provide assistance in a way that protects the rights of the impaired individual.
4. Afford recovering students who are not legally restricted the opportunity to continue their medical education without stigma or penalty.
5. Afford recovering faculty and other employees who are not legally restricted the opportunity to continue their careers without stigma or penalty.

6. Encourage the development of education programs which address the spectrum of issues relevant to chemical dependency and thereby engender the possibility of better understanding chemical dependency within the university community.

B

**REPORT
GEA STEERING COMMITTEE
MAY 15-16, 1990**

HUMANE APPROACH TO MEDICAL EDUCATION

Following is preliminary only, brought for discussion to initiate process of setting priorities and consideration of a plan of action. No item which follows should be accepted as anyone's fixed opinion. Exaggerated statements are made for emphasis, there being a full range of sincerity of problems.

CHARGE

- "Develop plan for enhancing humane approach to Medical Education"
(GEA Assignments following January Steering Committee)
- "Develop ideas and recommendations for creating a more human approach to Medical Education"
(Dr. Berg, letter, 2/5/90)
- "Create a list of priority issues for GEA to consider"
(Minutes of 1/11-12 Steering Committee Meeting)
- "Identifying Critical Issues and Priorities in Medical Education" and
"Develop ideas and recommendations for creating a more humane approach to Medical Education"
(3/90 Correspondent)

STATEMENT OF PROBLEM

Medical Students are subjected to an experience in school which does not allow them to grow personally, expand their horizons, and which forces them to lose their idealism and replace it with cynicism, narrowness, and selfishness, and perhaps greed.

Physicians who are products of today's education are generally highly scientifically knowledgeable and competent but are weak in the area of meeting the personal needs of patients. They are ill prepared to enter the private sector of the practice of medicine nor are they knowledgeable about the expectations that the public has of them.

"The experience that may produce a narrow, inhumane physician comes not from the premedical years but from the Medical School itself" (Anonymous, 1931 Graduate writing in A.E.D. Publication)

DEFINITIONS

Characteristics of Humaneness--Kindness, tenderness, mercifulness, considerateness, sympathy, benevolence, individuality, creativity, originality, warm, gentle.

Dehumanize--Make more Machine-like; Deny an individual to have or to develop the characteristics of Humaneness; not allow an individual, because of a power position, to possess the characteristics of Humaneness.

No Physician or Teacher believes themselves to be inhumane or non-caring. This is a definite problem of self-awareness.

All Physicians and Teachers are serious, dedicated, and believe they are doing the correct thing.

Is medical school a dehumanizing experience for the students? What characterizes the qualities of the Medical Student Experience?

Overload

Content

Emphasis placed on the scientific imperative, knowledge above all else.

Emphasis placed on the recognition of abnormal rather than a change in or variance of the normal resulting in limited approach to a particular "State", "System" or "Condition."

Emphasis on "Knowing vs. Caring"

Emphasis on "Science vs. Art"

Contact

Demands of curriculum are "Machine-Like"

No time given to allow for originality or creativity
(Compare Graduate Ph.D. with Medical Program)

Isolation of medical students from formative social and cultural environments leading to stunted personal growth in a profession that should require personal growth.

Nonacceptance of change by those in charge of Medical Education
(administrators, faculty, practicing physicians, medical students, hospitals, government officials, etc.)

Cultural evolution deemphasizes the old values of the Doctor
Patient relationship

Conflict of Internal Values within the profession (Teachers vs. practitioners; primary care vs. super specialties, etc.)

Unwarranted pressure on student because "I went through it"

The Hazing introduction to the profession

Knowledge and Science is king, as it expands, less and less time available for humaneness and understanding

Sexism

Racism

Put-Down method of teaching

Unnecessary competitiveness exists in curriculum (residency success)

Non-preparation of teachers

No formal preparation for teaching, Teachers are not really "teachers"

Assumed that preparation for teaching is not necessary

Failure to appreciate educational experiments and publications

Those who do the most teaching tend to be the least experienced (Residents, Young Faculty, Graduate Students)

"see one, do one, teach one" philosophy

Scientific imperative does not allow reward for teaching

Continuing use and expansion of techniques which once were effective.

Continual belief in passive learning

Goal of the Educational process is not explicit or agreed upon

Goals of Basic Science are not well stated.

Clinical Application vs. "real science"

Teaching takes place in a non-real world

Failure to reward teaching

The summated expectations of all teachers is excessive.

Individual teachers seldom accept this perspective.

There is little recognition, tolerance, or response to variations in individual learning styles.

Allowance of adversarial relationship develops. (Physicians and nurses do not support students, teachers accuse students of disinterest and not studying when students can't meet expectations.)

Workaholic aggressive attitude standard for physicians

Evaluation

Scientific Imperative

NBME--related to resistance to change--drives evaluation, and therefore drives the curriculum, excessively emphasizes the scientific imperative in Part I style, pass level, etc.

Non-standardized inconsistent evaluations depending on the continuing rotation of teachers

Clinical competence not well defined

Resistance to using judgment

SOLUTIONS

Reduce Overload of content

Reduce Overload of scheduling

Introduce programs to help students "understand people"

Give time and assistance to personal development

Continue the humanities of undergraduate education into the medical school arena

Hire Teachers

Reward Teachers

Require faculty development in teaching

Change to Active Learning Environment (e.g. PBL)

Change to a real world learning setting (ambulatory care, rural clinic, office setting, etc.)

Change the Licensure Examination System

Introduce Science of teaching into curriculum--may be useful for patient education as well.

SETTING PRIORITIES

Requires an understanding of GEA, its position, and the processes open to it to effect change.

Not a recommending body to any authority. Has no direct reporting line to higher(?) decision making bodies

Can pass advisory motions--unlikely to be effective with controversial issues

Can ask to testify before authoritative bodies--unlikely to be effective on issues of concern here.

Can join with other groups to develop an overwhelming consensus to present to authoritative bodies--most difficult

Distribute information to the individual members; (talk among ourselves)--effective at times

Plan meetings--probably most effective

Problem--Meetings tend to present trendy issues and are usually one sided

Debate has not been characteristic of meetings (NBME, PBL)

SUGGESTION

Need to plan a four hour (with a break) meeting at the national convention to introduce all sides of the issue of whether or not, and if so, how, medical education is a dehumanizing experience.

In the past few years a number of major changes have been agreed to that will influence medical licensure examinations of the future. Among these are:

1. Adoption of a single path to licensure, the United States Medical Licensing Examination.
2. Development of new examination blueprints (Comp I and Comp II) which will increase the number of integration and application items on the examinations and will decrease the number of items sampling traditional disciplinary domains.
3. Further separation of NBME Subject Test and Licensing Test development, scoring and feedback procedures to better accommodate the distinct functions these tests were designed to serve.
4. A decision has been made to no longer report discipline scores to students who take the NBME licensure test since the number of items covering each discipline has been decreased to the point where discipline scores would not provide reproducible estimates of discipline competence.

The AAMC Group on Educational Affairs (GEA) recommends one additional change in NBME score reporting practices. The GEA believes that NBME licensing examination results should be reported strictly on a pass-fail basis. That is, the student no longer receive a numerical score. Rather, the examinee would only be informed that he/she had passed or had not passed this component of the licensure examination.

The GEA Steering Committee offers the following points in support of this recommendation.

1. All licensure decisions are ultimately binary. The individual is either judged sufficiently competent to warrant licensure or is judged not to merit licensure until competence is increased. Reporting results as pass or fail is consistent with the inherent nature of the decision to be made.
2. Residency program directors currently use NBME Part I and/or Part II scores for residency selection purposes. Items designed for a licensure examination and those designed for selection should have different characteristics. The licensure examination should establish basic competence to practice without much regard for the performance of other examinees. The selection examination is designed to produce a large range of scores so that the most proficient examinees can be identified. This type of examination includes items from a broad spectrum of difficulty levels. Reporting NBME examination performance as strictly pass/fail will decrease alternate uses such as selecting residents and will allow development of a pure licensure examination.
3. Pass/Fail reporting would also mean that medical schools and the LCME have access only to information regarding the percentage of students passing NBME licensure examinations. Mean class scores would not be available. This change would eliminate the problem of over-interpreting differences in average class performance (changes from year to year or difference from school to school) that are not truly reflective of real differences in competence or achievement.